Evaluation of Rediscover the Joy of Holistic General Practice Programme

Scottish Rural Medicine Collaborative/ NHS Highland study on behalf of;

Scottish Government Primary Care Division

NHS Highland

NHS Orkney

NHS Shetland

NHS Western Isles

Introduction and Summary of Key Points

This evaluation has been prepared by the Scottish Rural Medicine Collaborative for organisations involved in the support and operation of the Joy programme; it is sponsored by NHS Highland subject to copyright, and is on behalf of;

Scottish Government Primary Care Division
NHS Highland
NHS Orkney
NHS Shetland
NHS Western Isles
The Joy Team

Rediscover the Joy (RTJ) is a programme, launched in January 2019, to support primary care in the Highlands and Islands, providing GP cover for practices, using flexible GP work placements, to places where the continuity of care has been difficult to achieve due to a shortage of available GPs.
The programme was created as a collaboration between the 4 northern health boards providing support to rural and remote areas.

RTJ had the following objectives;

Objectives

- Address the need for GPs in rural areas where recruitment was difficult.
- To use clearly defined values and a strong quality improvement ethos.
- Use part-time GP contracts allowing them to continue living in their normal residence and travel to undertake rural work in blocks of 1-4 weeks.
- To target retiring GPs.
- Create a sense of team and support through recruitment, regular VC & WhatsApp contact.
- Targeting PHEC training and support.
- To test whether the successful scheme of recruitment to the outer isles of Orkney, operating since 2010 could be replicated at scale.

Original values

Taken from NHS Scotland values;

- Care and compassion
- Dignity and respect
- Openness, honesty and responsibility
- Quality and teamwork

Evaluation Report

This evaluation report of the programme is to allow reflection and provide a resource to help the Joy management team further develop operational systems and strategy. The report contains;

Recommendations (45)
An analysis of success factors (29)
An analysis of Key learning points (30)
A detailed evidence data base
Sections suggesting further development work
References to related projects and papers

Full contents page is on Page 7

Highlights

Was the project a success?
The RTJ programme has been an unequivocal success and met all of the original objectives.

In what areas was it successful?
It has been most successful in testing the model at a regional Highlands and Islands scale.

Key successes have been;

- Recruitment has been an area of particular success with 4 health boards working together on complex detail to establish an agreed contract that was attractive to potential Joy GPs. Over 45 GPs have been or are in the process of being recruited.
- By the end of March 2020, 138 weeks of quality GP cover has been provided to 21 H&I practices, the equivalent to providing 3.5 full time GPs.
- Improving knowledge on specific challenges being faced by some practices and enabling solutions to be developed.
- Joy GPs do feel that they have `Rediscovered the Joy'. There have also been a few substantive post recruitments as a result and the scheme has helped retain many GPs who would have otherwise retired and been lost to the NHS.
- The management team have worked in an innovative and agile way helping to create a positive `can do' team feel.
- There has been a psychological uplift from being able to recruit GPs where many felt that this would not be possible.

How do we improve the current model?
(See learning points and recommendations sections).

Effective Induction

- Greater consistency on induction support for GPs not familiar with Scotland and better more standardised induction guides to be available in all practices using the scheme.
- Creation of a help video for professionals new to Scottish primary care IT systems.

Effective Clinical Governance

- The Clinical Leads for The Joy, AMDs and the Joy GP Clinical Lead need to further discuss and review how The Joy is leading to continuous clinical improvement.
- An expanded programme with MDT professions should consider a more formal governance structure to report and oversee Clinical Governance and initiatives.
- The GP VC needs to be developed to provide wider Continuous Professional Development (CPD) opportunities for Joy GPs.
- Future evaluation of the Joy programme should consider the social and clinical outcomes of the scheme for patients and the public health of communities.

Effective Management

- More effective communication and dialogue is required between the Joy management team, the wider Joy group and GP Support Team. Creative ways need to be considered to keep team buy in and a sense of being in a special cohort. Regular cascades of information (eg a regular newsletter e-mail) should keep stakeholders up to date on where the project is, and where it is going.
- The Joy management team need to make sure they spend time listening and looking at issues and ideas raised by staff supporting the Joy and Joy GPs.
- The risk register needs to be regularly reviewed and business continuity risks considered.

Development Work – Future Models
(See recommendations section)

The evaluation was also asked to consider future expansions of the programme covering a wider geography and other primary care multidisciplinary team (MDT) professions. Recommendations include;

If the programme expands, clarity is necessary on what professions will be included and the geographical coverage.

Joy management will need to review;

- Management structure
- Management delegation arrangements
- Professional representation and support for each profession
- Management skill sets required for an expansion

A more formalised management structure needs to include;

- More formal and fixed management meeting and cascade communication arrangements.
- An organisational diagram indicating managerial and professional leadership arrangements.
- More formalised clinical governance forums and reporting.
- Adequate admin support for the Joy management team.

- A wider marketing approach needs to be considered in discussion with stakeholders, especially if the project is to be extended to Multi-Disciplinary Team (MDT) professions.
- H&I primary care IT systems appear outdated compared to the rest of the UK. Joy management and local health boards need to consider raising the profile of this issue through the necessary NHS Scotland IT user forums and procurement channels
- Longer term funding arrangements will help keep the programme stable and allow more confident development of strategy and planning of RTJ initiatives.
- Practices are consulted on future Joy initiatives and their opinions, along with those of patients, are considered.
- The Joy team consider what they can do to provide solutions for NHS Scotland in a world having to live with Covid19.

Other key learning points from the evaluation

- There has been improving knowledge of operational or clinical issues in primary care. There has been an evolution in thought about finding solutions for some of the problems faced in provision in primary care services in some rural areas.

- 4 health boards worked very well together successfully to create an effective contract offer for Joy GPs with standardised terms and conditions that was both affordable and attractive enough.

- Although Scottish Government funding was a critical success factor, annual funding arrangements are problematic.

- Recruiting GPs directly to health boards takes time; a key delay is getting GPs from outside Scotland onto the Scottish GP Performers list.

- Welcome, handover and induction were recognised as a challenge in some practices early on. Key issues were identified as;

    - GPs were not given time or support to adjust or orientate in some practices. There was sometimes an expectation problem whereby practices and GPs took time to adjust.
    - Induction packs were poor in some places or not up to date.
    - Scottish primary care IT systems are different to England, older and less well integrated with other systems than other parts of the UK which meant that new Joy GPs took more time, initially, to see patients. However many GPs felt that they had more time available in rural practices to see and connect with the patients.

- Take up of Joy GPs is much higher in the Islands rather than the Highlands and some practices use it a lot more than others.

- Joy GP satisfaction is high, confirming that they do gain a valuable and refreshing experience; many have stayed out of retirement to undertake Joy work.
- Joy GPs did have concerns about raising quality issues with practices and sometimes lacked confidence in this area.

- The Joy management team has launched the programme, evaluated, evolved in response to challenges and improved practice. An energetic and agile approach was adopted from the very beginning enabling quicker responses and a willing ness to adapt.

- There are limits to the evaluation, patients and practices voices need to be heard and further work needs to consider how clinical outcomes for patients and public health for communities has changed.

[1]

[1] Picture Credits, Cover Loch Ness, May 2019 PIO, Page 5 Promotional Photograph for Wanderers and Adventurers promotion (Pexels) 2019

Contents

About the evaluation

Rediscover the Joy was a new project in primary care in the Highlands and Islands to recruit GPs on flexible contracts to undertake work placements at rural general practices where GP recruitment and providing regular GP cover has become a challenge.

Only a limited amount of evidence and experience was available as to how successful such programme could be so it set out to trial the idea using the experience of a smaller scale model in Orkney using NHS Improvement `test of change'[2] methodology.

An evaluation would need to assess if the test of change was successful and whether it led to improvements and benefits. By providing a cohort of (Joy) GPs, employed on flexible contracts, demand for placements - from GMS practices and health boards - could be assessed and operational lessons learned as part of any scale up to a larger or wider model[3].

The evaluation was expected to clarify the lessons learned from the set-up through the first cycle of Joy GP recruitment and placement. Assuming the scheme was to continue, the evaluation was also expected to make recommendations supporting future strategy and good practice.

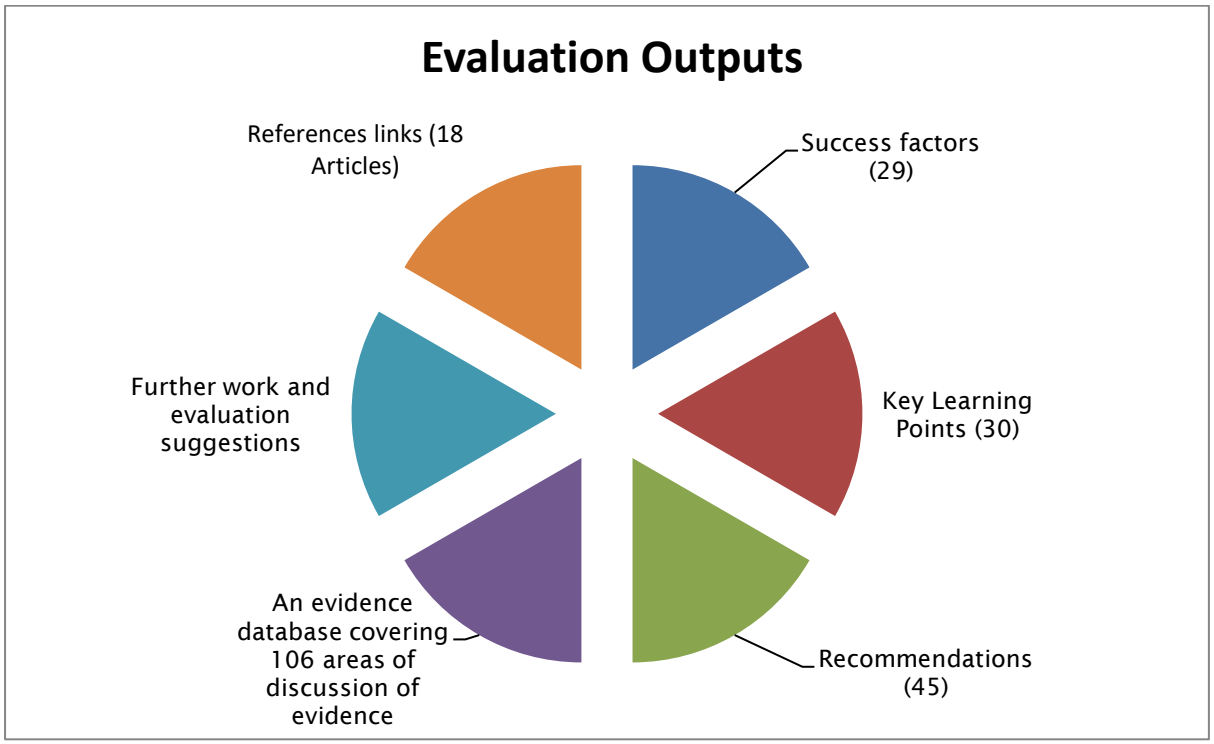
Scope

- The Joy project has been evaluated for the initial period of developing concept in the autumn of 2018 until a first cycle of operation had been completed in March 2020.
- The evaluation covers a scheme principally including the 4 health board areas in the Highlands and Islands, a substantially remote and rural area; it did not cover the urban area of Inverness.
- The evaluation covers only the GP service – engagement of Joy GPs on temporary flexible contracts, it did not look in detail at other primary care professions.
- The report is written bearing in mind that the scheme may expand to other geographical areas and include other primary care multi-disciplinary team (MDT) professions in future.

[2] NHS Improvement PDSA cycles and the model for improvement
https://improvement.nhs.uk/documents/2142/plan-do-study-act.pdf
[3] Larger, meaning covering larger geographical areas of Scotland, wider meaning `encompassing more primary care professions'.

Evaluation Outputs

This report contains the following main sections;



Background to the Joy Project

The project has been developed by key medical directors, primary care managers and human resources staff at 4 Scottish health boards (Shetland, Orkney, Western Isles and Highland) from 2018. The Joy team are closely supported by the Scottish Rural Medicine Collaborative (SRMC) programme team who have worked with wider initiatives to recruit and retain GPs in rural areas.

The Joy arose as a response to challenges in recruiting to regular, substantive, GP vacancies in rural areas across Scotland, which has been particularly serious for the 4 Highlands and Islands health board areas. The Joy project team, a collaboration of staff between the 4 health boards through the programme, sought, during 2019/20, to recruit GPs, for short term placements of 12, 16 or more weeks to general practices in rural areas. The main aim being to help practices in those areas to get better quality, experienced GP cover providing continuity and reducing the issues associated from long term dependence on locum doctors. For those interested in becoming a Joy GP, it could also provide fresh opportunities for them to reconnect with more rewarding, hands on and holistic experience of rural medicine and life in the Highlands & Islands.

The shortage of GPs for substantive posts in the Highlands and Islands is taken as a given, it has been referenced in many reports, most recently the Audit Scotland NHS Workforce Planning – part 2 Report (Aug 2019)[4] and, Shaping the Future Together, Scottish Government Report of the Remote and Rural General Practice Working Group (Jan 2020)[5] as well as anecdotal evidence on the ground (see AMDs presentation on the Islands recruitment challenges from September 2018 (see Appendix H.). The evaluation has been undertaken by the Scottish Rural Medicine Collaborative (SRMC), a Scottish Government funded organisation providing support to GP recruitment and retention in rural areas https://www.srmc.scot.nhs.uk/ . It is also sponsored by NHS Highland R&D department.

The Joy commenced advertising for interested GPs, through the BMJ (British Medical Journal), in January 2019 followed by a recruitment and selection event held in Strathpeffer in March. During this time contract details, terms and conditions were being agreed between the 4 health boards and GPs were gradually appointed from May with placement opportunities advertised to practices at the same time. The first Joy GPs took up placements in July. An initial evaluation of this first recruitment phase was made at this time (phase 1a evaluation, see Appendix A). Since July 2019, the number of

[4] https://www.audit-scotland.gov.uk/report/nhs-workforce-planning-part-2 (see Reference section 18)
[5] https://www.gov.scot/publications/shaping-future-together-report-remote-rural-general-practice-working-group/(see Reference section 12.)
Also of note is an internal SRMC `Towards a Sustainable GP Workforce for Scotland ' (Watson, Wooley, Watts) for consideration for release in 2020 (see References section).

placements available has gradually increased and takes place now in all 4 health board areas. Generally the scheme has been considered a success during the period. Discussions are currently underway on how the scheme could be rolled out to other geographical areas or include more primary healthcare professions; so far it has related only to GPs. It should be reinforced that the scheme is intended to support remote and rural practices and has not been designed specifically for urban areas. Intentionally, the scheme also did not cover the greater urban area of Inverness - population c70, 000 with 10 GP practices (see data in vdzl·yűńűl·ůńØŜ analysis section QA13) – and consequently the evaluation cannot make any comment about how well it could work in urban areas. Operation of the programme highlighted issues, challenges and opportunities which this report considers in more detail.

Overview of Methodology

1) Phase 1a Evaluation (Recruitment Phase)

See appendix A, the Joy management team asked for the SRMC to help with an evaluation of the project in May 2019 to report on the learning points from the first recruitment phase of the Joy (1a) and inform future developments of the programme. It was later agreed that the evaluation would continue into a second phase (1b) covering the initial operation of the scheme and how it worked in rural areas planning to report in spring 2020. The study has since been sponsored by NHS Highland R&D and the Principal Investigation Officer (PIO) was appointed by SRMC having good knowledge and experience of primary care operations in remote and rural areas (see appendix E). The report interviewed key staff involved (18) and makes a number of recommendations and observations relevant, if it were to develop. The phase 1a report was completed and circulated in June 2019.

2) Information Gathering – working with Shetland HrHub, Joy VCs

The PIO worked alongside the HrHub operations team, on location in Shetland, between May and August 2019 to help understand issues and have a vantage point on how solutions were being developed. The PIO also organised and sat in on regular Joy GP online VCs to understand issues and learning points, being raised by Joy GPs and Associate Medical Directors (AMDs). There were other general interviews of staff at this time that had not been able to be included in the phase 1a evaluation interviewing.

3) Initial Interviews

It was agreed to conduct initial interviews, asking only general questions, before a considered research approach could be developed and a number were also carried out with new Joy GPs as they arrived in post. Questions were very general - `why were you attracted to this post?', `what are your first impressions?', `what do you think the challenges are/ will be?' and `are you happy to be re interviewed at a later date?'

4) Research Planning

The research plan was developed during late 2019 for an evaluation of phase 1b to report around April 2020, after 8 or 9 months of Joy scheme operation. Two aspects were agreed;

a) The Joy was a running operation and would need some further recommendations on how to continue to evaluate.
b) The Joy operation had already commenced without any planned evaluation, this meant the project would have to be evaluated `on the hoof' as action learning and it would be difficult to assess pre identified performance markers and compare them to actual performance to planned targets. This made it a little bit more challenging when following, the NHS Improvement - Plan, Do, See, Act (PDSA) - test of change methodology.

As the programme developed, new issues and opportunities have arisen and the research has been expanded to include them particularly with relevance to likely aspirations for the programme in future.

An `action learning' approach was agreed and the report would contain;

Examination of Issues arising with themed learning points and key findings.
Qualitative assessment of whether good practice had been used.
vdzl·yűλűl·űλØŜ analysis of measurable data.
A simple literature search.
A summary with recommendations.

5) Official Research Sponsorship

Support and sponsorship for the project has been provided by NHS Highland research and development team and recorded on the IRAS UK research system (Ref. 270115). Approval for the research was confirmed by NHS Research Scotland (NRS) in March 2020 subject, to the necessary research compliance.

6) Formal interview setting – Interviews, ljdzl·yűλűl·űλØŜ analysis, literature search

Consideration was given to interview setting and agreed that up to a key 20 individuals would be interviewed using a devised standard bank of questions (see appendix B), the choice, adapted to role, of approximately 30 questions each, though in later interviews with Joy management staff more strategic questions were added. Certain roles were selected to ensure a balance of professions and geographical areas. Participants were given advanced notice of the questions along with project information and research consent forms. Answers were taken down in, mostly, telephone interviews by the PIO but, a follow up check was also done with each participant to see that they were happy with what had been recorded on their behalf.

vdzl·yűλűl·űλØŜ analysis was organised using 4 different data sets of information – placement history and location, placement vacancies advertised, statistics on Joy GP recruitment and origin. A literature search was undertaken - with the help of the UHI Centre for Health Science library in Inverness - to look at any other relevant UK or other initiatives (see Resources section).

7) Collation of results and thematic analysis

For qualitative analysis, responses from participant interviews were collated into the evidence grid (see Evidence section) as answers to good practice questions and responses to issues that had been raised by Joy team members since the start of the project. This enabled easy comparison and identification of key themes. Later interview questions were added to cover

newer issues arising or areas where there had been little comment. The interviews also raised additional themes for analysis and discussion.

Good practice points in the form of general evaluation questions (GE) were established by the PIO using their own experience as a health quality systems surveyor, broadly using CHKS[6]* Health and Care standard headings also broadly, linking to EFQM (European Framework of Quality Management)[7] categories (see section on Further Evaluation for discussion on quality systems).

Issues analysis looked at issues raised about the operation of the scheme at different times by members of the wider Joy team, management, health board staff, the PIO and Joy GPs. Some issues became less relevant towards the end of the evaluation period but newer ones arose as well.

8) Management Interviews

Interviews with Joy management staff were held at the end of the interviews whereby more general questions could be asked in light of new information and the likely conclusions of the report. The question bank had been added to several times by this stage.

9) Establishing conclusions

Conclusions were drawn on each good practice and issue point with first, a comment on the evidence that had been presented and also, data and knowledge of events. The PIO added recommendations developed from comments on the themes many of which were discussed with Joy management staff. Recommendations were therefore linked to discussions on the evidence provided and cross referenced to related issues and vdzl·yúλúl·úλØŜ analysis (see Evidence section). Learning points and success factors were also identified from the discussion sections and collated into separate lists also linked to recommendations.

10) Challenges to the evaluation reporting process

a) The project had started before evaluation had been organised. However, in principle the general sequence for the Joy from inception – funding –recruitment – deployment – evaluation could be followed to reveal lessons learned, a simpler approach and in line with the `See' part of test of change methodology.
b) The interviews conducted (18) are of a sample size taken from those directly involved in running the Joy or Joy GPs themselves. Though a number system is used to show comments made and anonymised, this will probably not be perfect.
c) In late March 2020, as the final interviews were being organised, Covid19 lockdown and priority reallocation of work within the NHS came into place affecting the PIO and most other staff involved. This delayed completion of the evaluation and deferred a wider

[6] *CHKS (Caspe Healthcare Knowledge Systems), originally part of the Kings Fund, have developed an accredited health quality assessment system covering NHS benchmarking, leadership and management systems https://www.chks.co.uk/CHKS-Standards

[7] https://www.efqm.org/

ambition to interview staff from GP practices using the Joy which has not been undertaken.

d) The evaluation did not look at clinical outcomes for patients or public health for the remote and rural communities. Longer term these will be the best indicators of how successful the joy programme has been, recommendations have been made for further work.

e) Analysis of the number of Joy GPs available for work has also been difficult as there was no insistence that the employment contract had to be completed or signed by GPs who had completed pre-employment processing but had not made themselves available for placements. In July 2019 33 GPs were available but, not all were contracted to work at that point. Since then numbers have varied with some new GPs added (c9) but how many of the original 33 are still available for work is not known. This issue is being considered by the Joy Hr team. Estimated that by May 2020 46 Joy GPs had been recruited. Possibly an issue for further work.

f) Financial figures have not been included as securing them after the Covid lockdown period would delay the final report so cost analysis and use of efficiency ratios has not been undertaken for this version. Unfortunately this makes it difficult to establish a cost/ benefit ratio for the scheme.

g) Although it is envisaged that recommendations, identification of learning points and success factors should be useful to an expanded Joy project, the shape of which is not fully known at the time of writing the report. The Wanderers and Adventurers initiative brought forward from October 2019, has recruited GPs to work in a general practice support role but falling after the main evaluation period it has not been included. Wider considerations are being discussed currently (eg expansion of the Joy into other rural areas of Scotland – since March 2020 the Joy now is open to practices from Ayrshire – but consideration is being given to expanding to rural and urban areas as well as including other multidisciplinary team professionals (eg Nurses, ANP's, pharmacists etc.). There are limitations on what can be drawn from the study as, in particular, it does not consider the opportunity cost of the scheme or the differences for urban areas, which may be significant or, for other MDT professions which will have quite different requirements in terms of professional support and ways of recruitment.

h) Unfortunately the evaluation completed as the Covid 19 lockdown commenced in March 2020 and covering the impact has not been part of the review however see Further work section (FW24).

11) Draft report and peer group review

A summary report was made available to Joy management team members in June 2020 and was presented to the SRMC Programme board on 1st July 2020.

The final approved report will be made available via the SRMC website.

The evaluation will undergo peer group review during 2020 with a final version planned.

Evidence

Good practice evidence
Issues evidence
Joy GPs evidence
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Good practice evidence

The following grid indicates the good practice points made, the test questions used and the results;

General Evaluation Questions					
Purpose - General Evaluation questions are to address general questions on leadership, effective management and governance. They were devised, bespoke, by the principal investigating officer (PIO) to test general governance and quality themes. Based originally on older HAQU (now CHKS), Health Information and Quality Authority selected standards on leadership and management but they are also loosely related to similar questions in ISO 9001 standards. The questions related to marketing are derived from the summary Principles of Marketing (Kotler, Armstrong et. Al, 2010).				*Learning Point – Makes an observation about learning that has arisen through the Joy operation.* *Critical or Key success factor – A fundamental factor that makes the joy successful. For a critical factor, take it away and the Joy will not or would have not worked. Key opportunities are potential future success factors.* *Recommendation – A suggested action(s) to improve the operation of the joy to achieve more benefits, reduce risks or develop strategy.*	See summaries of findings for success factors, learning points and recommendations in Evidence Section.
Reference No.	**General Theme/ Issue**	**Background & Question Rationale**	**How Tested in interview? (Question Ref.)**	**Relevant comments from Interview with participant ID and question reference no.**	**Conclusions/ Grouped Theme Discussion/ Cross Referencing**
Marketing Theme					
GE1	Effective Marketing	Could marketing and promotion of the scheme for recruitment purposes been better? Rationale To see how effective the	A1	*1031 A11 ..so, 2 aspects; 1) Joy Budget bought 2 x BMJ adverts - very effective with advice from BMJ themselves.* *1032 A11 Original BMJ advert was written with clinicians and it did its job if you look at the numbers of interested parties we have for both phase 1 =57 and phase 2 =48 of the Joy. We have good info from the BMJ on the number of hits etc. What we also*	*Evidence* *Consensus from project team is that marketing has been effective –* *a) Confirmed by Joy GP comments* *b) Confirmed by project team that marketing was successful (1034, 2019 campaign attracted 56 expressions of*

		marketing efforts have been to recruit GPs and raise the scheme profile. Efforts have included a BMJ advert, SRMC Website, v word of mouth, stands at key GP conferences.		*know is that the advert for Phase 2 was different to that for Phase 1 to attract individuals who were GMC registered and able to work in the UK and also conscious of the diversity mix We were always looking at the number of hooks the advert would produce, Professions. A lot of GPs interested would be of a particular age group and we knew they would be looking at the BMJ. f the Joy rolls out into other professions MDT we will have to have a look at the whole recruitment, marketing and communications strategy and ask the question `How do you recruit for each professional group?' It may be very different to the GPs.* *1034 A1 Marketing Effective - 2019 campaign attracted 56 expressions of interest, they have picked up 9 more since and 2020 campaign has so far had 10 applications and 10 more expressions of interest. BMJ advert has been most effective but useful contributions from SRMC website, hub staff chatting and answering queries and CS attendance at conferences.* *1036 A1 Used the BMJ on the advice of CS, was expensive but it was successful. If more time could have looked at head-hunters or marketeers but in the end we got a good response so would there have been any difference?* *1037 A1 Marketing was successful and done well, many others have commented. Picture and photo were really good and it was a good collaboration. Result exceeded expectations. As a traditionalist preferred the BMJ approach, advertising more on social media would have been opportunistic. Knew that the sort of people they were looking for would get the BMJ. Probably a bit of availability bias in the choice.* *1039/ 1040 A1 Marketing good and difficult to criticise really. BMJ advert had a good flavour and caught people's attention.* *1041 A1Marketing has probably been successful.* *1043 A1 From my point of view all happened very quickly, short gap between application and recruitment weekend at Strathpeffer. HrHub were brilliant at keeping in touch, if they didn't know the answer, they would find it. The time at Strathpeffer was really good. 1031 put across the idea that we*	*interest; they have picked up 9 more since).Phase 2 (2020) 48 expressions of interest.* *c) This is also seen as a critical success factor* *PIO- number of expressions of interest for the Joy GP jobs were very good (see phase 1a evaluation report, appendix A) and beyond what all- but one- of the team expected. This is also a critical success factor as without GPs being attracted by the marketing there would have been no recruitment possible.* *GPs recruited have been those typically, over 50 towards the end of their career keen on stable, relaxing or refresh work. Good for some of the work that is required but ` the sort of doctors, with traditional approach, that would read the BMJ' (1037). Not convinced that, in future, we will be using all the available marketing channels effectively to recruit younger GPs or GPs willing to take on more of a primary care development challenge. See also 1032 point that approach will be have to be reviewed thoroughly for MDT professions (also see discussion on `Wanderers and Adventurers scheme issue # 23 and diversity, issue #51).* *Recommendation (R1) – A wider marketing approach needs to be considered in discussion with stakeholders, especially if the project is to be extended to Multi-Disciplinary Team (MDT) professions.*

				were in a team very clearly and after a little while you did feel that you were part of a team. *1043 A7 A friend who had seen the BMJ advert, but I had already applied for locum work in Shetland so it was very convenient.* *1043 A9 Retiring from surgery after 35 years, I wasn't necessarily ready to give up work but I did need a different challenge, looked at Australia/ New Zealand, but very money culture which is different. Liked the idea of Shetland and the isles, ideal opportunity.* *1044 A1 BMJ advert hooked me straight away, timing for me was perfect, wanted something different, really appealing. My only job application since retiring in late 2018. Recruitment weekend was great.* *1045 A1 Did the job for me. Applied for a job I wasn't even looking for! Thought about doing locum work in Scotland a long time ago but put it to one side as too difficult for lots of reasons but then the advert was there. Key phrase was `One last challenge' thought it was now or never.*	
GE5	Effective Marketing	Marketing Budget - Has it been adequate? <u>Rationale</u> Have we been spending enough on marketing? Should we have accelerated it?	A2	*1030 A2 Major campaign being prepared on GP recruitment led by SG but important that there will be a Joy element to it and a holistic approach. Marketing being developed but programme will be delayed due to COVID 19 situation.* *1031 A2 Quite happy with where it sits, would struggle with capacity if profile were raised any more at the moment. High profile with Scottish Government with 2nd phase underway and first year evaluation. Profile good across the primary care leads for 14 boards and there is awareness of the scheme. Currently operates with 4 health boards and SRMC agreed that we would expand it out across Scotland comfortable with that, not all 14 yet. We are evolving gradually using the enthusiasm of individuals, boards will have the choice to opt in or out, their choice. With practices, profile is high with island board, with Highland more sporadic. There has been lots of awareness raising, eg LMC. Need to mature organically. Not enough (Joy) GPs recruited yet. Agreed that a better social media campaign next time around would be good, but would need to ensure that*	*PIO – The approach of using the BMJ to advertise plus attendance at GP and primary care events, by the Joy team, has been within resources though spend information not available. Per 1030 response likely that that a future joy arrangement will cover the whole of Scotland and may work in more urban areas so recruitment may happen on a national basis and be done as part of a national campaign by Scottish Government/ NSS. This means that the promotional effort will need to be looked at on this scale (also see issue #11 on promotional video).* *Recommendation (R2): New marketing and recruitment campaigns for an expanded Joy will probably be Scotland wide and need to be co-ordinated on a national basis rather than for 4 health*

				we have the capacity to manage the potential number of candidates.	*boards. When recruiting for a wider range of MDT professions, SRMC should seek to influence national marketing & recruitment strategy and also look to use a wider number of marketing channels in a planned way.*
GE5	Effective Marketing	Have we been spending enough on marketing? Should we have accelerated it?	A10	*1034 A10 Budget - Good enough, they knew from the first recruitment campaign that BMJ adverts were expensive and it has proven the best way to recruit even though an old fashioned medium.*	*PIO - consensus is that it has been adequate for the initial Joy scheme for 2019/20 campaigns, though not sure that there has been wider thinking other than using BMJ and promoting at GP events. However BMJ adverts have been successful though a little bit expensive (See R1, R2).Approach for MDT professions will need to consider a new strategy (see also R3 and information in appendix A and discussion on Joy GP promotional VCs issue # 11).*
GE6	Effective Marketing	Has there ever been a review of how the marketing has been done or the marketing budget? <u>Rationale</u> Test that the marketing mix and spend is getting reviewed and improved.	A11	*1031 A11 No, don't think so, 2 aspects; 1) Joy Budget bought 2 x BMJ adverts -very effective with advice from BMJ themselves. 2) SRMC Budget - (This is a separate issue, not directly related to the Joy - we need to think as SRMC how much time and effort we put into our conference attendances)- Conference attendance. Twitter campaign, also effective. Would be a good time to review. Also discussed upcoming SG promotional campaigns.* *1032 A11 Original BMJ advert was written with clinicians and it did its job if you look at the numbers of interested parties we have for both phase 1 =57 and phase 2 =48 of the Joy. We have good info from the BMJ on the number of hits etc. What we also know is that the advert for Phase 2 was different to that for Phase 1 to attract individuals who were GMC registered and able to work in the UK and also conscious of the diversity mix We were always looking at the number of hooks the advert would produce, Professions. A lot of GPs interested would be of a particular age group and we knew they would be looking at the BMJ. f the Joy rolls out into other professions MDT we will have to have a look at the whole recruitment, marketing and communications strategy and ask the question `How do you recruit for each professional group?' It may be very different to the GPs.*	*PIO – (See R1), review recommended.*

				1034 A11 2020 Campaign - BMJ advert agreed at team meeting in Edinburgh (Dec 2019), felt it was most effective/ sensible way to advertise as it attracted older GPs. They could have used more Videos and social media but Would it have recruited more GPs? 2019 campaign did well without. Also HrHub have no particular expertise with social media, only recently have a Facebook page and Twitter account. SRMC website useful and has brought in 3 or 4 applications. Marketing discussed at Edinburgh meeting with whole team.	
Recruitment and Induction Theme					
GE7	Effective Marketing/ Effective Recruitment	Have adequate numbers of Joy GPs been recruited in a timely fashion? <u>Rationale</u> Tests the original, current and possibly future expectations on what the scheme is capable of providing.	B1	*1034 B1 Recruitment - Long term process and in practice there has been a nice through flow. 1034 has recruited before in the academic world so expectations were quite correct. Long time line caused by a) Need often for a 3 month notice period b) PVGs c) Getting non Scottish GPs onto Scottish Performers list d) Reference chasing. Sometimes this is frustrating and Hub have to be patient. Generally though yes, we are getting a steady flow in good numbers.* *1036 B1 Yes, really lucky, 30 was a good number to start with as above expectations but not too little but not too many. Felt about right for a test of change, particularly on Hub capacity.* *1036 B4 Frustrations were not necessarily around recruitment, but long delays getting onto the Scottish GP Performers list and other delays around PVGs, occ. Health. Really time consuming and often cross border (Scotland/England), slow* *1037 B1 Could do with more (Joy GPs) now and there are often unfilled placement gaps, though probably recent Xmas cover not best example. Thought originally recruiting 33 GPs was fantastic, would have been happy with 12.Mass interviews at recruitment weekend was a good way to do it. There were delays getting people into post but mainly the length of time the admin processes take and probably an expectations problem at the time. Even though got some GPs in reasonable quickly.* *1041 B1 Enough GPs have been recruited for the WI, as far as he is aware, all practices that have asked for Joy GPs have been given. Did have his own expectations changed when he realised how long it took to recruit a Joy GP and the long lead times*	*<u>Evidence</u>* *Consensus is that there has been a `a nice through flow '(1034) not too little but not too many'.` Felt about right for a test of change, particularly on Hub capacity (1036)'. Important was the time taken to get applicants recruited with necessary legal and due diligence requirements and available for placements as soon as placements were available. A major block here has been referred to several times (1034) A long time line caused by a) There is a need often for a 3 month notice period b) PVGs c) Getting non Scottish GPs onto Scottish Performers list d) Reference chasing. Sometimes this is frustrating and Hub have to be patient.(1036) B4 Frustrations were not necessarily around recruitment, but long delays getting GPs onto the Scottish GP Performers list and other delays around PVGs, occ. health. Really time consuming and often cross border applications (Scotland/England), slow.* *PIO - Part of the original test of concept was `could enough GPs be recruited?' If so would the Joy recruitment and placement operation a) Have the capacity to manage the recruitment and placement process? or b) Be underutilised?*  *Consensus on responses suggests that a `useful' (subj.) number of GPs were recruited as part of the original campaign. The second issue was could Joy*

					GPs be put into placements quickly enough?, this required many things to be in place principally, employment contracts- with agreed terms and conditions - and available placements themselves. Clear that the delay in getting recruited GPs into work was a source of frustration at that time, but the frustration was probably the result of mis-matched expectations (for more detail about the initial recruitment see phase 1a evaluation report, appendix A). *Key learning point is that it takes time to get recruited GPs into post because;* *a) Robust recruitment process for applicants needs to be undertaken involving interview and selection.* *b) Need, often, for a 3 month notice period, very often, Joy GPs are selective about when they want to start work.* *c) PVGs are required.* *d) Getting non Scottish GPs onto Scottish Performers list is a slow process.* *e) Reference chasing takes time.* *This is also a critical success factor - without interested Joy GPs being recruited to be available on time, in sufficient numbers - but not too many at one time - with an acceptable level of employment due diligence - then the Joy scheme could not operate properly.* *Recommendation (R3): The first Joy recruitment campaign, following the date of the original BMJ advert in January 2019, to the first placement of Joy GPs in July 2019, took approximately 25 weeks. This time frame should be born in mind for a similar scheme or extension of the Joy to other geographical areas or*

					MDT professions.
GE8	Effective Marketing/ Recruitment and Induction/ Operation and management of the Joy	The idea of a Video made to help induct GPs with H&I IT - GP VC # 6 (26/9/2019) - Has anything been considered? <u>Rationale</u> This idea was suggested to Joy Management after a GP VC, but never taken up. Would this be a good idea and also how responsive is the Joy set up to considering new ideas? Also see issue #3, #22.	B3	*1031 B3 No, (idea) didn't surface. Real problem is we need to create a document of ideas and concepts. It would be excellent to go through all the old VC minutes and extract all the suggestions that were made and compile them into a document. We need to think about that.* *1031 iss2 The Scottish Primary Care IT system is horrendous compared to the English systems (apparently). I think this is an important point to highlight, but it is not an issue that The Joy can address. We are waiting for a new IT system and the procurement system has taken literally years and continues to drag o... It has been the continuous comments from the Joy GPs and the English GPs coming into INOC that has helped me realise how archaic our system (that we have got used to) is.* *1034 Heard of mentioned by (1048) originally, have an idea that CS knows more. Never saw anything.* *1034 B3 GP IT Induction Video - .was aware of the idea but thought that Ian Blair (IB) leading on it. 1034 thought that older GPs having trouble with Scottish systems, there have been no recent problems reported.* *1037 iss 2 In general NHS Scotland has many positives over England &Wales but IT is not one of them. E&W have had web-based clinical systems for about 10 years. We're still waiting on Scottish Gov't to tell us they're "fit for Scotland", and it's been "on the horizon" for many years. or example, NHS Shetland has been looking at trying to merge the IT of the mainland 2c practices (to provide clinical benefit to the patient, e.g. OOH), but it's hard to do because of the system – people from EMIS would physically have to visit Shetland to do it. If it were web-based, it could apparently have been done remotely.* *1039/1040 B3 Not aware of this but would be useful though complex to do as there are several systems being used.* *1041 B3 Good idea but not heard of this initiative before.* *1045 E9 We did discuss help video for EMIS on induction. Yes, there is not a complete feedback loop here to the Joy GPs, if you*	*<u>Evidence</u> Not many people have heard of the idea but Joy GPs feel that a support video makes good sense, particularly for when they first come to Scotland. There is quite a divergence of IT systems as – underlying low broadband capacity – Scottish primary care remains with older versions of key software (EMIS, Vision) and poor links with other systems (eg referrals, blood test results etc.) Idea has been recently referred to the Joy management team to reconsider (also see issue # 2 Joy GP Induction, #3 H&I Primary Care Systems, #22 Suggestion of a Help Video).* *Challenges of Scottish Primary care IT systems – This has turned out to be a key learning point, Joy GPs fresh in from other parts of the UK have had difficulty getting to grips with Scottish systems because they are 'klunky' and out of date. This point has not been raised by regular GPs presumably because they have grown used to working with an old system and may not be fully aware the greatly improved quality and functionality of what is available elsewhere (see comments 1031 & 1037). Joy GPs frustration comes through in the notes from earlier Joy GP VCs (July – Sept 2019).* *Recommendation (R4): A system needs to be developed to discuss and review ideas that surface. The Joy programme is in a position to break the mould and operate outside the normal NHS board structures and cultures, new ideas can be developed quickly and tested. This is a key opportunity.*

				raise an issue or an idea, you don't always get a response. In hospitals in England there is often the wall chart saying `You asked, we did' in relation to staff surveys/ patients etc.	*Recommendation (R4a): H&I primary care IT systems appear outdated compared to the rest of the UK. Joy management and local health boards need to consider raising the profile of this issue through the necessary NHS Scotland IT user forums and procurement channels.*
GE9	Effective Recruitment	Were the salaries, terms and conditions of employment a barrier to recruitment of Joy GPs? <u>Rationale</u> Test out the assumption that agreed salaries, terms and conditions (T&Cs) were attractive enough, does this issue require further scrutiny?	B5	*1031 A12 Flexible contracts not the main success factor, would put it as; 1) Strong vision - the strong core vision and values of the Joy excite GPs, allows people to feel hopeful and joyful when the vision and values ae strong. 2) Being part of a team - involving individuals to develop a team looking at underlying problems in a systematic way and help develop solutions 3) The flexibility that the contracts provide.* *1034 B5 Salaries - T&C - No, not a barrier. Only one GP dropped out of process over salary. Salary is made explicit on the advert so this was fairly self-selecting. Only one real attempt by a GP to try and renegotiate terms. Motivation for the role is for job satisfaction rather than salary.* *1036 B5 No, but we do have to try to act flexibly on what GPs ae looking for. T&Cs are ok; they just took time to sort out. Have input into travel decisions.* *1039/ 1040 B5 Seemingly not a barrier though salary is not super high, but not a problem, GPs are coming for other reasons* *1041 B5 Not an issue as far as is aware, not particularly a barrier as they have managed to recruit.* *1043 K1 Absolutely, great fun, worked for the joy in different places, not too onerous and in some places workload a bit too quiet* *1043 J122 K8 Overriding thoughts; As a retired GP wanted to do the Joy, and didn't mind working hard but wanted some time to take in the great locations. Part of the Joy is living in a different community and it has been great for that. Good, relevant accommodation is necessary as well as a work car, important for us was that I brought my wife to some placements and you have to think about the couple, what will the partner do? Experience wonderful, got the Joy, loved it, helped me carry on being a GP.*	*<u>Evidence</u>* *Joy GPs fairly adamant that salary is not the main factor in recruitment though, eg per 1045 it is a satisficing factor. Original recruitment campaign secured 51 expressions of interest for first recruitment (2019) and 42 for Second (2020). A critical success factor is that the GP employment contracts are very flexible and allow GPs to work in many places and when the GP wants to work, fitting in with lifestyle, these are the primary attractants more likely.* *PIO - Other job satisfaction and career factors are at play here. Core salary is a satisfier but really, the GPs are coming as well for other reasons, experience, change, The rediscover the joyful nature of the role, enjoying being a GP again, working in a team the variation The salaries, T&Cs were not a barrier to recruitment, neither , probably were they excessive (also see GE10 and recommendation (R5).*

				1043 K4 Yes, not all about the money. Some irritating things are the mileage rate only being paid from Scottish border but not a major bug bear. *1044 K4 Less of an issue for me, didn't read into it too closely, personally interested in the job because a great end of career challenge in interesting locations. Might be an issue for younger doctors.* *1045 K4 Yes, not doing the job just for the money. Salary fine though couldn't do it for much lower as I Lose other work in my local county due to being in Scotland and also have to arrange cover for my charity work whilst I'm away* *1045 K8a Absolutely loved it. Difficult start at first practice and I had some health problems of my own when I came so any negativity was mine. Am much more able to appreciate things now. Love it more and more. Very important to bear in mind that I come with my partner and he has to enjoy it plus important to be able to have some time off and go and look at the area, not really in for a 10 session week in the busy town practices as you seem to lose some of the point of being here. Can't believe I get paid for it sometimes. Privilege to spend time with patient and families and have done things I haven't done for a long time in England (terminal care etc.) It gets better as you go on.* *1046 B5 Not a barrier but it would have helped had the terms of the offer been clear in the beginning. 2020 campaign not likely to have these problems as terms more explicit.* *1047 B5 Don't know about GPs but cost for practices is very high for the Joy. Regular locum on their books is £4620 pw, HrHub (The Joy) charge £5674, quite a big difference. Probably why Orkney have not used the scheme too much.*	
GE10	Effective Recruitment	What were the challenges in setting pay, terms & conditions for Joy GPs? <u>Rationale</u> Are we sure that pay, employment Ts &Cs are adequate, equitable,	B6	*1034 B6 (seeB5)There were sometimes niggles on T&Cs, clear that non willing ness to reimburse travel expenses from England caused niggles with some English GPs. Difficulties reconciling 4 health boards in some areas (eg car hire).* *1039/1040 B6 Setting nuts and bolts of contracts were a challenge, but issues have been resolved and ironed out, good systems in place now. Only thing not resolved would be if Joy GPs*	*<u>Evidence</u>* *Setting terms and conditions required agreement between the 4 health boards and was carried out through negotiation and discussion between December 2018 and May 2019. This was time consuming as many issues were raised that required a solution. Most crucial were the agreements on basic pay rates (agreed between*

		practical to enable the Joy attract and retain Joy GPs? Issues around this mid 2019 (also see issue #8 GP Employment Contracts and #27 One Health board managing recruiting etc.)		*did out of Hours arrangements, but not aware of any who have. 1039/1040 J12 How do we change contracts? As the scheme develops, perhaps we should look at sitting down and reviewing again what the Joy contracts should include. Approaching one year on now and of the original wave of Gps some of them only wanted a year. How many will drop out? How do we change things? Enjoyed working with other health board colleagues, particularly the interviewing.* *1041 B6 4 health boards, 4 different ways of doing things. Concerns were highlighted on the level of pay as it could have disadvantaged some WI GPs but final pay level agreed was adequate, in the end, for a while, slightly cheaper for a Joy GP rather than a locum. Unfortunately ruling that VAT had to be added has changed that.* *1043 K4 …. Some irritating things are the mileage rate only being paid from Scottish border but not a major bug bear.* *1044 K4 … personally interested in the job because a great end of career challenge in interesting locations. Administrational Hub were fantastic in responding to queries and sorting things out eg Accommodation etc.* *1045 J12 K8 The joy is still evolving, paperwork will improve, HrHub will get more organised. One thing about the Hub is that they always try to do their best. We are inventing a new wheel.* *1046 K4 For me personally, excellent, replaced a locum and it was a good deal, particularly with free accommodation, travel from Scotland. Even annual and study leave built in.*	*the health boards and LMCs) and the agreement that NHS Shetland should be the employer of Joy GPs. Beyond that, billing arrangements need to be concluded, agreements over travel expenses, accommodation and medical defence union subscriptions. There were many nuances to the final arrangements and it was not until July that contracts were able to be offered to recruited Joy GPs. Some Joy GPs started work in July without contractual terms being agreed. During this time the HrHub staff (recruited themselves in March 2019) based in Shetland, started to build up a useful amount of expertise with contractual (terms and conditions) Ts and Cs. This, and the willingness to research answer to particular problems was well received by Joy GPs* *Two more recent points;* *a) NHS Highland is currently in special financial measures (k/a `Grip and Control') this may mean that the health board can decide not to use the Joy GP scheme or honour parts of the employment contracts (eg accommodation, travel or other costs) at short notice.* *b) A check with NHS Shetland tax advisor indicated that VAT must be charged to GMS practices outside of the NHS Shetland area. Practices may not be able to reclaim that VAT (if they are not registered) making Joy GPs 20% more expensive (see issue # 52VAT) . Approximately 80 of 98 practices in the Highland area are independent GMS type and this could dampen demand.* *1039/1040 makes the point that contract terms should be reviewed again given more knowledge and danger that Highland health board may not*

					always be able to support travel and accommodation costs. Creating the advantageous employment contract Ts and Cs for Joy GPs has also been a key success factor. The whole theme represents a key learning point on ; *a) How to create employment contracts with Ts & Cs that are affordable, flexible and attractive.* *b) How to work effectively across 4 health boards with different geographies, constraints and perhaps philosophies.* *Recommendation (R5): Review Joy GP contract terms and conditions annually between participating health boards (also see R36 on VAT issue).*
Clinical Governance Theme					
GE11 GE 12	Effective Clinical Governance	Do you feel that clinical management / governance arrangements are robust enough regarding the Joy project? Clear view of the perception of effectiveness of CG arrangements. Also a test of professional opinion and that accountability understood.	C1 C2 C9	*1030 F6 As a model, sensible, innovative, safe and plays to the strengths of those attracted to these jobs. Looking for a model with different leaders in different tranches, modular approach to developments for success and to motivate the next generation. Matching behavioural expectations - keeps some GPs sharp and at the top of their game. Positive in an infectious way.* *1030 J2 Yes, in a big way (10/10) Achieved what it set out to. 1* *1031 C1 Specific CG issues have been addressed promptly and clear that they have been addressed through discussions with GPs/ practices/ medical directors etc. Better systems? Lack of capacity to be able to develop. New clinical lead in post hope would help to change that. There has been a bit of a divide between clinical and HR side. We had an excellent day together in December in Edinburgh (HR Hub, Lisa, Martine, Lorraine, Mathew Pay and me). This was the first time that we spent any real time together. Recognised the importance of working more closely together. We established a system where we shared sensitive (and what might be considered almost trivial) information between HR and the Clinical Leads so we all maintained an overview. This sharing of information is strictly confidential*	*Evidence* *Management Arrangements* *(See wider discussion at GE19). Clear that management arrangements are in place and function, the Joy programme is operating and contracted GPs have been working on placements since July 2019. Clear also; the HrHub has gained in expertise and efficiency. From responses of the management team, the Joy project has been successful (see issue# 54); see comment 1030 F6 on the suitability of the model - `As a model, sensible, innovative, safe and plays to the strengths of those attracted to these jobs. Looking for a model with different leaders in different tranches, modular approach to developments for success.' Comment from 1034 D1 highlights some of the issues of holding effective meetings.2 Round up meetings were organised (Aug & Dec 2019) to tighten up communications and understanding between management, SRMC and the HrHub;*

				between the 5. I think this new system has been working well. The difficulty of working more closely together is often because of the distance involved between the executive and HrHub. Sure that others involved in the Joy feel a little bit outside that. Need to create an overarching governance document that clarifies these issues. *1031 C9 Not sure how we can easily demonstrate this? Looking at planned discussions at the upcoming recruitment weekend -to which there will be a recruitment assessment side and a development side - it is remarkable to see what we have developed so far. (DP) Perhaps it would be better to think about what benefits has the Joy delivered? (CS) difficulty is keeping the Joy 'fleet of foot' married to the vision and values without cumbersome (?) need to demonstrate on paper. Discussed Wick challenge, a lot of thought into this problem and no solution yet but we have incorporated a lot into the next stage of development the Joy David (W&A) is not a different philosophy but just a different way of contracting. 1036, 1046 and I have spent a lot of time thinking about how we re-focus the Rural GP Support Team and W&A on how it can help resolve issues in practices - that is a particular emphasis of part of the weekend for everyone. There has been an evolution in thought about some of the problems we now realise that we face, (PIO) perhaps a benefit of the joy is that we now have a better idea of some of the challenges we are facing (in primary care) and are starting to think about ways to solve them? Yes, 1036/1046 fully engaged along with new clinical lead. Thinking about how to join this process together.* *1032 It depends on your definition of management and who you are referring to as management eg is it SRMC is it Clinical Management is the Hub itself and therefore you will get different responses depending on what individuals think is the management … and therein lies the issue - confusing landscape and so I am currently working on a wiring diagram to make it clear how the Joy is managed. It has been confusing in the past as clinical leadership has got mixed up with operational management, as a consequence the wrong issues have been brought up in the wrong forums (eg What's App group)*	*1034 D1 ..much better since Edinburgh meeting (December 2019) but problems with earlier Hub meetings with poor attendance. Appreciate, quite a challenge over building a disparate team.* *1036 C1 (Joy Management) Robust, as professionals GPs shouldn't need managing, certainly not on admin.CG is evolving in Scotland and we will need to define what it means..* *<u>Clinical Governance Arrangements</u>* *Clear that there is an overlap with local health board CG arrangements for areas in which the Joy GPs are working and clear, that this is ultimately a health board responsibility - to ensure that robust CG arrangements are in place. Local Associate Medical Directors (AMDs) are part of the Joy management arrangements so ultimate clinical governance is secured this way. The fact that Joy GPs are NHS Shetland employees does create a technical fault line but AMDs came to an agreement (June 2019) that they would oversee and support GPs working in their own area in co-operation with HR/AMD Shetland. Lack of AMD capacity led to a further refinement with the recruitment of a GP clinical lead for Joy GPs in February 2020, it is hoped that this role will take this work up and lead on CG development work (see also GE11, GE12) .There is evidence that Joy GPs are linked in to CG type activity when working in practices (eg SEA discussions) and the Joy GP VCs (see GE17 and GE18a as well as Issue #7 Joy GP VC arrangements) and there have been direct discussions between Joy GPs and AMDs. Some anxieties expressed by Joy GPs that there is a lack of feedback on performance of Joy GPs and generally (See GE14, GE22 and issue # 21Feedback forms).* *Response from an AMD on C1 (CG arrangements) Have not been tested to the maximum yet. The AMDs have discussed arrangements and there are*

				everything had been a bit confusing and sometimes bonkers. Need to split things into Clinical Leadership, HR management and strategic management. Lesson #1 had been the crossover of roles into different areas had been confusing. #2 It was necessary to put someone in a new role to link between clinical leadership (KB/CS) and the HrHub team #3 The role of the Project manager was confusing…In 2020 the landscape is clearer now and there are better ways of working. The earlier havoc used a lot of additional time and effort to manage.. lots of valuable lessons. 1032 C10/37 Very important to evaluate the role of clinical lead to Joy GPs as we need to know where we are going and this could help with governance, communication and team cohesion - keeping people in the loop particularly as some people are not putting in, discussed example of evening meetings. *1034 D1 .much better since Edinburgh meeting (Dec 2019) but problems with earlier Hub meetings with poor attendance. Appreciate, quite a challenge over building a disparate team. New clinical role (recruiting Jan 2020) should definitely help.* *1036 C1 Robust, as professionals GPs shouldn't need managing, certainly not on admin.CG is evolving in Scotland and we will need to define what it means, very much about how teams perform in Scotland. The CG offer for the Joy has been the GP VC which has moved on to discussing GP experience in the H&I and SEAs. More quality improvement issues need work at the moment and this awaits the new clinical lead coming into post shortly. The Joy VC will continue to be a good vehicle for this.. Individually GPs still have to maintain their regular CPD.* *1037 C1 Have not been tested to the maximum yet. The AMDs have discussed arrangements and there are shared responsibilities, personally am comfortable enough with the arrangements. There have been no serious complaints or critical observations made.* *1039/1040 C1 Would like to see feedback on doctors and how well they are performing and what Joy GPs think of practices, certainly salaried practices. Worried about any unsafe practices identified, but have not seen any feedback.*	*shared responsibilities, personally am comfortable enough with the arrangements. There have been no serious complaints or critical observations made which provides some reassurance.* *PIO – Clear that there is a reasonably robust management framework in place and provided there is a commitment to continue regular ways to maintain communication- between different parts of the team- then it should remain robust for the current level of activity. However there is no reassurance that management arrangements will remain robust if the volume of Joy programme work increases (see discussion at GE19 Management Effectiveness, GE22 Feedback, GE23 Skillset, GE32, Communications).* *Clinical Governance wise, there is an accountability framework, evidence of clinical governance activity and the use of existing CG arrangements with the 4 health boards. The recruitment of a clinical lead means that a role now exists that can link to GPs, Joy management and the HrHub and, drive through initiatives in clinical effectiveness; event analysis and feedback for individual and organisational improvement (also see issue #37 on clinical lead role).This is a key opportunity to help drive through clinical quality improvements within the health board areas.* *Recommendation (R6) The activity and effectiveness of the Joy clinical lead role is assessed and reviewed over the course of the first year to establish the effectiveness of CG arrangements for the Joy as the programme changes and drive through some quality improvement initiatives (also see R9).*

				1041 C1 No problems, aware of regular Joy GP VCs. Probably need more clinical leadership from KB/CS and in 2 minds over whether arrangements are robust enough. Perhaps clinical management should be a separate paid resource. *1046 C1 The query is, not sure how this has been addressed. In some ways no idea what CG arrangements in place so there could be problems that we are not aware about? Important to have an idea on how issues are and some demonstration on what the process is (will discuss as part of new role).*	
GE13	Effective Clinical Governance	Is there effective line management and support in place for Joy GPs when working? <u>Rationale</u> Test what AMDs think is in place v the opinion of Joy GPs, might be early to assess this one. Consider for later evaluations.	C3	*1032 D8 Feel the Joy GPs have had a lot of support though…. From a HUB team perspective, normally GPs know where they are going, what they are doing; they should not need lots of support. We have done a lot enabling many things eg Accommodation, travel with partner, dogs. sorting out issues with expenses, travel and being there as a friendly voice at the end of the phone or a supportive email If they were working as a locum they would be going on their own with only a little note about where to go. There is a lot of structure and support available through the Joy if they need it (eg holidays, sick leave, CPD time etc.) this level of support needs to be communicated to prospective GPs… The clinicians have also put a considerable amount of effort into support - always being there to talk to the GPs and also engaging in regular WhatsApp meetings* *1036 C3 Line management - admin arrangements are made with local practice. KB/CS are de facto clinical leads and new clinical post will provide much more support. Line management is technically through HrHub as contract held by NHS Shetland.* *1037 C3 (AMD) Generally yes, they know where I am if they need me. Have fielded some phone calls, met one or two Joy GPs and did one exit interview. Doesn't have direct control in other health board areas. Felt the experience was good for Joy GPs and 2 applications for substantive posts as a consequence. Discussions with a Joy GP did lead them to look at practice of a local GP.* *1039/1040 C3 Line management seen as through the Joy scheme (& NHS Shetland) though they are working in the NHSH area.*	*<u>Evidence</u>* *Probably, the best comments are of Joy GPs themselves. The Joy GPs recruited (and interviewed) had good management experience and some had been partners in GMS practices so really didn't require too much support. As independent professionals, in Joy roles, GPs should not really require too much direct management anyway.* *PIO – Current arrangements are probably sufficient however, Joy GPs do need to be made aware who their line management/AMD contact/ clinical support is when in placement. They do not always seem to be aware.* *Recommendation (R7): Joy GPs are made aware who their line manager/ clinical lead, when starting placements.*

				Should be clarified, perhaps a named person? They can always use their local practice (where they are working) for support. *1041 C3 No probably, but not sure how much management is necessary for GPs. Not sure how much effort should be put in. What is lacking sometimes is a clear robust line on how to escalate problems quickly. GPs shouldn't require too much management, but perhaps more informal telephone support with home issues.* *1043 C3 Generally yes, got very effective support when dealing with an issue in Western Isles (from AMD). Knew my nominated line manager was around and contactable. Arrangement is good for placements but probably not a long term solution.* *1044 C3 Not sure -as a .. GP, used to being self-sufficient. Didn't really utilise the support, knew where I could get hold of it though. Hr Hub fantastic on admin questions. More of an issue for regular salaried doctors probably.* *1045 C3 Support variable. Clinical - Not aware of the support in Shetland or Highland, AMD made herself available and was there in Western Isles. In a way, not critical, as I am an experienced GP partner, can sort most things out myself. Admin - Challenging as a lot of queries on expenses, pensions etc.* *1046 C3 Yes, there is enough support, but GPs are pretty self-supporting. Good use of own colleagues and through What's App group and communications. Over and above that don't know. Good connection with CS and KB.*	
GE14	Effective Clinical Governance	Is Joy GP performance linked to appraisal and feedback mechanisms? <u>Rationale</u> In general terms it should be, but GPs working for the Joy, so far, have been appraised and revalidated	C4	*1037 C4 Not seen this so far, but appraisal process annual and GPs not quite at that stage and most Joy GPs getting appraised elsewhere. We could do it and AMDs could inform appraisals held elsewhere (eg evidence from contribution to SEAs etc.) Could use the Joy GP VC for this. Would have to think about clinical c leadership aspects in the appraisal.* *1044 C4 Linked to some extent, revalidated Nov 2019 so useful to reference. Would be good to have some feedback from*	*<u>Evidence</u>* *Not much evidence that GP individual performance linked to appraisal in an active way yet. One Joy GP (1045) has obtained their own feedback from Joy practices and fed back to their appraiser in England.* *PIO - It could be that the issue is not current yet as Joy GPs are still be appraised/ revalidated at their*

		through their home arrangements.		*practices. Feedback at recruitment weekend good.* *1045 C4 I have to provide evidence of my own performance and reflection as part of my own appraisal. I got spontaneous feedback from one H&I practice and on asking the hub got some feedback from mid-2019 from another in Shetland. Did complete the feedback form provided by the practices at the end of placement.. Could have been better – I think it should be routine to give feedback if at all possible – little things can then be managed before they become big things.* *1046 C4 Yes, but not too many appraisals done through the Joy yet (next year more relevant).*	*home base, but if the Joy becomes their main source of work then AMDs will need to be ready. The whole issue of feedback generally within the Joy programme is under separate consideration (see GE22).* *Recommendation (R8): Support needs for Joy GP appraisals are considered in an active way for 2020/1 onwards. All Joy GPs should be able to get feedback on their own performance in the role.*
GE15	Effective Clinical Governance	Does appraisal and reflection inform CPD for Joy GPs? <u>Rationale</u> Test if there is much process at all at the moment.	C5	*1036 C5 (AMD) Appraisal is very individual so depends on what the uptake is to the appraiser and won't necessarily inform the Joy. Important to keep up the Joy GP VC so we can ask GPs what will be useful in future? Not sure appraisal the right place in the Joy scheme. Could look at other ways.*	*PIO - See response to GE14, too early yet to assess.*
GE16	Effective Clinical Governance	What clinical or management problems have been highlighted? <u>Rationale</u> General question to test how AMDs see management and CG related problems (also see GE22).	C6	*1036 C6 (AMD) Contracts and admin things at the beginning. Western Isles practice example of an SEA, Practice took on board issues raised by a Joy GP. Some Joy GPs - personality complications and also some positive interventions. Wick - evolved into a separate project looking at different ways to tackle practice sustainability.* *PIO - C6 Several issues highlighted through early GP VCs* - *(Originally) T&Cs ,lack of contracts and detail for Joy GPs* - *Workload and organisation at Wick* - *Prescribing Reviews at a Western Isles practice* - *Variable quality of induction at several practices* - *Lack of information on latest policies, formularies in use in H&I* - *Problems with Lab results*	*PIO - See questions on feedback (GE22) how feedback is dealt with is probably the main issue.*
GE17	Effective Clinical	Are Significant Event audits discussed and	C8	*1036 C8 SEA - yes, needs to be a standing item with Joy VCs and encouraged.*	*PIO – From own knowledge SEAs were discussed, through Joy GP VCs, but also in practice meetings,*

	Governance	considered with Joy GPs? Clear from Joy VCs that SEA have been discussed with practices, is this consistent across H&I? Rationale SEAs are a recognised (CG) way to examine events and identify lessons learned and hare the learning.		*1044 C8 Discussed several on Joy VCs, general write ups would have been interesting and could have included in own appraisals. Wasn't really involved in a serious significant event while on the Joy, but if there was a big problem would be looking for some process around this but appreciate it is a difficult decision on what and how to communicate when there has been a serious event.* *1045 C8 Yes, covered some SEA's in Joy VC discussions and involved in one in Shetland about out of date drugs.* *1046 D8 Yes, through Joy GP VCs*	*evidence in WI & Shetland that carry over into regular SEA reporting systems, not sure about Highland practices.* *See also commentary on GE 18a, (Joy GP VCs) and issues # 19 Joy GP ability to diagnose business problems, #26 Challenging Quality Issues , #32 Formularies.*
GE18	Philosophy and values/ Effective Clinical Governance	How could you demonstrate continuous improvement? Rationale Test question for Joy management to have a feel for what improvements are going on as a result the Joy.	C9	*1031 C9 Not sure how we can easily demonstrate this? - it is remarkable to see what we have developed so far. Discussed Wick challenge, a lot of thought into this problem and no solution yet but we have incorporated a lot into the next stage of development the Joy. (W&A scheme) is not a different philosophy but just a different way of contracting. (There has been) a lot of time thinking about how we re-focus the Rural GP Support Team and W&A on how it can help resolve issues in practices. There has been an evolution in thought about some of the problems we now realise that we face, (PIO) perhaps a benefit of the joy is that we now have a better idea of some of the challenges we are facing (in primary care) and are starting to think about ways to solve them? (1031) Yes, CS/KB fully engaged along with new clinical lead. Thinking about how to join this process together.* *1036 C9 Everything up for review all the time. Feedback important on new documents, new protocols. This is an area Joy GPs need to take ownership, loop then from VC to action plan. Also need to watch for developing themes - small group work.*	*PIO – No conclusion, in a purely clinical sense, but new clinical lead role provides a balance with the 4 relevant AMDs for the health board areas. No sense that there is formal plan or structured CG reporting through the Joy organisation though, issues are clearly discussed. There does not appear to be a framework, plan or dedicated meeting on clinical governance specifically. Ultimately CG is really the responsibility of the local health board but the Joy is a significant initiative and should at least have some outlining plan and reporting.* *See also section on Further Work suggesting more work on the impact of the Joy on patient clinical outcomes and Recommendation (R17).* *Recommendation (R9): The Clinical Leads for The Joy, AMDs and the Joy GP Clinical Lead need to further discuss and review how The Joy is leading to continuous clinical improvement.* *Recommendation (R9a): An expanded programme with MDT professions should consider a more formal governance structure to report and oversee Clinical*

					Governance and initiatives.
GE18a	Philosophy and values/ Effective Clinical Governance	How effective has the Joy GP VCs been in supporting Joy GPs/ Reflective practice and/or development of the programme?	C11	*1031 E9 Need to think about Joy VCs, keeping a lessons learned log, action minutes or quality ideas and improvement spreadsheet. VC needs to be re thought out. Important for us to recognise that we need to empower people to be able to raise ideas and innovations and take them through to solution stage, this needs a structure putting in place. Clinical lead needs to be empowered to take this forward. Important to recognise and record what we are doing to improve quality and feed that back to health boards.* *1044 C11 Useful, excellent way of supporting (personal) reflective practice, having the minutes of the meetings was helpful. Feel it helps when on placement for the Joy and useful to patch in, need about 5/6 on the VC to make it work. Appreciate the efforts to try and get round the technology.* *1045 C11 To be honest, didn't really enjoy. A problem when you raise clinical cases and what you thought were pertinent issues, but other GPs didn't always seem interested and could be a bit dismissive. Also light hearted comments look odd out of context in the minutes. It made me anxious about speaking although I was interested in what the others had to say. Don't really want to contribute now as a little bit anxious. Connectivity awful so had a lot of problems. Thought the concept was good though. What's App group quite good and positive, but not often clinical.* *1046 C11 VC not bad but challenging as trying to 1) Provide support to working GPs 2) provide some link to professional development and CPD and can't do both. Looking at new models.* *1048 C11 Joy VC has probably been a useful forum for those that attend it but since Oct 2019 numbers have been low. It has served as* *(a) a temperature gauge for the mood of Joy GPs* *(b) Chance for Joy GPs to air anxieties* *(c) Chance to discuss clinical practice – contrasts with elsewhere* *(d) Chance to discuss clinical practice – reflect on own practice and share experience*	*<u>Evidence</u> The Joy GP VCs have run (so far) from July 2019 to February 2020*, 15 VCs running originally on a Thursday evening for about an hour. Notes are taken after each VC (1048) and disseminated to all Joy GPs and key Joy team staff. On average between 3 and 6 Joy GPs have attended, usually those in placement at that time along with PIO (as facilitator) and usually an AMD. There is a tendency for the same GPs to be on the VC, another 5 or so GPs who have been in placement have attended only one or two VCs. There is no specific agenda, just a general trawl to find out what issues are concerning Joy GPs and how placements are going. Since October 2019 a specific request was added to bring forward interesting clinical cases or issues which led to discussion of around 20 case histories in the later VCs covering a range of clinical issues (interesting but perhaps rare conditions, dementia, logistical challenges getting patients to hospital, evacuation procedures, blood test results, and access to consultants in H&I). Connectivity problems were often an issue a reflection on poorer H&I broadband and NHS firewalls.* *PIO – Joy VC has probably been a useful forum for those that attend it, but since Oct 2019 numbers have been low. It has served as;* *a) A temperature gauge for the mood of Joy GPs (feedback has been useful for Joy management).* *b) A chance for Joy GPs to air anxieties.* *c) A chance to discuss clinical practice – contrasts with practice elsewhere (in the UK and sometimes beyond.* *d) A chance to discuss clinical practice – reflect on own practice and share experience*

				(e) Chance to discuss clinical practice – Some interesting learning points *(f) Chance to air administrational concerns (important before Oct)* *(g) Provided a bit of group support when out on placement* *It has supported those who attended and management for feedback, it has not covered all Joy GPs and though there is some learning we have not yet managed to use it for proper CPD time. It does need review in the way it delivers continuous improvement.*	*e) A chance to discuss clinical practice – Some interesting learning points.* *f) A chance to air administrational concerns (important before October 2019).* *g) Provided a bit of group support when GPs are out on placement.* *h) Helped build a cohesive team of GPs.* *On the whole, Joy GPs seem to appreciate it (see comments 1044, 1045, 1046) but not all Joy GPs have attended, it is probably most useful when Joy GPs are on placement and appreciate some connection to their peer group.* *Though there is some learning, it has, so far, not yet managed to be used for official accredited Continuous Professional Development (CPD) time. The format does need review in the way it delivers continuous improvement. It may not be the perfect solution, but does at least, provided some support and reflection on practice (see also Issue #7 VC Arrangements, #44 Joy VC Changing). Key learning point.* *Recommendation (R10): The GP VC needs to be developed to provide wider Continuous Professional Development (CPD) opportunities for Joy GPs.* **This system may have been developed further now (May 2020)*
Management and Operation of The Joy Theme					
GE19	Effective Management	Effectiveness of the Management of The Joy - Have the management arrangements been successful?	D1	*1030 D1 Didn't know originally how the Joy would be managed as it depended on the number of GP candidates we would attract. We have, in retrospect, done very well. We had to organically grow the team and had to learn quickly, but in the end nothing was left undone. Sometimes things were done on a fairly ad hoc basis in the end, what we did was good enough and nothing*	*Evidence* *See overarching statement by 1030 `Didn't know originally how the Joy would be managed as it depended on the number of GP candidates we would attract. We have, in retrospect, done very well. We had to organically grow the team and*

		Rationale There is evidence from several people that management arrangements, though generally effective, had to be improvised and issues did arise. As the Joy looks to expand what has been successful? and what needs to be reviewed.?		*foreseen that we couldn't manage. In future, the management team will need to be bigger with more delegation.* *1031 D1 There is an aspiration for wider involvement but it is difficult for all the people to look at all the issues (?) the creation of the executive was a good idea but in practice difficult to communicate out very well what we are doing. Consistent attendance has been fraught with problems as everyone is phenomenally busy. PC leads and AMDs are juggling with time all the time. CS/KB have now taken on clinical leadership and it is working but it is not communicated well enough, we need to decide what we can communicate (see CG).* *Recruitment - This is a good testament to the joy we have managed to recruit 36 + ? Gps and organise recruitment events but how do you make this transparent? Need to be careful not to lose the agility of the Joy, but need to develop a good system of communications and management still.* *1032 It depends on your definition of management and who you are referring to as management eg is it SRMC is it Clinical Management is the Hub itself and therefore you will get different responses depending on what individuals think is the management - unless you have specifically said who or what you are referring to - and therein lies the issue - confusing landscape and so I am currently working on a wiring diagram to make it clear how the Joy is managed. It has been confusing in the past as clinical leadership has got mixed up with operational management, as a consequence the wrong issues have been brought up in the wrong forums (eg What's App group) everything had been a bit confusing and sometimes bonkers. Need to split things into Clinical Leadership, HR management and strategic management. Lesson #1 had been the crossover of roles into different areas had been confusing. #2 It was necessary to put someone in a new role to link between clinical leadership (KB/CS) and the HrHub team #3 The role of the Project manager was confusing and I think different folks thought that David was doing some feedback into the other areas! the Lead HUB GP is that interface and as such I (LH) have set up proper monthly meetings to keep people up to date and cascade information (both ways) correctly.MS understanding lessons document has*	*had to learn quickly, but in the end nothing was left undone. Sometimes things were done on a fairly ad hoc basis, in the end, what we did was good enough and nothing foreseen that we couldn't manage. In future, the management team will need to be bigger with more delegation' Key learning point.* *1031 discusses the dilemma of how workload of most Joy managers and clinical leads causes problems with communication across the team (a disparate team 1034). There are also hints of critical perceptions of the recruitment process; this was discussed as part of the phase 1a evaluation report (see appendix A). 2 face to face meetings to improve communications and pull the team together were held (August and Dec 2019) and these seemed to have helped in refocusing the tea and managing expectations. Generally the team don't meet often, with communication mostly on line or by phone, so, face to face meetings are very effective in periodically pulling things together, building a team and improving understanding. Other meetings are only sometimes effective (ie Hub VC meetings, planned monthly only happen occasionally and do not often have clinicians able to attend). 1032 makes the point the landscape has been confusing particularly with the lack of separation of clinical from management forums and also the role of SRMC staff and an up to date organisational diagram explaining management and professional accountability would help this.* *On the whole the HrHub have got on with promoting the scheme to practices in the 4 health board areas, advertising vacancies and placing GPs as well as handling salaries, expenses payments and resolving queries, this part of the operation now appears to run smoothly. The Hrhub now have a lot of knowledge on the*

				been useful however capacity is required to spend time in pulling together the lessons learned. In 2020 the landscape is clearer now and there are better ways of working. The earlier havoc used a lot of additional time and effort to manage... lots of valuable lessons. *1033 D1 Day to day management of bookings etc. - this part of the Joy works very well through the HR Hub. Leadership by 4 health boards - more difficult as they are all in different places and clinicians, with busy commitments do not always have the time and have to be tracked down when their input is needed, so a lot of effort spent on comms.* *1034 D1 Felt not much of an appreciation of what the HrHub do early on. Comms have been much better since Edinburgh meeting (Dec 2019) but problems with earlier Hub meetings with poor attendance. Appreciate, quite a challenge over building a disparate team. New clinical role (recruiting Jan 2020) should definitely help.* *1036 D1 Arrangements ok, always could be better. Could have been tighter in the beginning - governance and accountability. Expectations issue originally with the hub, but this improved after visiting Shetland in August and meeting with the Hub in Edinburgh (Dec 2019). Need to develop trust by understanding expectations.* *1041 D1 Joy management - not really involved, quite relieved that the HR Hub do a lot of the work.* *1037 D1 Skill sets ae very good, CS is a great innovator based on Orkney and experience. Hub has done a great job and keeps in touch with base very well. KB/CS generally take the lead because of capacity differences, but happy with that arrangement.* *1047 D1 Liaising with HrHub is very good, they respond quickly*	*nuances of dealing with both Joy GPs and practice arrangements, this is a key success factor and the expertise needs to be retained. The HrHub is a critical part of the operation and vulnerable if one or both staff take time off or leaves (see discussion at GE20 Communication of Management Information, GE23 Skills and capacity, Issues #12 Expertise of HrHub, #38 Management Meetings, #53 HrHub Capacity, #55 Agility and Recommendation R16 Business continuity risk).* *In terms of accountability, the Joy management team managed to secure initial funding from the Scottish government, kept necessary financial compliance returns up to date and been able to report coherently to Scottish Government. Currently a bid is being prepared for extension and enlargement of the Joy programme (See GE 11 & 12 for Clinical Governance aspects).* *PIO – The Joy management team have had to improvise with arrangements because, in the beginning, it was not known how many GPs could be recruited or, what the demand would be from practices. Management also has the challenge that the wider Joy team is dispersed and do not normally meet as a whole with most communications being done by phone or e-mail. The clinicians taking part as well as staff who have health board responsibilities are busy and cannot always commit to meetings or doing tasks allocated on time. All of the above does not detract from that the programme so far -and at the current scale - has been successful (see Success section, issue #54 Has the Joy been successful?). This suggests that management arrangements have been basically effective and a key success factor.* *Noted that management capacity is potentially a*

					problem but also that management skills are very good (See GE23), discussion is more relevant now, on the capability for an expanded Joy programme. *Problems with communication between the team – in terms of a perceived lack of information – is cited often as an issue (see GE20) as is the inability to feed suggestions up to the management team (GE29 and R18). Round up meetings appear to be occasionally useful in facilitating and getting over earlier confusions over management arrangements and meetings (1032). Regular Joy management meetings should probably be done weekly as they are, but with a periodical wider meeting, probably quarterly*, face to face (whenever again possible), involving the extended part of the Joy team. Many anecdotal comments during late 2019 suggested that the wider team did not feel as engaged in development of the programme in the way they once were. Unfortunately the planned March 2020 development event had to be cancelled (Covid 19 lockdown). Management structure is changing if the scheme moves to a new phase during 2020; this should be captured in an organisational structure diagram. In order to help keep the Joy participants together as an effective team, joy management need to continue to seek ways to keep regular discussions with that wider team on going.* *Recommendation (R11): More effective communication and dialogue is required between the Joy management team, the wider Joy group and GP Support Team. Creative ways need to be considered to keep team buy in and a sense of being in a special cohort. Regular cascades of*

					information (eg a regular newsletter e-mail) should keep stakeholders up to date on where the project is, and where it is going. *A related recommendation also makes the point from GE8 and Recommendation (R4) that good ideas sometimes surface from the wider team and that management continue to be open to this.* *Recommendation (R11a): The Joy management team need to ensure they spend time listening and looking at issues and ideas raised by staff supporting the Joy and Joy GPs .* *The evaluation was also asked to consider future expansions of the programme covering a wider geography and/or other primary care multidisciplinary team (MDT) profession. If this was necessary, what would need to be reviewed?. Recommendations for an expanded joy scheme include;* *Recommendation (R12): For an expanded Joy programme involving either/or;* *a) A wider geography* *b) Wider number of professions* *c) Using more Joy GPs or other professionals.* *A more formalised management structure needs to be agreed with;*

					a) *More formal and fixed management meeting and cascade communication arrangements.* b) *An organisational diagram indicating management and professional leadership arrangements.* c) *Adequate admin support for the Joy management team, possibly, consideration of the role of a joy operations manager if the workload is considered sufficient. Extra resources will probably be required for these roles.* *A more formalised management structure needs to include;* o *More formal and fixed management meeting and cascade communication arrangements.* o *An organisational diagram indicating managerial and professional leadership arrangements.* o *More formalised clinical governance forums and reporting.* o *Adequate admin support for the Joy management team.* **The more widespread adoption of MS Teams during the Covid 19 lockdown should help with this.*

GE20	Effective Management	Do you have an updated picture of where the Joy programme is at any given time - eg Placements completed, who is in post, forecasts, budget spend for the project, an overview of risks? <u>Rationale</u> Question links to the Joy Evaluation Phase 1A addressing concerns that people did not know what as going on. It is designed to test what management information is being circulated, but also possibly, what is also really needed.	D2	*1030 D2 Yes, get a good view, every Wednesday there is a team phone call and all the necessary information is available. There is a more formal quarterly report from LH.* *1033 D2 Generally yes.* *1034 D2 Yes - HrHub runs the placement system and forecasts so can see easily what is coming up. Also provide returns to 1048 on historical placements so knew what has happened. Management overview from Edinburgh meeting and also sees the Joy budget spend details.* *1036 D2 Probably not. Newsletter would be a good idea.* *1037 D2 Get enough information - vacancy notices, placement return so have a feel for what's happening.* *1039/1040 D2 Aware of some things, vacancies, schedule of placement history. Less so now than in the beginning.* *1041 D2 Aware of the issues, but difficult to keep everybody involved all of the time. In principle have Joy meetings, but they don't always happen and problems often with things designed by committee. ….don't want to detract from the fact that staff from 4 health boards collaborate very well now and things are improving all the time. Not aware of placement returns etc.*	*<u>Evidence</u> There seems to be some awareness, through regular discussion with PC Leads, vacancy lists, and placement history made available to the Joy team. Per 1030 the management team are well aware. There is perhaps less awareness of ; a) What the Joy management are planning b) What has happened to issues/ suggestions raised in the past (eg idea on induction IT VC, development of induction packs, SEAs) c) A feeling currently 1039/1040 that they are now much less aware of where the Joy is going. No evidence available on any sort of regular data set other than risk register and joy update presented to SRMC Programme Board (quarterly), staff involved in the scheme are not aware. There is a nice summary comment by 1041 `Aware of the issues, but difficult to keep everybody involved all of the time. In principle we have Joy meetings, but they don't always happen and problems often with things designed by committee. …don't want to detract from the fact that staff from 4 health boards collaborate very well now and things are improving all the time'. PIO - In tandem with GE19 and R12 an expanded Joy will need to develop a regular management data set, probably monthly, to indicate performance, keep a wider Joy team engaged and update decision making. Data could include; GP Placement History – eg weeks provided and where Placement Forecasts*

					Vacancies *Joy Staff resources anticipated* *Project spend* *This could be developed further, later, to include clinical indicators and how the Joy is ultimately affecting patient care though it would be a challenge to access the data informing this. Further evaluation will be required for larger scheme. See Further work section on KPI's.* *Recommendation (R13): A monthly data set is developed to indicate basic activity, placement history, vacancies, staff availability forecasts, project spend. Comparisons could now be set and used based on monthly activity in 2019/20. Further work should be considered to look at how clinical data can be gathered and used to show what changes the Joy is having on patient care.*
GE21	Effective Management	How well are GP performance management/ appraisal and clinical governance managed? <u>Rationale</u> It is good practice that there is a robust management process in place for employed GPs	D8	*1036 D8 Could be better, but what info is really needed? Need really to have a communication plan for practices hence the newsletter idea. Practices probably have not been communicated enough and they are perhaps the missing part of the equation. Need to have an iterative process. Different approach with the locum issue.* *1046 D8 Only one GP has so far asked for a Joy appraisal but there will be more as the project continues and GPs move away from their old professional bases. Next year more important. Bear in mind in England you can ask for an appraisal from any of your significant employer.*	*PIO - Not yet been tested , AMDs will need to consider this point into 2020/1 as demand for appraisals increases and a full years engagement with the joy will have been achieved by some GPs (see also GE14 & R8.on GP feedback and appraisal).*
GE22	Effective Management	Are feedback forms for placements and practices being returned and reviewed?	D9	*1030 D9 Don't know, no visibility. I know they exist and assume that they are being acted upon appropriately.* *1032 D1 & 38 We originally wanted to cascade a small newsletter and needed input from clinicians and an*	*<u>Evidence</u>* *There is some use of feedback forms by both the practices (on Joy GPs) and Joy GPs (on the practices). It is clear that information contained in feedback reports can be sensitive, particularly if*

		Rationale Feedback forms were planned to be an integral part of the process and a version was prepared ready for use in May 2019. This test checks that process works and results are being collected and assessed.		*understanding of what individuals wanted to know about so part information, part interest stories, part focus on a clinical topic etc. There was a plan to discuss this at the development weekend earlier this year (cancelled due to Covid19 shutdown). We could spotlight individuals or practices; we aimed also to get the input from the new GP clinical co-ordinator. Needed to understand what would/wouldn't be helpful to people could merge it with GP practice vacancy bulletin. In practice the Joy team do spend a lot of the time on the phone so there is a lot of knowledge in people's heads but it is not really captured in a consistent way. It is good practice and a way to keep Joy GPs in the loop and for those still making their mind up. As part of the HUBs action tracker this is a topic to be discussed with the team lead in June.* *1033 D9 Seen some - specific to Shetland only. Observation that people only fill the form in when they are unhappy or there is a problem so positive aspects appear less. Don't have visibility of the whole scheme feedback.* *1034 D9 Practices Feedback -Form/process designed by clinicians and Hub don't get 100% returns back. They do get to look at the forms straight away before passing on to Med Directors. One or two issues highlighted on which they have acted. Form needs to be reviewed but really it is a clinician's form and there is a lot of sensitivity over comments made on practices or Joy GPs. Challenging area.* *1036 D9 Feedback forms have been reviewed, but not in the way that was anticipated. Seen by med directors when there is an issue. Now realise there are sensitive issues with HR and GDPR aspects that need to be managed sensitively, complex. If it is sensitive perhaps should not be written on a feedback form?* *1037 D9 Feedback - Don't routinely get it, the Hub should though. Would be useful if Hub shared because we could use it to improve on things. Would like feedback on general issues (eg referral policy)Happy to be involved when needed.(*1048 there was a separate discussion here on the complications from the HR releasing information on Joy GP or Practice issues and circulating widely as this could be quite a sensitive and even legal area).*	*there are challenging issues or comments on levels of performance, this means that confidentiality and data protection aspects need to be considered. This is an area in which to most employees, it would be very sensitive ie discussion of their own performance. In this case it includes Joy GP, and practice staff/ local GPs as subjects of the feedback. This will explain why there has been limited general feedback to the Joy team from the forms, only direct discussion where individuals are concerned. See comment from 1036 (AMD) `Now realise there are sensitive issues with HR and GDPR aspects that need to be managed sensitively, complex'* *PIO – Practically (& legally) it is safer to keep the feedback discrete. However, in a good clinical governance sense, feedback needs to be widely understood to enable continuous improvement. More feedback also needs to be considered to help keep the wider Joy team in touch and engaged, see 1032ideas on a newsletter.* *Recommendation (R14): A discussion needs to be held on the best way to use feedback within the Joy. Effective feedback systems on performance, challenges and success, both clinically and managerially, need to be worked out and described. There are of course confidentiality and data protection rules that – for good reason - prevent identification of individuals so this has to be borne in mind.* *Good feedback is essential to managing the team effort, anticipating problems*

				1039/1040 D9 No, we don't know. We would want to know. There ae issues that maybe we are aware of and could help with practice management or staff at practices where there are issues, certainly 2c.Some fear that Highland practices need more attention to quality (eg on induction) with high use of locums.	*and fostering team involvement. This should be described as part of any Joy governance documents and description of formal Joy structure. This should aid continuous improvement.*
GE23	Effective Management	Do Joy management team have the capacity or a good enough skill set, managerially or clinically, to run the programme? <u>Rationale</u> Is the Joy well enough resourced in skills or capacity to manage safely and effectively?, a separate question to GE19 (management systems).	D10 D11	*1030 D10 The team has the right skill sets. Reminded periodically how awesome everyone else is, there is a huge amount of experience. Team always take it seriously but have some fun as well.* *1030 D11 At the moment we are at the limit of our capacity, optimum. This is being considered in future developments and we are bringing in a more expansive plan with better delegation levels to make the programme sustainable in the future. This reflects the move from being a pilot, which the Joy so far has effectively been, to permanent operation with time, resources allocated with proper job descriptions etc. Proof of the concept has been established and is strong.* *1030 J2 Yes, in a big way (10/10) Achieved what it set out to. 1030 J2 Success factors - a) Creative people running it, freedom to do creative thinking and applying that. B) Expertise, HR expert with experience of living in the islands, a great service visionary but also a willing ness to take responsible risks, also AMD voice of reason and…an experienced project manager that can bring some process and organisation. Team dynamic also very good. c) Initial SG funding, without prescriptive control and some freedom. d) NHS Shetland willingness to host Hub and take responsible risks,. e) Using evidence base to do what needs to be done. The Joy is not actually novel, ability to reference that has happened in the past.* *1031 D10 D11 The skills set we have are very good but feel there are elements of dysfunction sometimes. Skills and structure, difficult to answer. Possibly more the issue is team behaviours, some members need structure and formality, some don't stick to the point sometimes, there is sometimes too much noise in the system. I think what we have done in the first year was OK (it*	*<u>Evidence</u> General consensus from responses are that skill sets are good, both managerially and clinically.1030 discusses the management team dynamic with a good mix of skills with a lead clinician, lead HR professional and project manager. The team is very active and willing to take responsible risks and the culture probably operates in a markedly different way to other NHS department. There is enough evidence to suggest that with the addition of a project manager to the management team (Sept 2019) that it is better balanced in skill mix also (see phase 1a evaluation recommendation). The team is clearly dynamic and with the Joy concept proven, they are looking at wider ways the success can be brought to other areas. This is a key success factor (see also issues #55 Agility and #56 Inspiration).* *It is also true that there have been some frustrations, mainly capacity related, per 1031 `The skills set we have are very good but feel there are elements of dysfunction sometimes. Skills and structure… Possibly more the issue is team behaviours, some members need structure and formality, some don't, there is sometimes too much noise in the system' also 1041 `Between the Joy team we probably have the skills but not the capacity. Don't have time for meetings often; e-mail traffic only goes so far. Better to have 10/20 minute conversations but also difficult to organise.' Per 1032 `my time on the Joy (on*

				could have been better) but we evolved as things progressed. We now have the benefit of hindsight and need to set this up so it functions smoothly and with clarity. . *1032 D10 D11 Problem is nature of the expanded Joy program not yet known. For example, my time on the Joy (on average 0.5days pw over the last 3 months has been more that 1 day per week on average) is given as goodwill, it's necessary but not funded, this is an example of where they Joy is heavily reliant on goodwill. Skill sets are good and the current team has the skills required. More admin support will be required, if the Joy includes other professions (eg more interaction with professional leads, NMC (Nursing and Midwifery Council). Professional Nursing time will need to be part of the clinical governance structure as will potential AHP lead support Generally the amount of traffic, communication and necessary support for staff will increase and this will require administration.* *1033 D10 Skill set good, support from SRMC good but we are going into a new stage now and moving up a gear so not sure what skills we don't have in future.* *1033 D11 Need to draw the management in - who are the core management group?. With potentially 14 health boards, med directors , primary care leads and other professions there is great risk of it all becoming unwieldy. Have to get it tighter and not too many chiefs. A real problem coming is who do I answer to? and the decision making process becomes confused.* *1034 D10 Skill sets - Clinicians don't always have an understanding of operational issues but they have tended to recognise this more recently and put a lot more trust in the Hub. Generally there are good skills around and some good examples of team working (eg face to face meetings with joy management team).* *1036 D10 D11 Yes, Joy management HR/Clinicians have the necessary skills but do need to develop them personally. (The) Hub has basic skills on human relationships, but very important to develop those skills, should think about talking more rather than resorting long e-mails. Communications skills.*	*average 0.5 days pw over the last 3 months has been more that 1 day per week on average) is given as goodwill, it's necessary but not funded, this is an example of where they Joy is heavily reliant on goodwill'.* *Capacity is touched on in many interviews (see Issue #38 on Irregular Meetings) and this is probably symptomatic of an organisation that is having problems getting time for the management team to cover all but the most important issues. It is also probably symptomatic that some people feel that there is little or no feedback (see GE22) because the management team is so busy..* *1033 draws in a point that there is sometimes confusion over roles and the way that this could be a more serious problem if the Joy expands to other health board areas, this is confirmed by 1031 who feels that future management structure is important in the same way that skills and capacity are and 1032 that management arrangements need to be made clearer (response to GE19 D1). (See also HrHub capacity, discussed at Issue #53, #59 on stress, GE19 on Effective management system).* *Recommendation (R15): Joy management team are unlikely to have the capacity for an expanded scheme, they will need to review;* • *Management structure* • *Management delegation arrangements* • *Professional representation and support for each profession* • *Management skill sets required for an expansion*

				1041 D10 Between the Joy team we probably have the skills but not the capacity. Don't have time for meetings often; e-mail traffic only goes so far. Better to have 10/20 minute conversations but also difficult to organise. Hub try and co-ordinate bigger meetings.	*See also (R12) for a more formalised structure for an expanded scheme.*
GE24	Effective Management	Is there a Joy project risk register and is everyone in the team aware of what's on it? Rationale A regular review of an active risk register is good managerial and clinical governance practice. Reviews need to be acted upon and fed into management operations to clarify and where possible, mitigate risk.	D12	*1030 D12 Think there is but never seen it.* *1032 D12 There is a register; It is in use and is shared with Shetland HB/SRMC and Scottish Government as funders of the Programme. It is a requirement of any area of business to enable governance and oversight, on how the risks are changing over time and what mitigating actions (eg Covid19 risk to the Joy) are taken. Also managing the legal definition of NHS Shetland as an agency and the risks of being an employer for so many people. There is a new cohort of people about to be employed that we don't know and the risk profile has been raised. Register underpins how well we (health board) can engage with the Joy.* *1031 D12 No we don't use the risk register really, aware that one is kept.(I think - not really aware of it at all)* *1041 D12 Aware of risk register but not seen recently.* *1048 D12 Risk register noted at SRMC Programme Board Meetings, just need to be more reassured that Joy management are using it.*	*Evidence* *Evidence is scant that Joy management as a team actively use the risk register or that the wider Joy team are aware of it, though they probably do consider risks often. However, a register is submitted to the quarterly SRMC board meetings as part of the Joy update report so basic compliance is achieved. As the Joy gets bigger active use of the register will become more important.* *Recommendation (R16): The risk register needs to be regularly reviewed and business continuity risks considered (see also R11).*
GE25	Effective Management	How will the Annual event planned learn from the recruitment weekend of March 2019? Rationale Planning for the event has been underway since Dec 2019 but are the lessons from the first recruitment weekend in Mar 2019 being considered?	D13	*1033 D13 Think there has been learning. 2020 event is in Glasgow so loses remote and rural aspect but is more efficient, transport is easier. The event has changed to be more a development and recruitment event, a double event. Still using the weekend timings but have built in a lot more planning time which was the problem in 2019.* *1034 D13 Recruitment Campaign 2 (2020) Applications Received (16/2/2020) 42, 33 Shortlisted (includes 2 for W&A). Shortlists being referred through to recruitment weekend (21/3/2020).* *1036 D13 They did learn from the original recruitment weekend, felt that the original case studies were a bit patronising so will be*	*Evidence* *The planned March 2020 event fell victim to the COVID 19 lockdown, but it was high in the Joy team thinking as they went to recruit a second wave of Joy GPs. The first event is considered to be a key success factor and learning point with the Joy project. The first recruitment event (March 2019) was considered to be a success (see phase 1a evaluation report) and has certainly been important in influencing the shaping of the 2020 event it is considered to be a key learning factor.* *A report on the first event was included as part of*

				doing things a little bit differently with new cohort in a different type of venue. *1037 D13 Hoping to go to next recruitment event being planned. Always considered that it would be a 2 in 1 event. Good for a CS led update meeting to share experience etc.as well as recruitment.* *1039/1040 D13 Not been involved with. Would like perhaps to have been given the option but commitment is high so possibly not. 2019 event was very rewarding.* *1048 D13 Importance of the 2019 event cannot be understated as;* *(a) Creating a good and realistic impression with prospective Joy GPs* *(b) Team building within the Joy team & for Joy GP cohort idea.* *(c) A learning experience for all.* *Ownership of 2020 not seen as so democratic. However event must have likely to be successful based on learning from previous year.*	*the phase 1a evaluation and there were lessons to be learned principally that ;* *a) Longer Lead in time over planning is required,* *b) Careful selection of venue to avoid tourist season and reduce travel burden.* *These factors were certainly been considered with the 2020 event with a much longer lead time and hotel chosen near Glasgow. The format of the event was changed as well to incorporate an annual event where the wider Joy team and current Joy GPs could also attend to enhance the team building aspects. Clear that the event has wide benefits for team updating, planning, networking and building a GP cohort.*
GE26	Effective Management	Have there been any efficiencies made by the Joy project? <u>Rationale</u> Are there any time or cash savings in any part of the Joy operation, eg Reduction in locum fees, savings in staff time etc.? (see also issue #47 Resources used by the Joy)	D15	*1030 D15 Too early to say. Reduction in locum fees in some areas and perhaps less staff time used altogether. Main differences are qualitative benefits.* *1033 D15 For NHS Shetland, yes because we don't have the VAT issue that other health boards do so we are not paying the £900 pw locum charges and they are getting a GP at standard rates. Other efficiencies - not much else, perhaps some small savings of practice manager time, HrHub takes over all the actions. Big improvements are in qualitative level, greater consistency.* *1039/1040 D15 Not really aware, may have been some efficiencies for practice staff in not having to recruit locums, but locum arrangements in Highland very stable with experienced locums so not a lot of hassle saved*	*<u>Evidence</u>* *NHS Shetland has replaced many – what would have been locum bookings - with Joy GPs and also, as host health board, is not liable for VAT charges that GMS practices in other areas are. The approximate efficiency saving is significant ;* *NHS Shetland used 48 weeks of Joy GP time in 20 placements.* *Av. Cost of a Joy GP pw (£85k ÷ 52 weeks) £1,600 pw.* *Locum cost (incl. agency charges c £2,400 pw) saving therefore is c £2,400 - £1600 = £800 x 48 weeks = £38,400.* *The other health board areas could also have*

					made some smaller efficiencies but hard to assess without detailed analysis and adjusting for regular, less expensive, locum arrangements operating in some areas(eg OINOC). ***Caution**, these are very rough figures and actual locum charges may have been lower using direct recruitment of individuals rather than going through agencies.* *Otherwise, there is not too much direct efficiency. However, per 1030, benefits are likely to be qualitative and provide longer term stability in primary care in the four areas.* *See also discussion at issue #47 How much time and resources has the Joy used up? Also discussed as part of ljdzl·ýůůl·ůŀØŜ analysis section.*
We Didn't Know What We Didn't Know Theme					
GE27	Sustainability of Model	What has been the effect on other MDT members (incl. regular GPs)? <u>Rationale</u> The question as to how the scheme affects practices and other professionals who are not engaged in the scheme needs to be considered.	E5	*1033 E5 MDT have generally welcomed it, there are reliable people (GPs) you can trust coming back regularly. Relationships have been built up, effect has been very positive.* *1037 E5 No feedback really - small experience from Joy GP working at Lerwick HC. Feel that Joy GPs well received, certainly no negative feedback from non-doctors. Discussed difference of buy in between Joy GPs and regular locums. Thinking about it there were some examples of wider Joy GP involvement with teams (eg Induction Pack, non-clinicians discussion time)* *1039/1040 E5 Difficult to comment, no negative responses.* *1044 E5 Might have changed things, just a little bit! I learned things from them. Haven't upset them, but don't really think I've changed the world either though.* *1044 K7 Very much so. With Wick sensed fatigue with the number of locums.* *1045 E5 Hope the effect on MDT has been positive and we have brought them something different. I think they are quite interested in having an outside view and I have been invited to CG*	*<u>Evidence</u>* *This aspect has not been tested in detail and though there are a wide range of MDT professionals working in primary care, they have not been included in interviews for this evaluation.. A view comes from Joy GPs who have worked with the MDTs closely but only, usually, on short placements so the interaction has not been intense. Question K7 (see GP7) was used with Joy GPs to ask if they felt appreciated by the staff/patients? Responses to this suggest that there is a mixed response from MDTs. On the positive side Joy GPs appreciated when they take leadership in a practice or sit in on practice meetings and the teams do appreciate an outside view in remote and rural places. Expectations have to be balanced by the fact that often MDT professionals often see a stream of locums to a practice and may have a bit of fatigue when dealing with a Joy GP. The views of involved MDT staff need to be interviewed and included in future evaluations.*

				meetings, but it must be frustrating for them sometimes. *1045 K7 Yes, but a bit of wariness on both sides. Patients because of having to explain themselves regularly to locums. Practices for having to deal with a lot of temporary doctors, possibly sometimes with issues. Seemed to be appreciated personally and several places asked me to go back. Think you make your own appreciation sometimes – you can't expect to just walk in and for everyone to think you're fantastic.* *1046 E5 Model can be disruptive to MDT work, in the same way that it is for locums generally. Planned activity with patients can be difficult if you are not the regular GP (palliative care example) Support to MDT has been generally positive but it does have the potential to be negative* *1046 K7 Appreciated yes, by practices. Patients - difficult to say, they were very accommodating as perhaps they have some idea that it is hard to get regular GPs sometimes in remote areas.*	*See also GE33 on support to practices and MDTs, Further work and Future Evaluation sections.*
GE28	Patient Aspects	Are local communities aware and do they have opinions? <u>Rationale</u> Ultimately, the project's success should be defined in terms of what it has done for patent care. A start in this analysis will be what do local communities in the H&I think..	E6	*1033 E6 There has been a bit of publicity about the scheme, have spoken to Community Councils and some things picked up by local newspaper. Generally it has been very welcome.* *1037 E6 No not really, may have been referred to on social media* *1039/1040 F6 (Communities) Probably unaware* *1044 E6 don't think they are aware. Do explain my role when on consultation. Perhaps an official Joy badge might be an idea? Patients pretty resigned in many places.* *1045 E6 Communities - Not sure they know what the difference is but , I do explain to patients quite often why I am there and that I am supporting the local doctors.* *1046 E6 (Local communities) not particularly aware.* *1046 K7 Appreciated yes, by practices. Patients - difficult to say, they were very accommodating as perhaps they have some idea that it is hard to get regular GPs sometimes in remote areas.*	<u>*Evidence*</u> *Not too much evidence that communities are aware of the scheme with the exception of Shetland where there has been some publicity. Some Joy GPs have also explained their role during consultations.* *PIO - Also see discussion at issue #60 (Impacts on patients), this evaluation has not focused on patient care outcomes or community impacts in any detail and, longer term, and this should be a very necessary part of fully evaluating whether the Joy has been successful. General Evaluation (GE) questions considered cognisance of the Joy by MDTs (GE27) and communities (GE28) but not patient outcomes (see section Methodology and challenges also Further work section).* *Recommendation (R17): Future evaluation of the Joy programme should consider the social and clinical outcomes of the scheme for patients and the public*

					health of communities. *See also recommendation (R43): Practices are consulted on future Joy initiatives..*
GE29	Development of the Joy	Joy GPs brought forward several ideas during the Joy VCs, which ones have been taken forward? <u>Rationale</u> Challenges at one practice were given detailed discussion at several Joy GP VCs as well as other ideas . Did Joy management take account of these ideas? (See also Issues #9 Practices with High Workloads #19 Practice Problems #26 Joy GP Challenges)	E9	*1030 E9 Aware of the discussions around practices in trouble and the idea behind using 2 or 3 times GP time to help practices get over problems. This led on to the W&A scheme which is being developed.* *1031 E9 Need to think about Joy VCs, keeping a lessons learned log, action minutes or quality ideas and improvement spreadsheet. VC needs to be re thought out. Important for us to recognise that we need to empower people to be able to raise ideas and innovations and take them through to solution stage, this needs a structure putting in place. Clinical lead needs to be empowered to take this forward. Important to recognise and record what we are doing to improve quality and feed that back to health boards.* *1044 E9 Not really aware of any changes. We did discuss the idea of 2 GPs at Wick, but don't think it has happened yet.* *1045 E9 Can't think of any ideas. We did discuss help video for EMIS on induction. Yes, there is not a complete feedback loop here to the Joy GPs, if you raise an issue or an idea, you don't always get a response. In hospitals in England there is often the wall chart saying `You asked, we did' in relation to staff surveys/ patients etc. If we just had some regular e-mail updates sometimes, as a group, it would help.*	*<u>Evidence</u>* *From notes taken at Joy GP VCs several ideas were discussed over a 5 month period. Ideas raised include;* *a) Ideas on induction & Locum packs* *b) Solutions for practices that need extra cover or in depth GP support.* *c) A top tips for EMIS users* *d) A Video made for EMIS users to help during induction* *e) Use of Joy VC for case studies and CPD* *Per 1031 `Need to think about Joy VCs, keeping a lessons learned log, action minutes or quality ideas and improvement spreadsheet. VC needs to be re thought out. Important for us to recognise that we need to empower people to be able to raise ideas and innovations and take them through to solution stage, this needs a structure putting in place. Clinical lead needs to be empowered to take this forward.'* *PIO – The Joy scheme, as a consequence of being new and able to be reconfigured, has a great opportunity to include new and perhaps untested ideas. This of course, has to be done in a responsible and safe way but there should be wide encouragement to bring forward ideas on development of any part of the operation and these must be considered and reviewed by the management team. There is a real opportunity to continue learning this should perhaps be made explicit as part of the vision and values of the*

					scheme. Recommendation (R18): A lessons learned log needs to be kept and reviewed by Joy management. The wider Joy team and Joy GPs need to be encouraged to keep bringing service delivery ideas, no matter how radical, forward. The management team should not discourage this and should consider making innovation a key part of the values and philosophy of the future Joy.
Limitations of The Joy Theme					
GE30	Marketing Recruitment and Induction Limitations of the Joy	Will some practices become difficult to recruit Joy GPs to? <u>Rationale</u> Some concerns during phase 1a evaluation that some practices may be difficult to recruit to without adjustments or extra incentives, less interesting locations, heavy workload or higher deprivation areas. Testing if the Joy model can support all rural general practices in Scotland or are there limits?	F4	*1034 F4 Not something she is aware of, only perhaps in Wick.* *1041 F4 It may become hard to in some areas and this could be a failure of the project. Joy Drs were employed to make a difference and we should be able to use the opportunity to support all practices. Even though we give Joy GPs a choice they are actually employed so we can direct them to practices where they don't necessarily want to be. Feeling that HrHub finds these conversations with Joy GPs difficult.* *1037 F4 Possibly if word gets around hence bad reputation. Don't think it would happen, there should be enough flexibility in the current system to cover (they did it in Unst at Xmas!). Joy fits the bill for small and rural, may be more problematic for urban/ larger practices where less attractive.* *1039/1040 F4 More and more practices going salaried so possibly a more tricky world. But we should have some leverage to tell Joy GPs where they are working.* *1046 F4 Some practices cannot ask for 10 sessions per week and hope to attract GPs! At least a day off per week is normal to relax/ destress and perhaps enjoy a bit of the location. Practices need to provide enough support on the work/life balance for Joy GPs.*	*<u>Evidence</u>* *Some the of the reasons Joy GPs have come to the H&I is for the `great locations' (1043) `looking for a way to go back to Shetland' (1046)`interesting locations' (1044). No evidence on whether the GPs would be willing to go to other less scenic parts of Scotland, or those with deprivation and other problems. Certainly plenty of discussions about a Wick practice (with workload challenges) and one GP fairly adamant that they would not go there. Some reservations brought forward during interviews. However, placements are short (below 4 weeks) and GPs will usually be willing to trade 4 weeks some where they don't like for some weeks in a practice they do.* *PIO - Probably not, placements have generally been short More problematic perhaps if scheme is expanded to other areas in Scotland without the outdoors scenery, fresh air, rural refresh and a working holiday attractant. The answer may hinge on what expectations Joy GPs have before they come and this will be relevant as to what they perceive as the benefits, it may be better to promote the scheme on holistic rejuvenating*

					practice experience and being part of a team rather than the scenery (also see issue # 5 on Highland practices, # 9 on GP Expectations and Ijʊ·ýŰŰ·ŰØŜ analysis on unfulfilled placements QA7 & 8). Key learning point under QA7. *Recommendation (R19): Will some practices become difficult to recruit Joy GPs to? – This issue needs more consideration if the Joy is to be expanded to a wider geography and more professions. Clear that this model is for remote and rural areas and was designed as a solution for remote and rural problems.* *The marketing message will need to be reviewed if the model is to include non H&I or urban areas.*
GE31	Sustainability of the model	How close are we to a wider oil rig model taking place in any location? <u>Rationale</u> This question is to try and get a broad appreciation of how close an oil rig model of manning rural GP practices actually is – in a particular area - (where GPs work in shifts or on a placement system). This is a first default model if sustainability of regular services becomes challenged through lack of available GPs. Acceleration of the trend – to an oil rig	F5	*1033 F5 Honestly not sure, we are sort of doing it in some locations (eg Whalsay c 5 years). Have discussed with community councils when it happens, not unusual. We like to try to keep continuity by having the same people (GPs) come to the same practices if that is possible.* *1034 F5 Getting close to oil rig model in some places in WI now (eg South Uist). Likely to be moving that way in around 2 years. Agreed that the Joy was more a stop gap rather than a long term solution.* *1037 F5 Yes getting closer to it in some locations. The old model of a GP coming in for a substantive post at 46 weeks for year in a small rural practice is fading now, more likely can only get someone for 30 weeks per year or less, so starting to drift that way in some locations. Must be more flexible now to recruit.* *1039/1040 F5 More likely now in some locations (Kinlochbervie, some areas in Caithness).*	*<u>Evidence</u>* *The consensus is yes, probably will happen a lot more in H&I areas as full time recruitment and if the traditional model breaks down (see 1037 comment). May not be the worst thing and possibly quite sustainable in some areas as per the Orkney experience (see evaluation phase 1a report), they have worked with this system for nearly 10 years.* *PIO – this model may work in rural clusters if introduced gently and the Joy should then be able to support. There are potential problems if it has to come into place very quickly over a widespread area. The Joy team may be invaluable in helping with the expertise built up by the management team and HrHub. Oil rig model will need more active management and staff time in setting up and will be better if co-ordinated between health*

		model - means that there will be greater demand for Joy GPs to fill gaps with more administrational recruitment and placement activity required.		*1047 F5 Cover is at that now in Orkney islands but here Orkney scheme has been successful in getting GPs, pre-retirement, who sometimes work part of the year abroad. Generally they move on or retire after 2/3 years. Key to it is the flexible contracting.* *1048 F5 Consensus, yes, probably will happen a lot more in H&I areas as full time recruitment an old model breaks down (see DM). May not be the worst thing and possibly quite sustainable as per the Orkney experience (see Evaluation Phase 1a report).*	*boards so there are not the negative effects of competition.* *See references section for articles on Orkney arrangements and model.* *Recommendation (R20): Even if the Joy does not continue in its current model, health boards should look into better collaborative arrangements and consider the benefits of the HrHub model in terms of much more flexible, creative recruitment and contract arrangements. The Joy management team and HrHub have a lot of experience now.*
GE32	Effective Management & Governance	Evidence suggests that communications are not always effective; does this put a constraint on the Joy model? <u>Rationale</u> Referred to more as an issue in the Phase 1a evaluation and also reflected in GE23 (Capacity). Sense that planned meetings don't happen and communications from the top are irregular.	F8	*1030 F8 Was an issue but we have addressed in an active way (See D section answers).* *1031 D7 Executive meetings minuted, with actions, have used What's App and attend anywhere though some meetings cancelled. If no time can be found then the meetings don't happen, they do tend to get replaced by more (specific) functional meetings though (eg upcoming conference event prep meetings).* *1032 D5 We originally wanted to cascade a small newsletter and needed input from clinicians and an understanding of what individuals wanted to know about so part information, part interest stories, part focus on a clinical topic etc. There was a plan to discuss this at the development weekend earlier this year (cancelled due to Covid19 shutdown). We could spotlight individuals or practices; we aimed also to get the input from the new GP clinical co-ordinator. Needed to understand what would/wouldn't be helpful to people could merge it with GP practice vacancy bulletin. In practice the Joy team do spend a lot of the time on the phone so there is a lot of knowledge in people's heads but it is not really captured in a consistent way.* *1033 D4 Good comms through Joy GPs with discussion on the*	*<u>Evidence</u>* *There is not really clear evidence that they are <u>not</u> effective but, from anecdotal evidence (PIO), a sense that - to some participants- they don't always know what is going on with the Joy and feel they could be better. Not really captured by the evidence which provides mixed responses.* *PIO – In this case the interview questions have failed to test the issue clearly however, it is clear, anecdotally, that some members of the wider Joy team feel that they do not know what is going on sometimes. This could be because they have been missed out because they haven't been proactive enough to keep in touch. The point is that as the Joy expands and the management structure, delegations and meeting structure change then the information cascade from those meetings, needs to be more effective. It may be something as simple as a cascade e-mail, regular newsletter or copy of minutes gets circulated as a matter of principle (see ideas from 1032 response).*

				What's App group. Good comms with the HrHub team. More difficult when you get to the wider group, seems to be growing arms and legs and not easy to know who is dealing with what. Needs a core group defining. *1033 D7 (Hub meetings) Kind of fallen off. GPs are generally too busy to attend, always a risk with busy individuals and not a lot you can do. Dec 2019 round table meeting in Edinburgh very good but difficult to repeat regularly.* *1033 F8 The joy needs a core team identifying who runs the project. There has to be fewer people with the ability to make decisions and the team must be balanced and accepted. When the core team is defined a more effective way of working can be developed with better communications.* *1034 F8 Communications - Has been a major issue but things have improved a lot recently. Link between PC Leads and practices is very important and not sure how effective that is in all areas.* *1034 D7 (Meetings Problems) Meetings - Yes, problems with regular VC meetings as everyone busy. Regular Wednesday VC (LH, Hub, MS, CS, KB) proving much better, regular, smaller but more manageable. Previous Hub VCs a bit unworkable.* *1036 D2 (Kept aware) Probably not. Newsletter would be a good idea. Vacancy lists and placement returns should be set up to be automatic. Data helpful. Feel that we have got good data and am re assured on placements.* *1037 D2 Get enough information - vacancy notices, placement return so have a feel for what's happening.* *1039/1040 D2 Aware of some things, vacancies, schedule of placement history. Less so now than in the beginning.* *1041 D2 Aware of the issues, but difficult to keep everybody involved all of the time. In principle have Joy meetings, but they don't always happen and problems often with things designed by committee. There is regular contact though. Not always are of future operations, but don't want to detract from the fact that staff from 4 health boards collaborate very well now and things*	*Recommendation (R21): To improve engagement and teamwork, the Joy management team need to cascade information regularly to the wider Joy team. The cascade could include, e-mail, regular newsletter or copy of minutes, but it should at least use one of them*

				are improving all the time. *1041 F8 Small constraint at the moment and communications can be managed, but will be more a factor if scale of the Joy increases (size).*	
Compared to values, philosophy and original intentions theme					
GE33	Values, philosophy & Original intentions	Has the scheme supported GPs', MDT's & Administrators in Rural care in the 4 health board areas? <u>Rationale</u> Related to stated values, philosophy and original intentions (per website) also see responses to GE27 (effect on MDT members)	J1	*1032 J2 Successful, yes. We have achieved a test of change and made a model work and learn lessons from.* *1033 J1 Believe so, except Orkney. Has definitely helped the Shetland practices, particularly the smaller ones. GPs here are now getting their annual leave breaks etc. Joy has been very supportive.* *1034 J1 Yes, but also successful in other non-tangible ways. Has given a hope message to many practices and some are now much more positive that recruitment can be done (one practice managed to get 2 x GPs afterwards). Morale improved but real test will be if the Joy has to pick up failed practices.* *1036 J12 If you want to do something effectively you have to involve the people who are doing it. Coherent involvement needs to include respect and care for the patients. Perhaps, along with practices, this has been a neglected part of the Joy it has been a little bit (only) 2 sided at the moment.* *1039/1040 J2 Yes, done what it set out to do. Important that it is not seen as the solution to everything, it is one tool only can't expect miracles or to solve all problems in primary care.* *1047 B5 Don't know about GPs but cost for practices is very high for the Joy. Regular locum on their books is £4620 pw, HrHub (The Joy) charge £5674, quite a big difference. Probably why Orkney have not used the scheme too much.*	*<u>Evidence</u>* *Main evidence is quantitative (see section on Ijd‡I·yÚ‰Ú·Ú‰ØŜ data analysis) In 9 months of operation 138 weeks of GP time (equivalent to approximately 3.5 WTE GPs over 9 months) has been provided at remote and/or rural practices in the H&I by trained experienced GPs. This has enabled a continuity of care that would have otherwise been unobtainable and provided relief to GPs and MDTs (also see response to GE43- If there had been no Joy?).* *PIO - Appreciate that the effect may have been small to some teams and the point of 1039/1040 is pertinent that the Joy is useful, but only one tool and cannot solve all problems in (rural) primary care. 1032 comment is relevant in a wider sense, `Has the joy been successful (as a model)?' (see discussions at issue #54). Missing is the actual practices or MDT teams opinions themselves, per 1036 comments (also see section on Further work).*
GE34	Values, philosophy & Original intentions	So far, has the project been successful in terms of what it was originally set up to do?	J2	*1030 J3 Yes, in a big way (10/10) Achieved what it set out to.* *1030 J2 Success factors - a) Creative people running it, freedom to do creative thinking and applying that. b) Expertise, HR expert with experience of living in the islands, a great service visionary but also a willing ness to take responsible risks, also KB voice of*	*<u>Evidence</u>* *Consensus that in general terms, the Joy has been successful, however, what success meant, in concrete terms, is a little bit subjective to members of the wider Joy team. Management*

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<td><u>Rationale</u>
Related to stated values, philosophy and original intentions (per website)</td>
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<td>reason and experienced project manager that can bring some process and organisation. Team dynamic also very good. c) Initial SG funding, without prescriptive control and some freedom. d) NHS Shetland willingness to host Hub and take responsible risks, initial drive of RR and LH. e) Using evidence base to do what needs to be done. The Joy is not actually novel, ability to reference that has happened in the past.

1031 J2 Yes, in terms of basic ambitions has been successful (say 6/7 out of 10), it has provided a workforce for rural practices in health board areas where there have been serious shortages. 1031 A12 … would put it as; 1) Strong vision - the strong core vision and values of the Joy excite GPs, allows people to feel hopeful and joyful when the vision and values ae strong. 2) Being part of a team - involving individuals to develop a team looking at underlying problems in a systematic way and help develop solutions 3) The flexibility that the contracts provide.

1032 J2 Successful, yes. We have achieved a test of change and made a model work and learn lessons from.

1034 J1 Believe so, except Orkney. Has definitely helped the Shetland practices, particularly the smaller ones. GPs here are now getting their annual leave breaks etc. Joy has been very supportive.
1039/1040 J2 Yes, done what it set out to do. Important that it is not seen as the solution to everything, it is one tool only can't expect miracles or to solve all problems in primary care.</td>
<td>opinions are clearer, that the joy was successful and reference is made to the following areas;

- workforce has been provided for practices and health boards with serious rural GP shortage (1031)s
- Test of change and the model tested (1032)
- Learned lessons (1032)
- helped on the ground in practices to provide capacity (1034)
- Done what it set out to do (1039/40)

Original objectives were set out in a document from June 2019 (Rediscover the Joy of holistic General Practice) describing the programme to prospective GPs, but they were also available on the Joy pages of the SRMC website.

Against the objectives specified we can give the following responses;
<table>
<tr><td>Address the need for GPs in rural areas where recruitment was difficult.</td><td>21 rural practices in 4 different health board areas have benefited from Joy GP cover (Successful)</td></tr>
<tr><td>To use clearly defined values and a strong quality improvement ethos.</td><td>Values clearly defined and aligned with NHS Scotland values. There is a strong quality ethos though this does need to be more organised in terms of clinical governance reporting and activity (see Recommendation R9) (Successful.)</td></tr>
<tr><td>Use part-time GP contracts allowing</td><td>This is exactly how the scheme has</td></tr>
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					them to continue living in their normal residence and travel to undertake rural work in blocks of 1-4 weeks.	*worked for the 16 participating GPs (Successful).*
					To target retiring GPs.	*Of the GPs recruited during 2019 over 75% were over 50 and in or approaching retirement (Successful)*
					Create a sense of team and support through recruitment, regular VC & WhatsApp contact.	*This is borne out by interview responses of the Joy GPs and other members of the Joy team however, see GE18a and recommendation R10 on the Joy GP VC).(Successful, but `sense of team' very subjective).*
					Targeting PHEC training and support.	*Not described in detail in this report, but many Joy GPs have been on Pre Hospital Emergency Care Training and appreciated it. The BASICs organisation who hosts the training have been provided additional resources to be able to deliver more training to the expanding cohort of Joy GPs.(Successful)*
					To test whether the	*Yes, the scheme has*

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<tr><td>successful scheme of recruitment to the outer isles of Orkney, since 2010, could be replicated at scale.</td><td>been successful using an expanded version of the Orkney model.(Successful)</td></tr>
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It is also clear, from ljdzl·ýűλűl·űλØŜ analysis, that the Joy has been successful in recruiting more than 40 Joy GPs and has provided 138 Joy GP weeks across 21 rural practices in the H&I, this is a measurable success but, what this meant to;
a) An improvement in the recruitment and retention of rural GPs in these areas.
b) Clinical care of patients in these areas
c) Sustainability of the current model of primary care in the H&I
remains unproven.
PIO – Probably in terms of concept, it is clear that the Joy model is successful, it can work and provide support to practices with challenges and help them get consistent and good quality cover, it should be safe to assume that this helps their morale and provides hope. Perhaps the learning is that we have a better idea on what success factors could be and more information to support a case for a wider but more explicit test of the Joy model.
This evaluation is making note of what factors have been key or critical in the process of making the Joy programme work (see section), but it is harder to assess exactly what that success really means without further work (see also issue #48 Future evaluation process and Further work section).
Understanding key success factors and learning points should have the effect of improving knowledge and visibility of operational and
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					clinical issues in primary care (see discussion at Issues #9 Practices with a high workload, #24 Expectations mis-match, #26 Challenging quality issues). *A key area for further work (see section) would be to assess how the Joy has improved patient clinical care and community public health outcomes (see discussion at issue #60 & GE28 and recommendation R17 – Clinical Outcomes for patients).* *Recommendation (R22): Any change of model and operation of the Joy needs to continue to be evaluated, this time including some defined success indicators and potential benchmarks considered at the start. Future evaluations should consider how effective and efficient new models are in providing solutions for primary care service provision across in Scotland as a whole and clinical outcomes for patients (see also see section on future evaluation).*
GE35	Values, philosophy & Original intentions	Has the project moved away from its original vision or values? <u>Rationale</u> Related to stated values, philosophy and original intentions (per SRMC website).	J3	*1030 J3 No, the vision is flexible enough, the values haven't changed. Happy workforce is a good workforce.* *1031 J3 No, not on vision or values though the activity has changed. Now is more challenging for team members when looking at practices with sustainability issues. Moving away now from strict rural remit and looking how it can be applied to other opportunities (?) situations (?).All things can, perhaps should, change but not vision and values.* *1032 J3 Not in all cases. Vision and values outcomes should be related to outcomes for patients therefore supporting practices to deliver that. Hasn't always been a joyous process for some GPs - particularly where they have been in practices in difficulty and*	*<u>Evidence</u> Consensus that Vision and Values have remained constant but per 1031 the activity is changing.* *Recommendation (R23): Vision and values need to be re-visited when the programme changes or expands - to ensure they are still relevant.*

				were unaware of the true nature. The aim was to support practices and enable good quality GPs to deliver services - so to that end we have not deviated *1033 J3 Probably changed a little bit because everything is evolving. Now looking more and W&A. Does the vision now need adjusting because nothing stays the same?* *1041 J3 Generally yes, but some drifting.* *1046 J3 Will change as geographies change/ scheme expansion. Scheme is evolutionary and you only discover things as you go on. Important now how you use quality indicators.*	
GE36	Values, philosophy & Original intentions	Has knowledge & expertise been Shared? <u>Rationale</u> Related to stated values, philosophy and original intentions (per website)	J4	*1031 J4 Probably not. Have shared with Scottish Government and PC leads within the team. Joy VC, not as effective as it could have been, lots of sharing on GPs What's App group.* *1033 J4 Amongst the What's app group certainly a lot of sharing of information and thoughts? Looked at developing the website but this is a very dry approach and not everyone's cup of tea. It really needs a human factor to work. What's App group certainly shares but much of this does not come back to the movers and shakers (of the Joy). We are discussing a hard copy FAQ type fact sheet hand out as part of further development. Longer term, we need to do more about our on line and virtual presence. Cannot do this if programme closes early.* *1041 J4 Yes, a lot has come through KB/CS.*	*<u>Evidence</u>* *There is insufficient evidence here to assess exactly the volume of what has been shared. Clear, probably, that there has been wide sharing of knowledge and expertise but not sure of the volume or value. Examples;* *a) Within the management team between members with very different experience and backgrounds.* *b) Between the HrHub and management team/ HrHub and practices (eg at Hub meetings, discussions with practices)* *c) Between Joy GPs and MDTs/ Joy management/ HrHub- eg the Joy GP VC, GP What's App group, Joy GP participation in practice team meetings* *d) Joy part 1a evaluation (recruitment and inception)* *e) By participants at the first recruitment weekend (Mar 2019)* *f) Joy evaluation phase 1b (this evaluation) through to SRMC and Scottish Government primary care division.* *What has been shared has only been part*

					recorded (eg Joy GP VC notes, notes of HrHub meetings, Joy management meetings, evaluation reports). *PIO - This area is a little bit amorphous and needs to be reconsidered with any reorganisation or expansion of the project (see also discussion under GE11 GE12 Clinical Governance). This evaluation may help.*
GE37	Values, philosophy & Original intentions	Has a creative, cohesive, supportive team of GPs been created? <u>Rationale</u> Related to stated values, philosophy and original intentions (per website)	J5	*1033 J5 Think we have a great team now and very welcoming to new people.* *1043 A1 The time at Strathpeffer was really good. CS put across the idea that we were in a team very clearly and after a little while you did feel that you were part of a team.* *1046 J5 Yes, There is a team feel and GPs stay in touch and take an interest in how it's going (see WA group).* *1048 J5 Yes, but not all Joy Gps want to take part in it. Experience from Joy GP VC is that probably around half the active GPs take regular part but others don't. Certainly a feeling of a team that interact independently with each other. Also What's App group active as well though content drifts into social rather than work things. Within the (Joy GP) team there are sub groups of self-selecting GPs who stay in touch and provide support for each other.*	<u>*Evidence*</u> *Joy GPs often have interaction with one another, either one to one or through the What's App group or Joy GP VCs. The phase 1a report which covered the recruitment weekend (Mar 2019) explained that ..`The Joy team took a deliberate approach using the weekend to evaluate the candidates, but also to bring out the candidates own qualities, ideas and buy in to the process 'it was clear that this had happened and Joy GP responses tend to confirm it eg `1043 (Joy GP) The time at Strathpeffer was really good. CS put across the idea that we were in a team very clearly and after a little while you did feel that you were part of a team'.* *PIO –Evidence tends to confirm that a team has been created, one that GPs interact with each other independently, but not really sure of how inclusive a team and how fully cohesive it is in practice. Unfortunately the planned development weekend open for all joy GPs in March 2020 had to be cancelled in response to CV19 lockdown; this would have been very helpful with team building.* *Recommendation (R24): Joy GP, or other MDT professional team building needs to be considered as an active, conscious and regular exercise. This should be reviewed by the joy management team for*

					effectiveness and improvement and a useful means of feedback on the health of the teams. Team building needs to be considered for the Joy management team itself and other operational teams within the Joy (eg HrHub).
GE38	Values, philosophy & Original intentions	How many Joy GPs have been through a recruitment/ selection weekend? <u>Rationale</u> Related to stated values, philosophy and original intentions (per website)	J6	*1041 J6 Not sure what people thought of the weekend but it was very good in helping cohesion as putting names to faces and meeting people has helped a lot later in making it much easier to chat and communicate.*	*<u>Evidence</u> 14 GPs went through the March 2019 weekend out of a cohort of approximately 26 offered posts in the first wave in Spring 2019 (see phase 1a evaluation report, appendix A).This lower number reflected problems stemming from the short notice and perhaps remoteness of the venue. More GPs were recruited after the weekend.* *PIO – this question reflects more an original intention and concern. The success of the recruitment weekend was discussed in the phase 1a evaluation report.*
GE39	Values, philosophy & Original intentions	How many use the smartphone messaging group or what's App group ? <u>Rationale</u> How well used is this facility?	J9	*1046 J9 Quite a lot of contribution and useful discussions some GPs less active but listen in. It is a very helpful service.* *Per 1030 interview 23/12/2019 – WA group sometimes a source of dis information.* *1032 D1.in the past as clinical leadership has got mixed up with operational management, as a consequence the wrong issues have been brought up in the wrong forums (eg What's App group) everything had been a bit confusing.*	*<u>Evidence</u> Not tested, but some concerns that What's App group has been a bit of a distraction.*
GE40	Values, philosophy & Original intentions	How closely do Joy GPs work with the clinical lead?	J10	*1033 J10 Work with the new clinical lead very closely, will review in 6 months, but this also means a long term commitment.*	*PIO - J10 Emphasis of this question has changed since the appointment of a new Joy clinical lead in Feb 2020. This was originally a test question to check the connection. See also GE11, GE12, and GE18. Could be a longer term consideration for further evaluation (see Further Evaluation section)..*

					Recommendation (R 25): Effectiveness of the role of the Joy GP Clinical lead needs to be assessed and evaluated in a future Joy programme (see also R6 and R9).
GE41	Values, philosophy & Original intentions	Is there any other point that you wish to make over the Joy project are there any lessons you feel we should be aware of? <u>Rationale</u> Have we missed anything?	J12 F11	*1032 F11 Will need to work towards better outcomes for patients; 1) The Joy needs to expand to Multi-Disciplinary Roles and widen the offer. 2) How do we support practices in crisis/struggling We need to think about a crisis team and perhaps a different financial model where they Joy is paid directly by SG to provide that support with a team intervention. We have excellent skills; model could be adjusted/funded to work in areas of high deprivation, remote and rural etc. More of a team approach to failing practices etc.* *1033 J12 See above F11. We can't plan if we don't know what funding/ resource we will have. What will the exit strategy be if we have to close by say, Mar 2021?* *1037 J12 Don't know how phase 2 of the Joy will work. Big driver and attractant - remote rural, small, rediscover the Joy. Expanded project becomes less different and not sure how it will work. Pleased where the existing model has got to, particularly for Shetland. A lot of work to set up, but met great GPs, covered a lot of work, great to be part of it. Longer term - may not be able to keep the initial cohort going as GPs will drop out and need replacing. Need to look at other professions as well, 50% of practice nurses (are) over 50 and recruitment problems so could we not use the Joy model here as well as many of same factors apply? Not sure an expanded SRMC remit into all professionals in all areas will work (all things to all people?). Also bear in mind Cohort 2 of Joy GPs (Wanderers & Adventurers) may have different skill sets and attitudes to first cohort and we may have to review how we work.* *1039/1040 J12 How do we change contracts? As the scheme develops, perhaps we should look at sitting down and reviewing again what the Joy contracts should include. Approaching one year on now and of the original wave of Gps some of them only*	*Questions F11 and J12 were trawling questions asking if there were any further points interviewees would like to present (J12) or how do you see the Joy developing (F11)?* *Points raised;* *a) (1031) Crucial point about future funding. If no funding, no plan and also exit planning needs to start now as HrHub employment contracts due up Sept 2020.* *b) (1032) Joy can now widen the offer to primary care by including MDT professions and creating flexible crisis support teams to operate in many different circumstance.* *c) (1045) The hub will always do their best. Echoed in many interviews.* *d) (1037) Future of the Joy (also aired in some interviews)- beyond the scope of this evaluation, however see summary points.* *e) Review of Joy GP contract terms & conditions. (see R5 and discussion at GE10)* *f) (1039/1040) Enjoyed working with other health board colleagues* *g) (1036) Practices haven't been too involved, missing part of the equation? (see discussion at issue # 60 Practice Involvement and R43).* *h) Diversity – see discussion at Issue #51.*

				wanted a year. How many will drop out? How do we change things? Enjoyed working with other health board colleagues, particularly the interviewing.(See also discussion at GE10) *1036 J12 If you want to do something effectively you have to involve the people who are doing it. Coherent involvement needs to include respect and care for the patients. Perhaps, along with practices, this has been a neglected part of the Joy it has been a little bit (only) 2 sided at the moment.* *1044 K4, Personally interested in the job because a great end of career challenge in interesting location* *1045 J12 K8 The joy is still evolving, paperwork will improve, HrHub will get more organised. One thing about the Hub is that they always try to do their best. We are inventing a new wheel.* *1046 J12 Anxieties over T&Cs - Will be much simpler and easy to get across the basic offer early on next recruitment. Inclusion - Just some concerns as GPs so far recruited are all quite similar, white , middle aged, middle class , perhaps 2/3 men. Not as this is a problem but it is not a diverse mix and it may mean The Joy is seen as not so inclusive or open. Noticeable coming from England.*	
GE42	Values, philosophy & Original intentions	In terms of diversity, most Joy GPs are white, 2/3 men, over 50 mostly, does this create an issue? <u>Rationale</u> Does the joy have a diversity issue or, has this aspect been forgotten?	J13	*1031 J13 Not an issue for me. We targeted the market for GP's approaching retirement so the demographic we got was reflective of that group. Can't think that any group has been excluded.* *1032 J13 No that is the nature of the demographic expected in phase 1 of the joy -this is part time posts and therefore will appeal to a higher percentage of those at a particular stage in their career. The Equality aspects are not an issue when you think that the Medical Director is Female the GP Lead is Female and a proportion of Phase 2 are female. We monitor all equalities data as we are legally obliged to do so and we would amend campaigns to look to attract specific types.* *1033 J13 Don't think it's a problem (probably)? Our original marketing aimed at O50s and we are only reflecting the demographic of UK GPs anyway. Majority O50 are male, majority U40 are female. There were some candidates from other*	*<u>Evidence</u> Opinions from most interviewees suggest that this is not an issue with the Joy. The same point is repeated - marketing for the posts was aimed at later career doctors so that is what you, eventually, got. To an extent that demographic and ethnic makeup are reflective of the local populations. Recruitment was open to all GPs and didn't discriminate any identified social group. The posts would have been unlikely to attract GPs with young families given the need for a stable home, base, schools, childcare etc. Good detailed response see (1045) comment.* *PIO - Raised in an early interview and built into a later question (J13).Conclusion is that the answer is no, but worth raising the profile of the*

				backgrounds for the scheme but they didn't have GMC registration and so had to be screened out. *1039/1040 J13 Good question -Perhaps places would benefit from a more diverse approach.* *1044 J13 Not really, in reality Joy demographics represent composition of retiring part of GP workforce in the UK, just a blip really. Scheme appeals to those about to retire for a lot of reasons. Not always feasible for younger people with families.* *1045 J13 I think it reflects the nature of the GP demographic group who would apply for this sort of role. Not a big issue as the demographics of this group reflect the demographics of the communities they are serving and often the demographics of the practices they are replacing. Some places very grateful to have a woman GP. We are serving a very disparate population and I suspect not many younger doctors would have the experience to deal with some of the issues you face in the H&I. Modern GP practice in urban areas does not necessarily give the skills or independent frame of mind to cope with some of the situations you face. Also younger people with families wouldn't necessarily want this sort of role, I couldn't have taken it on when my children were younger.*	*discussion point.*
GE43	Values, philosophy & Original intentions	What would have happened if there had been no Joy project? <u>Rationale</u> Enables reflection on what the success factors / benefits of the Joy have been	J14	*1030 J14 SRMC would have lost focus, many GPs in the H&I would have a lot less hope.* *1031 J14 What they Joy has brought has been; a) To prove we could recruit doctors when prevailing belief was that you couldn't. b) Changed attitudes so that there has been more hope that solutions can be found though we have to be flexible with what we can offer. Challenging the old mind set. If no Joy - Would have lost a lot more GPs in the H&I, some of Joy GPs would have left health and retired/ been lost to the NHS. For SRMC it might have been critical, we would have been struggling to show what SRMC had actually done with GP recruitment and retention projects.* *1031 A12… success factor, would put it as; 1) Strong vision - the strong core vision and values of the Joy excite GPs, allows people to feel hopeful and joyful when the vision and values ae strong.*	*<u>Evidence</u>* *Another twist on the `How successful has the Joy been?' approach.* *Opinions on a hypothetical question come from different angles but agree that generally primary care services and morale in the H&I would have been worse off. Themes group around;* *i. A psychological uplift from recruiting GPs where many felt that this would not be possible. Hope perhaps? (1031)(1039/1040)* *i. Retained many Joy GPs who would have retired/ been lost to the system (1031).Key learning point.* *i. Not managed to recruit to some substantive*

				2) Being part of a team - involving individuals to develop a team looking at underlying problems in a systematic way and help develop solutions 3) The flexibility that the contracts provide. *1032 J14 Would have been more expensive on locums, more problems and CG issues and a more expensive model. Some practices may have gone under and reverted to health board management. The test of change worked, but if we hadn't have tried we wouldn't have known and there would have been a lot of time lost talking about should we have a Joy? Even if the joy doesn't continue in future it will have been worth it.* *1033 J14 We would have been in a worse place! (We have) Recruited 2 substantive GPs from the scheme, cheaper than locums. New blood has come in with new ideas and ways of working from outside the H&I.* *1039/ 1040 J14 We would have been worse off. The Joy means there a greater resources and a wider team that we can draw upon. Against a background with a lot of problems, it is nice to have an extra positive tool to use.*	*GP posts (1033)* *v. New blood, new ideas in from outside (1039/1040)* *v. If no joy, people would have still been talking about (1032)* *PIO – Later question added to the interviews so it was missed by some participants. A few useful points were raised clarifying success factors (see summary of key and critical success factors section).* *Arguably Joy GP time has replaced locum GP time in the 21 practices where the Joy has provided GPs and this would perhaps mean a qualitative improvement, but much more difficult to measure and prove this in this evaluation. A key problem assessing the success of the Joy was that the evaluations were organised retrospectively (see discussion at GE34).* *Useful question for further evaluations though, see future Joy evaluation (issue #48).*

Issues evidence

Issues Evidence						
Since the commencement of the Phase 1b evaluation of the Joy (July 2019), issues have surfaced, usually out of discussion with doctors or managers running the scheme or, from discussions with participating Joy GPs. This section is an attempt to capture those issues, look at how they were approach and tease out key learning points for the study. The issues raised has been kept in chronological order to retain the link of what people felt were important at the time (eg issues 1-10 very prominent in July 2019, . 10- 45 between September and December 2019 and 46 – 60 in 2020 often in response to evaluation interviews.).			*Learning Point – Makes an observation about learning that has arisen through the Joy operation.* *Critical or Key success factor – A fundamental factor that makes the joy successful, take it away and the Joy will not work.* *Recommendation – A suggested action(s) to improve the operation of the joy to achieve more benefits, reduce risks or develop strategy.*		
Issue Number	**Issue Area**		**Background + Later Evidence**	**How Tested**	**Relevant comments from Interview with question reference no.**	**Conclusions/ Grouped Theme Discussion**
1	Recruitment and Induction	GPs seen just as normal locums and not any differently by practices	Experience of first 3 Joy GPs into post. Though practices were not unfriendly, GPs were given no special welcome or much time to induct. Relations with practices were quite reasonable, but there was a feeling that the practice didn't understand that there was any difference between them and regular locums. This was made aware to AMDs and Hub during July. Work on induction checklist is currently ongoing (based on work by GP in Shetland). Nov 19 –Regular practices are becoming more aware, but still an issue with some Highland practices	Interview Tested – Perception Marketing Questions A1, A4, B2, B4, B8	*1033 B2 (Good Induction?) Yes, they have now. Practices and GPs have different views as to what should be in an induction. Experience from early on in the scheme resulted in the creation of a template by KB (Sept/Oct 2019), this went out to all practices in Shetland and was well received (trialled in Broadbay). There has been no negative feedback from Joy GPs since.* *1034 (GP Induction) .know that quality varies amongst practices. They have been working on a standardised induction sheet with KB and trialling in the Western Isles. (HrHub) not actually received specific complaints themselves.* *1036 B2 Induction - Process of evolution. Different understanding of what it means between med directors/ hub/ practices. Appreciate now the wider induction requirements that the Hub consider, a full detailed checklist covering the duties as an*	*Evidence* *This aspect of expectations / arrival at practice not directly tested by questions B2 etc. however, see responses, particularly Joy GPs. Seems to become less of an issue as time goes on. The whole issue of GP induction materials and packs has received attention though not clear if this has cascaded to all practices, especially in NHS Highland area.* *PIO – Clear that for some practices, initially, the appearance of Joy GPs with little previous experience of Scottish systems, was a bit of a shock and they needed more support than the regular locums – in terms of handover and induction. General support from NHS Shetland, as the employer, has been good, the issue has been at practice level.. More the issue now is to make sure that good,*

					employer. For 2c practices and locum arrangements , induction much more about quickly orientating a GP to get them working-basics of what you need to know to do the job. What has this meant for the joy - an iterative process, but we did actually point this out at the recruitment weekend and Joy GPs asked if they could help and the reaction was OK. The GPs wanted it to be better and some engaged later on tasks to help improve it. *1037 B2 – Not sure, probably seen as locums by some staff in some practices.* *1039/1040 B8 Wick experience was a good example of this early on but feels that problems over expectations have resolved now.* *1041 B2 Good induction - Generally we are learning as we go. Shetland has acted as the centre on induction guidance, but there are problems with guides designed by committee. He has not had much feedback; just one GP who felt H&I induction was good.* *1043 K3 Generally pretty well, difficult for practices because they see a lot of strangers coming through. Not getting any feedback from practices which is a bit frustrating..* *1043 K7 Some patients very grateful in small places and some appreciated having a different GP.* *1044 K3 Different for each practice. Wick busy and lots of part time staff/clinicians, I was the only one there every day. Not treated badly but not much camaraderie, not anyone's fault. The others were very good, great welcome at Broadbay and Acharacle, enjoyed being alone at Carbost.*	*up to date, induction materials, some protected time and support is available at the beginning of the placements (also see issue # 32 Formularies, # 41 Access to local clinical guidelines and procedures)* *Recommendation (R26): Better, more standardised induction guides to be available in all practices using the scheme. New Joy GPs must be given protected time and support to get to grips with IT systems, patient referral and logistics information - for their location - before commencing work fully.*

					1044 K7) (Treated by Practices) Very much so. With Wick sensed fatigue with the number of locums. *1045 K3 Some initial teething problems on both sides. It would have been a good idea not to have been put on call at the first practice on the first day as no idea where everything was or how IT worked, wasn't thought through by practice. Later practices were all fine and accommodating, invited to meetings etc. Unst had an outstanding hand over package, head and shoulders above others, the regular doctor/PM had really thought it all out even down to the useful everyday tasks/ routine. Helps to plan your day very efficiently, the model induction.* *1045 K7 (Treated by practices) Yes, but a bit of wariness on both sides. Patients because of having to explain themselves regularly to locums. Practices for having to deal with a lot of temporary doctors, possibly sometimes with issues. Seemed to be appreciated personally and several places asked me to go back. Think you make your own appreciation sometimes – you can't expect to just walk in and for everyone to think you're fantastic.* *1048 B2 This was very much an issue when the first Joy GPs were inducting (Jul/Aug 2019). Using thermometer of the Joy GP VC it gradually became less of an issue over time as expectations adjusted. Clear that many practices may have trouble distinguishing. More the issue is to make sure those regular Joy GPs/ Locums have good concise handover details and that new Joy GPs get a decent period to induct with up to date and relevant induction materials, particularly on IT systems.*	

2	Recruitment and Induction	Induction very variable and quality poor in 3 practices	Sometimes, GPs given very little time to induct. IT systems were clunky and not intuitive, phone number lists were sometimes out of date, there were no other GPs to ask (2 GPs were sole doctors) this led to very stressy first few days. GPs got better at systems and surroundings and problem resolved in first week. Hr Hub Meeting 21/8/2019 Work ongoing on a FAQ for practices spelling out what is required for a Joy GP coming in incl. induction checklist and guidance on induction time etc.	Interview Test – Induction and recruitment Theme (B) Questions B2, B3, B4	*1033 B2 (Good Induction?) Yes, they have now. Practices and GPs have different views as to what should be in an induction. Experience from early on in the scheme resulted in the creation of a template by KB (Sept/Oct 2019), this went out to all practices in Shetland and was well received (trialled in Broadbay). There has been no negative feedback from Joy GPs since.* *1034 (GP Induction) .know that quality varies amongst practices. They have been working on a standardised induction sheet with KB and trialling in the Western Isles. (HrHub) not actually received specific complaints themselves.* *1037 B2 ..can't speak for everywhere. Saw the problem first hand at Lerwick recently with a Joy GP and induction pack not ready, would hold hands up here.GP had actually worked on a pack that they had developed at Brae so she understood the issue. Resolved her support by spending time with her on first day and that was best practice. Have somebody from management sit down with a GP and establish induction needs. Practices should really have a generic induction pack with local add your own bits.* *1039/1040 B2 Difficult for us to say, not aware of how good induction is at different practices or any marked improvement. Discussion as to how much induction GPs actually need and difference between quick orientation for short term placement and more involved induction with HR aspects etc.* *1043 K6 (Good induction) No not everywhere, a bit patchy, but some practices really good*	*<u>Evidence</u> (See also evidence for related issue #1 No special support for Joy GPs). Clear that since the original poor experience that work was done to improve induction process and materials. 2 Basic packs were updated in Shetland and Western Isles and made available widely. Comments by Joy GPs suggest that there is still some variability.* *PIO – Welcome, handover and induction were recognised as a problem area early on with stories coming back through the Joy GP VC. Learning Point, key problems were identified as;* *a) GPs given no time to adjust/orientate in some practices. Quite often practices did not know the difference with general locums who were used to Scottish systems.* *b) Induction packs were poor in some places or not up to date.* *c) Scottish primary care IT systems different to England, more `klunky' which made GPs took more time to see patients initially (see discussion at Issue # 3 and recommendation 4a).* *See recommendation R25 (on induction guides) and R27 (on support for IT system induction), clear that good practice is not just a case*

					(South Uist, Glen Elg). Some locum packs not brilliant. *1044 K6 (Induction quality) Variable. Wick - in at the deep end, didn't know Vision so a difficult first day. Better with others but, so long as you took your time, you could get there. Carbost - particularly good. Dr there did very well with a book. Overall, was sufficient.* *1045 K3 (Induction quality) Some initial teething problems on both sides. It would have been a good idea not to have been put on call at the first practice on the first day as no idea where everything was or how IT worked, wasn't thought through by practice. Later practices were all fine and accommodating, invited to meetings etc. Unst had an outstanding hand over package, head and shoulders above others; the regular doctor/PM had really thought it all out even down to the useful everyday tasks/ routine. Helps to plan your day very efficiently, the model induction.* *1048 Early issues of problems with induction and materials – which surfaced at early at Joy GP VCs (see notes) was fed back to the Joy management team during Summer 2019. Seemed to be less of an issue after Sept 2019.*	*of handing a new Joy GP the induction manual (see issue #41 on Access to local clinical guidance).* *Recommendation (R27): As well as the help from a good, up to date induction manual, particularly on first Joy placement, Joy GPs will also need;* *a) Time to orientate,* *b) Support getting into accommodation and understanding local transport, secondary care, OOH , dispensary and other logistical arrangements* *c) A good handover, where possible.* *d) Support from an experienced user working with the primary care IT systems. (See also R26).*
3	Recruitment & Induction Theme	Practice IT systems difficult to work	First 3 GPs came from English practices using EMIS System integrated software. Scottish systems are on much older versions – EMIS PCS, Vision X. Necessary on Scottish systems to come out of main medical record to access other systems (eg SCI Store, blood results etc.) which slows down the patient appointment and is distracting. Over time GPs become more	Interview Test – Induction and recruitment Theme (B) Questions B2, B3, B4	*1031 iss2 The Scottish Primary Care IT system is horrendous compared to the English systems (apparently). I think this is an important point to highlight, but it is not an issue that The Joy can address. We are waiting for a new IT system and the procurement system has taken literally years and continues to drag o... It has been the continuous comments from the Joy*	*Evidence* *Main evidence came from Joy VCs (from July 2019) but also see Joy GP comments. This has been a Key learning point. Scottish systems were not developed to the extent that they have been in England, partly because underlying broadband speeds have*

			proficient but it is a bit of a culture shock at first. Mentioned many times on early Joy VCs (#1, #2, #7 #10 etc)		*GPs and the English GPs coming into INOC that has helped me realise how archaic our system (that we have got used to) is.* *1037 iss 2 In general NHS Scotland has many positives over England &Wales but IT is not one of them. E&W have had web-based clinical systems for about 10 years. We're still waiting on Scottish Gov't to tell us they're "fit for Scotland", and it's been "on the horizon" for many years for example, NHS Shetland has been looking at trying to merge the IT of the mainland 2c practices (to provide clinical benefit to the patient, e.g. OOH), but it's hard to do because of the system – people from EMIS would physically have to visit Shetland to do it. If it were web-based, it could apparently have been done remotely.* *1043 A7 Some things… were a problem because of the computer systems, they are not as sophisticated as those in England. They are clunky and there is a risk having to transfer data across systems manually, this makes workload a bit worse. Transcription errors should be avoidable these days.* *1045 K1 Interface was difficult to start with, Scotland and Scottish NHS IT systems very different and I didn't know what I didn't know when I came. Had worked in Shropshire for 25 years before that.*	*been slower and less robust in rural areas. Migration to Office 365 is only happening slowly so primary care has to run with older versions of EMIS and Vision and they are not compatible with other systems in use so GPs often have to close one system to go into another.* *PIO - This issue has prominence at national forums (eg the Primary Care IT Users Group) but there are no short term answers. Generally the Joy GPs settle down with the Scottish systems but it is a shock sometimes on first placement (see Issue # 2 and R27).The idea of a help video was also raised at a Joy GP VC (#7). See discussion at GE8 on Scottish Primary Care IT systems.)* *Recommendation (R28): Creation of a help video for professionals new to Scottish primary care IT system (see also R27).*
4	Recruitment & Induction Theme	GP withdrew after all the processin g substantia	Lot of effort, no result (Also raised as an issue under Issue #35 Email from a frustrated GP and # 43)	Interview Test – Induction and recruitment Theme (B) Questions B2, B3, B4	*1034 B4 - Frustrated GPs -Not aware directly from GPs that there was a problem. Setting up contracting process in early 2019 was difficult and time consuming as they had to create bespoke contracts almost an agreement on hours/ T&Cs etc. Took a long time to put in place. …sensing frustration from other Joy*	*Evidence* *Only evidence of 2 GPs quitting the recruitment process, one blamed it on delays.* *PIO - This issue had a high profile during a period of difficulty in*

		lly complete.			*team members. This may have stemmed from a lack of awareness from clinical staff on what was involved in putting the contracts and robust process together. To help they prepared an FAQ to help GPs but don't think they ever lost a prospective GOP because of delays. They did a lot to stay in touch with them.* *1036 B4 Frustrations were not necessarily around recruitment, but long delays getting onto the Scottish GP Performers list and other delays around PVGs, occ. Health. Really time consuming and often cross border (Scotland/England), slow. Perhaps we didn't make that clear at the beginning. KB and CS went to Shetland (Aug 2019) to help understand the position and so that HR not acting in isolation.* *1041 B4 Aware of some frustrations but also understands that recruitment takes time and there was probably an expectations problem in the beginning with the slow pace of the NHS.*	*May/June 2019 when long delays in getting recruitment processing done was causing frustration all around. Root of the problem is getting the rest of UK GPs registered on the Scottish GP Performers list, this process is still slow but attempts have been made to improve the speed.* *Not much evidence that the scheme has lost potential Joy GPs because of delays appointing/ placing. Less of an issue now.*
5	Marketing/ Operation of The Joy	Practices in NHS Highland area don't seem to be aware of the scheme or if they are, not aware of the criteria.	Expectations very different from Highlands practices, tendency to see the hub as an external locum agency, *attempts to bid down costs (can't) *asking for cover for substantive posts. *asking for a lot of cover for 6-12 month period, (hub can only work up to 3 months ahead) Very much an expectations issue and practices have not had much contact with their own NHS Highland primary care leads. Discussed with Evan Beswick & Fiona MacKenzie 15/10/2019. Communications different in Highland, there are a lot of practices therefore comms much more `one to many'. They have	Interview Tested – Marketing Theme (A), A4 Induction and recruitment Theme (B) Questions B2, B3, B4	*1034 A4 - Highland practices - Difficult to tell, not sure how widely information on the Joy has been disseminated. However clear that highland practices are responding g and this has increased gradually over time of 106 placement bookings 44 come from highlands (42%). Was a suggestion in the beginning that they did not know about the scheme? Much more in line with expectations now.* *1039/1040 A3/A4 More aware now, people/practices do talk about it though they don't always understand how the scheme works. Not everyone sees the scheme as a positive and with the recent inclusion of VAT (charges) then it is more expensive for GMS*	*Evidence* *Clear that the relationship between the Primary Care leads and the practices are different in the 4 health board areas. NHSH has approximately 88 rural practices compared to the Islands combined total of 28 and relations, with the practices, are more occasional and communications `one to many' rather than one to one. Also there are many GMS practices in NHSH (71 out of 88) and they tend to have less direct involvement with the health board and are more independent minded.*

			sent out information on the Joy to practices, but sometimes practices are so busy that they don't notice. (see also Issues #8 Employment Contracts, #13 Advertising for Locums and #29 VAT)		*practices. Not so much a problem for 2c practices but there are not many ways around that. They had a similar problem with a GP Fellowship scheme. Locum agencies were more competitive as VAT only charged on arrangement fees.*	*The take up for NHSH practices of Joy placements has gradually increased (only 4 requests in July 19, 9 in September, 17 in December). There is wider information available on the scheme in NHS Highland since October 2019 (SRMC revamped intranet page, NHSH Intranet page). Also see vdzl·yÚlÚl·ÚlØŜ analysis section for differences in numbers and practice type.* *PIO – Per 1039/1040, awareness of the scheme in Highland has improved month by month and anecdotally, NHSH practices do seem more aware. Whether the take up rate approaches that of the islands remains to be seen. More an issue may now be the VAT problem whereby NHS Shetland has to charge GMS practices (outside NHS Shetland area) VAT for placement fees (see discussion under Issue #52). The situation is also different with different types of practice. Many GMS practices have well established locum arrangements which they don't want to disrupt unnecessarily and the price of Joy GPs is a more critical factor.* *Key learning point – The empirical evidence is that take up of Joy locums by NHS Highland based practices (adjusted for population size or practices numbers) has been far less than the islands (see analysis at QA2) The nature of each health board area is different, typically, the number of practices but also the balance*

						between health board (2c) and GMS (17c, 17j) practices. Therefore the attractiveness of the Joy, to practices, varies between areas. The difference may be compounded by the complication of the VAT extra charge issue (see issue #52 VAT). Further evaluation should examine why this difference persists and in what better way the Joy could serve NHS Highland? (see Further work section).
6	Limitations of The Joy	Some practices putting in very long range requests for cover (ie more than 6 months).	More than the Hub can cope with on placements at the moment (July 2019), often requests are not from priority practices (* single handed or substantive vacancy for more than 1 year) <u>Nov – 2019</u> Evidence is that practices are getting better at putting requests in (discussion with the Hub, Oct 2019) tendency now is more for very short notice, short requests (also see the opposite problem at issue #20, practices are putting in short notice only a few days placements).	Interview Test – Limitations of The Joy (F) Questions F1, F10	*Issue raised initially by HR Hub in July 2019, a concern that Hub could not plan or make commitments that far into the future.*	<u>*Evidence*</u> *There were and continue to be longer range requests for placements (the current longest are 8 months ahead) typically as small practices consider their GP leave arrangements.* *PIO - This was much more an issue in July 2019 when the first placement requests were being received. This was not raised as an issue by Hub staff when discussed as art of this evaluation. Considered that early on there was a period of expectations setting and establishing the rules with practices. This runs in a fairly straightforward manner now.*
7	Clinical Governance Limitations of the Joy Original Philosophy and Values	Joy GP VC Arrangements	VC arrangements difficult; 1) Setting a time as GPs are in clinics all week. 2) Private lap tops do not work in NHS buildings, NHS lap tops do not work out of home area. 3) Broadband pretty patchy outside of main centres. Regular time of Thursdays 1800 two weekly arranged as a compromise. The Direct Access software constrains limits where NHS laptops can work and Wi-Fi access in NHS buildings is	Interview Test – Clinical Governance (C) C11, Limitations of The Joy (F) Questions F1, F10 Philosophy and Original Intentions (J) J7	*1043 C11 Joy VC very good, despite the technology they were effective in discussing issues and a way of providing support when you were out there in placement. You got some feedback about how the whole project was working etc. They were much appreciated.* *1044 C11 Useful, excellent way of supporting (personal) reflective practice, having the minutes of the meetings was helpful. Feel it helps when on placement for the Joy and useful to patch in, need about 5/6 on the VC to make*	<u>*Evidence*</u> *Issues around the VC well understood by Joy Management team and Joy GPs. See discussion under GE18a on the clinical governance aspects and issue#44 on changing nature of the Joy VC.* *PIO – See notes of discussion with 1046 as part of the evaluation (opposite). Despite the shortcomings, it is very often a good meeting*

			limited to only locally issued equipment. Though VC calls can work on private laptops away from NHS premises capacity to have more than perhaps 10 participants is limited unless dedicated NHS VC facilities are used which will mean GPs travelling and using clinic time. <u>Nov 2019 –</u> VCs have settled down as the limitations of the system become understood. 1) NHS Highland Laptops have direct access controls enabled which means that it is not able to work with the NHS Scotland Video Conferencing Service and older software (eg WebEx has been disabled) – this means SRMC staff have to host online calls with their own lap tops away from NHS premises. For the conferences to work everybody has to be on their own devices away from NHS premises. 2) Broadband is patchy and some sites have problems (eg Wick) 3) Regular meeting time of 1800 on Thursdays seems to work for most people, but not all the time. 4) Which GPs take part varies quite a lot so format has to be changed. (See notes from VCs) (Also see Issue GE 11 & 12 Clinical Governance, GE18a Joy VCs and Issue #44 Nature of VCs Changing)		*it work. Appreciate the efforts to try and get round the technology.* *1045 C11 To be honest, didn't really enjoy (VCs). A problem when you raise clinical cases and what you thought were pertinent issues, but other GPs didn't always seem interested and could be a bit dismissive. Also, a light hearted comment looks odd out of context in the minutes. It made me anxious about speaking although I was interested in what the others had to say. Don't really want to contribute now as a little bit anxious. Connectivity awful so had a lot of problems. Thought the concept was good though. What's App group quite good and positive, but not often clinical.* *PIO discussion with 1046. There are several agreed points ;* *a) Joy GP VCs are a good opportunity for GPs to feed back both clinical and administrational issues.* *b) They are a good opportunity for Joy management to pick up on issues, look at solutions and provide support.* *c) They provide a good opportunity to look at clinical effectiveness and significant event learning.* *d) They also provide the opportunity for CPD, group networking and mutual support.* *In practice there are challenges;* *1) There is not wholesale buy in from all Joy GPs and when GPs are not working in placement they do not usually attend. Numbers are quite low peaking at around 7 in*	*happening on average every fortnight. By early 2020 feeling that it does need to be refreshed. Key learning points.* *See recommendation (R10) (GE18a) Joy GP VC format and agenda needs now to be reviewed by the Joy clinical lead.*

					September down to only 2 or 3 in February. *2) NHS internet connectivity in Scotland is not usually good; GPs coming in from England can usually be heard/seen more clearly than participants from the H&I. Restricted firewalls on NHS Health Board devices mean that participants have to use their own devices away from NHS premises. Quite often participants cannot get in to the call. Root cause has been given as poor broadband connectivity in rural Scotland. Things will apparently improve as health boards migrate to cloud based systems over the next ¾ years and the Scottish Government R100 project comes to fruition. As a consequence, calls are often disrupted and delayed, not a consistent experience. For the Joy to look at renting its own software to by-pass NHS restrictions may be possible but not likely to solve the problem as we cannot get away from patchy broadband in the H&I.* *3) Despite the shortcomings, it is very often a good meeting happening on average every fortnight. By early 2020 feeling that it does need to be refreshed.*	
8	Recruitment & Induction	GP employment contracts terms and conditions	Complex issue. General terms were agreed between health boards/LMC on BMA rates (3/2019). GPs offered placements were offered general terms depending on duration of placement(s). In early July, GPs working on placements had still not received final contracts and were not really sure of what they were being paid for what. There	Interview Test – Recruitment and Marketing (B) B1, B4, B5, B6 Limitations of The Joy (F) Questions F1, F10	*1033 Flexibility of GP contract a critical success factor.* *1034 B5 - Salaries - T&C - No, not a barrier. Only one GP dropped out of process over salary. Salary made explicit on the advert so this was fairly self-selecting. Only one real attempt by a GP to try and renegotiate terms. Motivation for the role is for job satisfaction*	*Evidence* *See key discussion under GE10 (Employment T&Cs)* *PIO - This is a real area of success with 4 health boards working together on complex detail to establish an agreed contract that was*

			were several unknowns; a) Determinant of rate of pay – annualised hours or pay as you work (zero hours) b) How long is a week in sessions? Is a week 5 days or 7 days? c) What about GPs working more than 40 hpw (eg in Wick) d) How do T&S payments work – from where are GPs able to claim travel expenses on commencement/ departure. Do they get an allowance for using their own car for work? How is accommodation provided? The HrHub response has been that terms cannot be agreed until it is clear how long a GP will be working for. However, the GPs don't want to commit until they know their exact T&C for a given scenario. More visibility is being provided but also clear that different health boards have different ideas over T&S eg NHS Highland will not agree to pay travel expenses from point of entry into Scotland and Grampian SSTS system does not allow users, who are not Grampian employers, access. Options for GPs can be provided, but zero hours contracts make planning difficult. Also GPs may be able to arrange their own work with practices but a complete free for all means that unpopular weeks and practices with challenges will be hard to secure placements for. Creation of set of FAQ (Frequently Asked Questions) (draft) for discussion 21/8/2019 Hr Hub meeting Contract is offered for basic 40 hpw but supplementary contract for different locations extra hours/ ooh etc.		*rather than salary. (seeB5)There were sometimes niggles on T&Cs, clear that non willing ness to reimburse travel expenses from England caused niggles with English GPs. Difficulties reconciling 4 health boards in some areas (eg car hire).* *1034 B6 (seeB5)There were sometimes niggles on T&Cs, clear that non willing ness to reimburse travel expenses from England caused niggles with some English GPs. Difficulties reconciling 4 health boards in some areas (eg car hire).* *1043 K4 Yes, not all about the money. Some irritating things are the mileage rate only being paid from Scottish border but not a major bug bear. Personally had some issues with the Medical defence subs. Learning point is to explain to them that you need `split cover' for England and Scotland, some societies don't like the idea of double cover, could save £700.* *1044 K4 Less of an issue for me, didn't read into it too closely, personally interested in the job because a great end of career challenge in interesting locations. Might be an issue for younger doctors. Administrational Hub were fantastic in responding to queries and sorting things out eg Accommodation etc. Some hoops to get through including getting onto Scottish GP Performers list. No major issues.* *1045 K4 Yes, not doing the job just for the money. Salary fine though couldn't do it for much lower as I Lose other work in my local county due to being in Scotland and also have to arrange cover for my charity work whilst I'm away* *1036 B5 No, but we do have to try to act flexibly on what GPs ae looking for. T&Cs are*	*still attractive enough for potential Joy GPs. Agreement over terms and conditions has also been challenging. A side effect, not to be underrated, has been the development of sense of working as a team between staff from different departments and health boards. There has been a lot of mutual support. And understanding.* *Critical success factor* *See recommendation (R5) (GE10).Review Joy GP contract terms and conditions annually.*

			Nov 2019 – T&C's generally seems to have been accepted by the GPs and there appears to be much less discontent. Certainly no longer discussed so much on What's App or online Joy GP VC. Some GPs have not signed their contracts and work on a `wait and see if they like it 'basis before deciding to commit to a 12/18 week contract. Sometimes the odd glych (see issue # 15). New GP not warned that they would be paid a month in arrears, bit of a shock (Nov 2019, VC # 12)		*ok; they just took time to sort out. Have input into travel decisions.* *1041 B6 4 health boards, 4 different ways of doing things. Concerns were highlighted on the level of pay as it could have disadvantaged some WI GPs but final pay level agreed was adequate, in the end, slightly cheaper for a Joy GP rather than a locum. Unfortunately ruling that VAT had to be added has made it more expensive again.* *1039/1040 B6 Setting up nuts and bolts of contracts was a challenge, but issues have been resolved and ironed out, good systems in place now. Only thing not resolved would be if Joy GPs did out of Hours arrangements, but not aware of any who have.* *1039/1040 F1 Challenge is also how you keep the current good relationships if the Joy expands. One of the great strengths has been learning how to build the model, but the great strength has been building a team that works well together, across 4 health boards.* *1039/1040 J12 How do we change contracts? As the scheme develops, perhaps we should look at sitting down and reviewing again what the Joy contracts should include. Approaching one year on now and of the original wave of Gps some of them only wanted a year. How many will drop out? How do we change things? Enjoyed working with other health board colleagues, particularly the interviewing.*	
9	Recruitment and Induction We didn't	Practices with high workloads / managem	Joy GP raised the issue of working in a town practice with a number of challenges. The practice had survived using a lot of different locum doctors for a prolonged period of time	Interview Test – Marketing (A) A7, Recruitment and Induction (B) B2, Clinical	*1031 C9 Discussed Wick challenge, a lot of thought into this problem and no solution yet but we have incorporated a lot into the next stage of development the Joy. KB, CE and I have spent a lot of time thinking about how we*	*Evidence* *The GP placement at a practice with issues in the NHS Highland area revealed an existing and potential problem in the management of*

	know Limitations	ent problems	On a 4 week placement (Jul/Aug 2019) the (Joy) GP felt that the workload was heavy and very quickly he was assuming the role of lead GP taking on extra responsibility and working long hours – not really what he had signed up for. There were good aspects to the practice, staff were supportive and welcoming, they were also grateful for his contribution to MDT training etc. but the town also had some heavy duty social problems and needed more support. Responsibility for primary care service provision ultimately rested with NHS Highland Health Board. A suggestion was made (at Joy GP VC # 2 25/7/2019) putting in two Joy placements together, perhaps on less than full time, for practices with challenges. 2 Joy GPs would re inforce each other and remainder of MDT. Discussed at Hr Hub meeting 21/8/2019 considered as a solution for Wick/Thurso. <u>Nov 2019</u> – Discussed again at several online VCs (particularly VC#8 24/10/2019), also see issues #10 Expectations, #24 False Expectations and particularly #30 Support to one specific practice. The issue was also discussed at SRMC Programme Board workshops (Nov 2019) as, perhaps utilising the `Flying Squad ' concept of Joy GPs. Clear not all GPs comfortable in performing in this type of role. (see also issues #23 Wanderers and Adventurers Scheme, #45 on medication reviews).	Governance (C) C8, We didn't Know (E) E1, E7 E8, Limitations of The Joy (F) Questions F1, F10	*re-focus the Rural GP Support Team and W&A on how it can help resolve issues in practices - that is a particular emphasis of part of the (Mar 2020 recruitment weekend) for everyone. There has been an evolution in thought about some of the problems we now realise that we face,* *1031 #9 W&A just one solution, trying to create part of the solution, just a concept really. Shows different ways of working, helps with support for individuals and opportunities of working in a pool. Would make a good case study, really good example of different ways to find a solution. Breaks away from the problem of trying to fit round pegs into square holes, different way of thinking and working. Not doing the same old thing and getting the same old results.* *1034 A7 - Practices with challenges - No, Joy GPs were not briefed and HrHub not aware of any issues early on, would have to check with PC leads. Most GPs going in blind to the way practices were. In reality most concerns seemed to centre on Wick and first placement, but even though he (GP) had a challenging first placement he always said that he would be willing to go back. Issue was raised by CS/ KB with PD on Wick and activities in place to improve.* *1036 (AMD) A7 Didn't spend enough time thinking about this issue. We were up front with candidates at the recruitment weekend (Mar 2019) about the way things were in rural primary care in Scotland and sustainability issues. Less time in individual interviews to discuss with GPs. Clear that there were sustainability issues in some practices but from*	*primary care service provision. There has been more consideration of the issues at the particular practice and this falls more under the NHS Board primary care management level than the Joy project team. Clear there are other practices where there are workload and other problems but this has not been explicitly discussed as part of the evaluation. Problems known about, which could also occur elsewhere, have been;* *a) Backlog of medication and prescribing reviews* *b) Disorganised medical records, time consuming to sort out.* *c) Extra time required by GPs to deal with patient's social, mental health, drugs and alcohol issues.* *d) Lack of leadership and support for MDT staff at a practice.* *PIO - This challenge brought together 3 different issues;* *a) Adjusting expectations for Joy GPs (see issue #10) – a possible marketing failure has arisen.* *b) How do health boards manage more ingrained challenges within practices* *c) Could the Joy be part of the solution?* *Problems - uncovered at one practice- has acted as a catalyst to examine*

					AMD level we don't always know who has what issues as(in many places), practices are mostly GMS. Clear that with English based GPs who have worked with CQC they might find it very different because in Scotland that work is only just evolving. *1037 E8 Discussed the expectation of the Joy remit and partly the way that the scheme had been sold to the Joy GPs. Clear that some Joy GPs have the ability and have taken this role on to a limited extent but not originally what they were expected to do. Joy GP feedback was useful eg at Wick where problems were highlighted, but this should really trigger management action in Highland to come up with a plan to provide solutions rather than the Joy GP carrying on as a management consultant for practices. There are several models that could be applied to Wick but the challenge does need to be defined. Big discussion of these sorts of issues at recent NHS Scotland meeting on 2c Practices. Big divergence of opinion in some areas and clear that there was a real patchwork of practice quality and development across Scotland. Comes back to the point though, it probably isn't the Joy's responsibility t sort out practice management problems, that lies with health boards.* *1039/1040 E1 At the time of the start of the scheme, no (not aware of practices with these problems). More simplistic approach was that they wanted to get Joy GPs in to work, cover first. Practice profiles provided by the Hub, but do not suggest any issues. We have learned a lot about our own practices from the Joy, CG aspects have been highlighted.*	*the issue in detail and look at potential solutions that the future Joy could offer. This crystallised as the `Wanderers and Adventurers scheme' (W&A) that has been promoted since October 2019 and has been included as part of the 2020 Joy GP recruitment campaign.* *The W&A concept looks at using small teams of Joy GPs willing to work in practices(perhaps with challenges) for a more extended period helping to provide stability and look at improving systems and support to the whole practice MDT. (See discussion at Issue #24 Concerns that Joy GPs being sold too upbeat a message)* *The issue has also raised two other questions;* *a) Are there other problems in primary care that we don't know about but should? This could be the case with GMS practices where less is known about day to day operation. What quality systems do we have in primary care generally and are they robust enough?* *b) Can the Joy/ W&A provide any solutions to this challenge?* *Clear that there are some big questions on how to manage service provision and quality in primary care in rural Scotland that go beyond the*

					1041 A7 Problem Practices - Yes, some awareness, was raised as an issue at Recruitment Weekend (Mar 2019) the role of Joy GPs to support / help with quality improvement of practices. Joy GPs probably not warned of practices with difficulties in Western Isles (WI). In WI most practices are still independent GMS so less knowledge of practices that may have issues. Was aware that some conversations were happening on GPs What's App group but not involved. Lack of feedback in the system perhaps? *1043 A7..Some things , I realised , were a problem because of the computer systems, they are not as sophisticated as those in England, they are clunky and there is a risk having to transfer data across systems manually, this makes workload a bit worse. Transcription errors should be avoidable these days.* *1044 A7 All practices have to some extent. Surprised by Wick, didn't expect these sorts of challenges. Problems were the systems, Docman, prescribing etc. Time consuming, but you did get 15 minute appointments. Had to work as if I was a partner really. Remain open minded, it was fine really. Could I have turned things around? That takes time and you have to take time to fit in. Offered the practice informal help where I could. The way the Joy was advertised did set a high bar and expectations so this could be a problem.* *1045 A7 No awareness in advance, aware of the problems 1044 was having in Wick from the Joy GP VC. Wick was an outlier possibly. Had my own experience of Brae and Stornoway, a busy town practice which was not*	*scope of this evaluation or the Joy current remit.* *Perhaps the best point, raised by 1031, is that we have a better idea of the problems that we are facing in primary care. Some of these were not widely known before.* *These are key learning points and a success point of the Joy, that issues are getting highlighted that were not particularly prominent at management level* (see also, discussion at GE 30 *Difficulty Recruiting and Issue , GE34 Original Intentions, #23 Wanderers and Adventurer, #24 Concerns Joy GPs being sold a too upbeat a message, #45 Prescribing management problems).*

					what I really wanted although I did enjoy it and am going back there in June. Not sure if it would have helped much if I had known because I was trying something different, key is to keep an open mind.	
10	Recruitment and induction	The Joy GP expectations	Clear that GPs coming have differing expectations and the job doesn't quite match up. Eg 1) Longer appointment times hampered by IT system 2) Practices are used to a high turnover of locums, this generates admin/ audit and CPD that needs to be done and also means that, as non-regulars, the practices are slow to engage with Joy GPs sometimes. 3) GPs may feel that they have come for a winding down job into retirement and may not want to put the hard work in. Expectation of rural and remote, but many practices on the islands are less remote from local hospitals. <u>Nov 2019 comment</u> Quite often it is an `eye opener' for some GPs coming in from England and some anxieties, usually in the first week, but after that, GPs tend to settle and they are coming back for more placements. Clear that better anticipation by practices and better induction processes help. Positive results – GPs now reporting positive aspects – what could be termed the Joy proper. Eg Great countryside More time now in practices. More time to get to know patients A de stressor from practice in England – improved work/life balance	Interview Test – Marketing (A) A5, A7, Recruitment and Induction (B) B2, B3, B4 B5 B6 B7 B8 , We didn't Know (E) E1, E3, E4 Limitations of The Joy (F) F1 F4 F10 Joy GP Experience (K) K1 K8a	*1031 E8 It is an expectations issue on what the Joy means, the roles have developed now and there are 2 distinct aspects of the project/job a) A steady rural practice job, empowered as far as patient care is concerned. b) A role helping with difficulties in practices, a more empowered role to make change, help with flow and system building, facilitate change using skills. These improvements won't just happen by people walking in there (to practices), it will need to be facilitated and structured. Looking at a session on this at the development weekend in March. The really important thing is that GPs won't be forced to undertake the second aspect of the job (development and wider support of practices) but we need to make the structures to allow this to happen, if they want to.* *How have GPs been supported? 1032 D8 Feel the Joy GPs have had a lot of support though some might feel that's not enough. From a HUB team perspective, normally GPs know where they are going, what they are doing; they should not need lots of support. There is a lot of structure and support available through the Joy if they need it (eg holidays, sick leave, CPD time etc.) this level of support needs to be communicated to prospective GPs. It could be that for some GPs the expectation is really high as well.* *1033 B8 Not aware of a problem. Sometimes headaches agreeing expenses but all GPs taking up post OK and often they put positive*	*<u>Evidence</u> Review of the notes of the first Joy GP VCs in July 2019 does reveal a higher level of anxiety from Joy GPs around quite a few issues (poor induction and handover, Scottish Primary care IT systems, workload, employment contracts etc.). By November 2019 these issues were no longer being raised presumably as GPs bedded into the process. Clear some things were different to practice in other parts of the UK (IT systems, complicated logistical arrangements for patients getting to hospital, dispensing, GP accommodation as well as a different attitude in NHS Scotland towards clinical governance). As part of the evaluation interviews Joy GPs who have worked through the whole period are bringing up more positive aspects.* *PIO – An issue that was raised in Summer 2019 about expectations problems. This potentially, could have been a serious problem if the initial wave of Joy GPs were feeding back to the wider world that they remained unhappy. Clear that there was an adjustment period where administrative problems needed to be resolved and anxieties worked through and also clear that induction*

					feedback out to GP friends who take an interest. *1036 A7 Didn't spend enough time thinking about this issue. We were up front with candidates at the recruitment weekend (Mar 2019) about the way things were in rural primary care in Scotland and sustainability issues. Less time in individual interviews to discuss with GPs. Clear that there were sustainability issues in some practices but from AMD level we don't always know who has what issues as..practices are mostly GMS. Clear that with English based GPs who have worked with CQC they might find it very different because in Scotland that work is only just evolving.* *1037 A7 There were discussions at the recruitment weekend (March 2019). AMD's gave a broad overview of their own areas but Highland was an unknown quantity. Aware that practices have challenges of different kinds but it wasn't a big discussion point at the weekend. The marketing campaign was much around a rounded general practice experience, selling the small remote and rural practices rather than Wick for example.* *1039/1040 B8 Wick experience was a good example of this early on but feel that problems over expectations have resolved now.* *1043 A7 Thought there probably would be (practices with problems) because we knew that there were GP recruitment problems in the Highlands. Hopefully we wouldn't have to deal with anything reported as dire as Wick (eg heavy workload) Some things , I realised , were a problem because of the computer systems, they are not as sophisticated as those in*	*process was not always good in every practice (see discussion on issue #2 on induction process). However, also clear that, on reflection Joy GPs, generally, are happy with the experience in the longer term (see responses opposite to K1/ K8a (Did the Joy Experience live up to expectations?/ Do you feel that you have had the benefit of the Joy?)* *See also response update opposite (Nov 2019) GPs now reporting positive aspects – what could be termed the Joy proper. Eg `Great countryside, More time now in practices. More time to get to know patients, A de stressor from practice in England – improved work/life balance'. Working as part of a GP team, What's App group, GP VCs etc.'*

					England. *1043 K1 Absolutely, great fun, worked for the joy in different places, not too onerous and in some places workload a bit too quiet, uncomfortable being paid for on-call when this happens.* *1044 K8a Yes I definitely did. Was a bit nervy on what to expect after BASICCs week. Even after first attachment felt good and it got better each time.* *1045 A7 No awareness in advance, aware of the problems 1044 was having in Wick from the Joy GP VC. Wick was an outlier possibly. Had my own experience of Brae (odd) and Stornoway a busy town practice which was not what I really wanted although I did enjoy it and am going back there in June. Not sure if it would have helped much if I had known because I was trying something different, key is to keep an open mind.* *1045 K1 Not sure what my expectations were? (in the beginning) It was interesting, different, but got the Joy over time. Interface was difficult to start with, Scotland and Scottish NHS IT systems very different and I didn't know what I didn't know when I came...Last 3 placements were lovely, even good working through the grey winter.* *1045 K8a Absolutely loved it. Difficult start at first practice and I had some health problems of my own when I came so any negativity was mine. Am much more able to appreciate things now. Love it more and more.* *1046 K1 Yes, definitely, atypical experience as had worked in Shetland before and was looking for a way to go back on a stable contract that allowed for work elsewhere.*	

11	Marketing	Decision for a promotional film	The Joy team have commissioned a Video – for what market? How has format/content been chosen? What is intended distribution channel? Producer is Liz Musser a respected Shetland film professional. Promotional VC available 4/11/2019 has been loaded onto Highland Intranet and SRMC Website. Quality good. Not sure how project was decided.	Interview Test – Marketing (A) A1, A2, A5, A6	*1032 A5 Promotional videos came from a successful bid to SG for funding that enabled them to allocate some money .A concern, early on, was that several GPs who had been selected weren't showing any interest in working, only 9 of the original cohort had put in for placements and there was a feeling that we should do more promotion to encourage them. Logic was; 1) We needed something to showcase how things worked, that teams were friendly and enabling. 2) It could be used for future promotional activities. There was a good response to the Videos and more GPs did come and start work after that increase from 9 to 19 however, a plan to bring an evaluation exercise forward to the development event planned in March 2020 unfortunately, had to be cancelled (Covid19).This work will be picked up as part of us moving into Recovery and is on the Hubs Action Tracker* *1034 A5 – Aware , not familiar with* *1041 A5 No particular opinion, not really aware of them.* *1043 K2 (Aware) Yes, I was in it!. Agreed though not sure how many people have got to see it.* *1044 K2 (Aware) No, not (aware) at the time (of recruitment), vaguely aware when it was made. Not mentioned on What's App etc.* *1039/1040 A5 Never seen them, SRMC website isn't really a go to site for primary care in NHSH.* *1045 K2 Saw it, as sent by 1043, not aware of it anywhere else or SRMC website.*	*Evidence* *See history (1032) The videos were commissioned by NHS Shetland and made (in good weather) in Aug/Sept 2019 being loaded onto YouTube on 19/11/2019. To date (April 2020) there have been 190 views. The videos were loaded to the SRMC website under/Rediscover the Joy/ HR Hub – Project Joy and also available on the NHSH Rediscover the Joy Intranet Page. They have also been referenced in some of the printed promotional materials. Critically speaking they are good quality, professionally made, promotional pieces of film speaking from a Joy GP point of view but also talking to other health/ Joy professionals involved.* *PIO – Needed to clear up the decision process as to why and how the videos were contracted and produced. They are good quality, well made, but the wider Joy team does not seem to be aware of how they were made or even how to find them. It could be that they have not been used, so far, as effectively as they might. Learning point. This also leads on to discussion on the Joy web presence (see issue #61).* *Recommendation (R29): Link for the current videos should be included in all adverts. Any future marketing campaign should have wider discussion amongst Joy team - to get in a*

						wider range of ideas and buy in. The role and assessed effectiveness of the videos should be considered at Joy management meetings and whenever new marketing is planned.
12	Operation and management of the Joy	Understanding the nature of Joy GPs and intricacies of wide range of practices personalities and local arrangements.	Aware that HrHub expertise is developing. Part of the value of Hub Hr Team is building up contacts, awareness and expertise in getting an optimal good fit efficiently of GP & participating practice. Once experienced, they will be very efficient at this and those skills, operational judgement and memory will be very valuable. Process takes time as nature and expectations of practices/ Joy GPs/ Hr Hub need to be reconciled. There are around 50 practices likely to use the scheme 36 Joy GPs (2019). Development of hub learning process needs to be captured Longer term skill and learning being developed by the Hub and primary care leads. Assessment of hub capacity being considered as role develops and new hubs are considered.	Interview Test - Recruitment & Induction (B) B4 Management and Operation of The Joy (D) D1 D2 D3 D4 D5 D6 D9 D12 D15 We didn't Know (E1)	*1032 D15 F1 53 HrHub model has worked well and they are currently working with 19 employed people. There is capacity. There is a national e-Rostering system in development and if the Joy were to increase in size we would need to look to more technical electronic based tools to support administration and reporting which is currently very paper based One of the major issues is around funding - year by year disables medium to long term planning SG supported funding runs out on 31/5/2020 and NHS Shetland already taking risk of employing hub staff with no guaranteed funding* *1033 D1 Day to day management of bookings etc. - this part of the Joy works very well through the HR Hub. Leadership by 4 health boards - more difficult as they are all in different places and clinicians, with busy commitments do not always have the time and have to be tracked down when their input is needed, so a lot of effort spent on comms.* *1036 D1 Frustrations were not necessarily around recruitment, but long delays getting onto the Scottish GP Performers list and other delays around PVGs, occ. Health. Really time consuming and often cross border (Scotland/England), slow. Perhaps we didn't make that clear at the beginning. KB and CS went to Shetland (Aug 2019) to help understand the position and so that HR not*	*Evidence* *The HrHub and other HR staff at NHS Shetland have been on a steep learning curve since the start of the programme. Skills and knowledge acquired have been;* *1) A rigorous understanding of employment contract terms and conditions necessary for GPs employed on temporary or irregular work contracts.* *2) Understanding of the necessary employment compliance process for GPs (references, PVG, Scottish GP Performers list).* *3) Processing GP travel and subsistence expenses claims and payments.* *4) A good, increasing, understanding of local arrangements at practices (travel, accommodation, surgery operating, locations, local management, support and potential local problems etc)* *5) An ongoing `getting to know' and becoming familiar with the Joy GPs as*

					acting in isolation. *1039/1040 E1 At the time of the start of the scheme, no. More simplistic approach was that they wanted to get Joy GPs in to work, cover first. Practice profiles provided by the Hub, but do not suggest any issues. We have learned a lot about our own practices from the Joy, CG aspects have been highlighted.* *1039/1041 F1 Challenge is also how do you keep the current good relationships if the Joy expands. One of the great strengths has been learning how to build the model, but the great strength has been building a team that works well together, across 4 health boards.* *1041 D2 Aware of the issues, but difficult to keep everybody involved all of the time. In principle we have Joy meetings, but they don't always happen and problems often with things designed by committee. There is regular contact though. Not always are of future operations, but don't want to detract from the fact that staff from 4 health boards collaborate very well now and things are improving all the time. Not aware of placement returns etc.* *1044 C3 GPs, used to being self-sufficient. Didn't really utilise the support, knew where I could get hold of it though. Hr Hub fantastic on admin questions. More of an issue for regular salaried doctors probably.* *1045 J12 K8 The joy is still evolving, paperwork will improve, HrHub will get more organised. One thing about the Hub is that they always try to do their best. We are inventing a new wheel.*	*they come in. There are many bespoke arrangements and agreements as well as learning to work together.* *6) Providing an information service for Joy GPs, Joy management and others.* *PIO - The growth of knowledge and experience by the HrHub has been a key success factor for the project. Ongoing success will depend upon;* *a) Ways to retain the knowledge and expertise of the Hub .It will be difficult to get back if lost. Bear in mind that there are only two experienced staff and if they leave, getting the knowledge and expertise back will take time.* *b) The Hub knowledge and expertise will have a useful role in any expansion of the scheme or advising other HR staff working on similar schemes.* *c) The ongoing role of the Hub in building and maintaining a network should be valued. It has been instrumental in building a network (between the wider Joy team, practices, Joy GPs and others from other health boards) and a team that make the Joy work.* *(See also issue # 53 HrHub capacity).*

						For future development; *Recommendation (R30):* *(1) Capacity of the HrHub needs to be understood in terms of its ability to support future developments of the scheme.* *(2) Future planning of Hub models need to bear in mind the key assets of;* *(a) The expertise built up administering the scheme and working with practices/Joy GPs* *(b) The critical role of maintaining the network.* (3) *With only 2 staff, business continuity contingency needs to be considered should either (or both) of the staff leave. Knowledge and procedures should be written down as a critical risk management requirement.*
13	Recruitment and	Practices are	Makes it more difficult for The Joy to be successful as they are competing with locum	Interview Test – Marketing Theme	*1034 A3 Highland practices - Difficult to tell, not sure how widely information on the Joy has*	*Evidence* *Per 1034, 1039, 1040 responses and*

	Induction Operation and management of The Joy	advertising for locums at the same time as being a joy practice	agencies who pay better (recent example of a single handed practice in Highland). Difficult to get around as practices have to fill gaps as best they can. Though the Joy should not be as expensive the program will not be able to fulfil all placements. Discussion Hr Hub meeting 21/8/2019. Likely that practices in Highland do not fully understand the concept of a Joy GP (ie greater commitment, consistency and clinical leadership). Renewed effort required in promoting the scheme in Highland but practices are picking up `word of mouth' from each other and awareness is growing. See also the issue of a locum GP setting up their own locum contracts with Joy practices. (issue #39)	(A), A4 Induction and recruitment Theme (B) Questions B2, B3, B4 VAT Theme (Issue 5)	*been disseminated. However clear that highland practices are responding g and this has increased gradually over time of 106 placement bookings 44 come from highlands (42%). Was a suggestion in the beginning that they did not know about the scheme? Much more in line with expectations now.* *1039/1040 A3 More aware now, people/practices do talk about it though they don't always understand how the scheme works. Not everyone sees the scheme as a positive and with the recent inclusion of VAT then it is more expensive for GMS practices. Not so much a problem for 2c practices but there are not many ways around that. They had a similar problem with a GP Fellowship scheme. Locum agencies were more competitive as VAT only charged on arrangement fees.* *1047 B5 Don't knew about GPs but cost for practices is very high for the Joy. Regular locum on their books is £4620 pw, HrHub (The Joy) charge £5674, quite a big difference. Probably why Orkney have not used the scheme too much.*	*discussion at issue # 5.* *GMS and 2c practices will view the Joy scheme differently* *PIO - Many practices in Highland and Orkney work with well-established networks of locums. Now that Joy GPs are, for some practices c 20% more expensive (see 1047 response to B5 and VAT issue at issue #52). This means that GMS practices may consider arranging their own locums first before coming to the Joy, it's a lot cheaper. It is an issue the Joy need to bear in mind when placement requests are not forthcoming (see also discussion at issues # 5 Awareness of the Scheme and #29, #52 VAT).*
14	Operation and management	Base line for standard practice equipment	Joy practices have varying equipment for GPs, sometimes Joy GPs arrive with their own equipment but there are often shortages. Cost of standardised bags for practices is high (£1100) so who bears the cost? Solutions being worked upon. <u>HrHub Meeting 21/8/2019</u> Clear there are two types of practice. 1) Remote & Rural with no nearby SAS or hospital support. 2) Rural – where practices do have availability to some back up service.	Interview Test – Discuss PCG Leads Part of phase 1a Evaluation	*1033 BASICs issue has settled. It is a must have for remote and rural practices. The issue is still getting folk (GPs) onto the list for the course and this is done a variety of ways (capacity for BASICs training is limited). They ae working to establish a stand-alone BASICs course for the Joy. Not sure if needed for W&A scheme.*	*PIO – Originally considered to be a serious problem - levelling the repository of emergency care equipment and drugs held in remote locations for use by duty GPs. Much of the equipment now is in place and the emphasis is more on trying to ensure that Joy GPs are given BASICs emergency care training.*

			Depends on the type of practice which bag they need. Clear now that one size does not fit all, guidance for practices will cover this and The Joy funding can cover £500 contribution to R&R practices to revamp bags. Photos will also be provided of what actually should be in a bag.			
15	Recruitment and induction	Accommodation and Cars for Joy GPs	Most cases accommodation and a car can be provided but some practices are unable or unwilling to provide either. Special arrangements then have to be put in place. (Also see Issue #8 GP Contract Terms & Conditions).	Interview Test – Recruitment & Induction (B) B5 B6	*1034 B5 There were sometimes niggles on T&Cs, clear that non willing ness to reimburse travel expenses from England caused niggles with English GPs. Difficulties reconciling 4 health boards in some areas (eg car hire).* *1039/1040 F1 Problems with `Grip & Control' in NHS Highland and an expanded scheme incurring more T&A costs raises questions with finance team. They may not be able to keep providing free accommodation.* *1043 K4 Yes, not all about the money. Some irritating things are the mileage rate only being paid from Scottish border but not a major bug bear. Personally had some issues with the Medical defence subs. Learning point is to explain to them that you need `split cover' for England and Scotland, some societies don't like the idea of double cover, could save £700.*	*Evidence* *Generally accommodation and work transport can be provided by practices in, just a few cases this can't be done, or, for some reason, the accommodation provided is not considered acceptable by the GP.* *The exact GP contractual terms of engagement resulted in a bespoke supplementary contract for each location a good solution (discussed in the Joy Phase 1a evaluation report), this has been generally acceptable to Joy GPs. Destabilisation may occur if for example NHS Highland are no longer able to offer the terms that he other health boards can (see comment by 1039/1040)* *PIO – Provision of reasonable accommodation and practice transport is probably a key success factor for the scheme as it increases the satisfaction and retention of Joy GPs.* *See Recommendation (R5) (GE10) Review Joy GP contract terms and conditions annually between participating health boards.*
16	Operation and	Indemnity insurance	Insurance paid for the board's covers 2c practices (CNORIS) but not the independents	Interview Test – Issue #16	*Has this problem been solved now? – 1033 Generally yes, an arrangement has been*	*Discussed in phase 1a evaluation. Issue generally solved now, HrHub*

	Management of the Joy	for 17J and GMS practices	(GMS) who would have to pay their own. Will CNORIS cover Joy GPs?. Likely yes, but being explored (Aug 2019) High indemnity costs will put off potential Joy GPs. <u>Nov 2019</u> Cover for GPs not covered by 2c arrangements will be provided by the Hub but where necessary and will commence when the GP actually commences so purchased individually.		*made with MDD (US)who will provide cover for Joy GPs, not for W&A, max 18 weeks cover. C £440 per person per week. Some technical issues with one GP and has to be sorted out prior to employment.* *1043 K4 Personally had some issues with the Medical defence subs. Learning point is to explain to them that you need `split cover' for England and Scotland, some societies don't like the idea of double cover, could save £700.*	*have the necessary knowledge. See comment by 1043.*
17	Operation and management of the Joy Limitations of the Joy	Risk that phase 2 funding cannot be found and The Joy closes	NHS Shetland financially exposed as 26 GPs on their books Assess at SRMC Programme Board (Nov 2019). Funding ongoing through 2020 but funding will cease for hub staff c Oct 2020 so longer term solution required.	Interview Test – Limits of The Joy (F) F9 F10	*1030 J2 Success factor for the Joy* *1030 17 (Pitch for more funding) Yes, ideally 3 years ahead rolling funding which means you have responsibility, accountability and surety so that you can plan properly. If not, we're onto an exit strategy, but how do you stop the Joy now?, How long would that take?, would be very difficult. Perhaps we could look at a commercial model* *1030 17 (Pitch for more funding) It would demonstrate the following benefits; Economies of Scale, Efficiencies, Connectivity, quality and on patient satisfaction.* *1032 F7 (NHS Shetland) Absolutely still willing but it is a risk they need to manage and monitor. For 19 GPs it is quite manageable and for the new cohort on zero hours contracts but what would it mean if funding was pulled and NHS Shetland at risk?. Then neither other funding streams would have to come into play ie ?the funding SRMC get or NHS Shetland continue to utilise and cost up model or ultimately close the model down - Scottish Government are unlikely to want that to happen as it would go against their National Recruitment Ambition.* *1032 F9 (Phase 2) Bids are in but absolutely no*	*PIO – Considered by 1030, 1031 as a Critical success factor was the willingness of the Scottish Government;* *1) To provide initial funding for the Joy.* *2) Not to be overly prescriptive on how the funding was spent, this particularly helped the team deal with the unknowns of setting up a new operation.* *Also per 1032, the Joy is not, at the moment, self-funding ie programme costs have not been offset by the savings in locum fees by health boards/GMS practices. Therefore a continued Joy will, for now, require continued funding.* *The case for a new model of the Joy is being developed by Joy management team (Spring 2020).*

					acknowledgement by SG at the moment.. In reality we need to sit down and work out how to fund the model in the longer term. Would help us for our own ambitions. In the short/medium term it would be foolish not to carry on and find a little bit of funding to enable continuation of services and not have to face GP negativity for lack of support. Funding must go to a three year footing but we also need to make it `wash its face'. Paper expected by SG on this by Dec 2020. Meanwhile we may have to increase (charge out) rates (for Joy GPs) as a step towards this , but SG will have to provide some funding otherwise we will have to work out how to do a recovery plan. *1032 J14 (What if no Joy?) Would have been more expensive on locums, more problems and CG issues and a more expensive model. Some practices may have gone under and reverted to health board management. The test of change worked, but if we hadn't have tried we wouldn't have known and there would have been a lot of time lost talking about should we have a Joy? Even if the joy doesn't continue in future it will have been worth it.* *1033 F7 Don't see it as a problem. Wanderers and Adventurers (W&A) is using contracts with local health board. Only risk is if other health boards stop using Joy GPs.* *1039/1040 J14 We would have been worse off (without the Joy). The Joy means there a greater resources and a wider team that we can draw upon. Against a background with a lot of problems, it is nice to have an extra positive tool to use.*	
18	We didn't know	The Joy has not made	Would be better if initiatives were linked as may be working against each other in some localities where longer term aspirational developments	Interview Test - We Didn't Know	*1031 E4 The thing is that the project has grown so much - when we started it was just about getting people in. Now we have an opportunity*	*Evidence* *See comment from 1031, the challenge is probably making NHS*

		connections with local primary health and social care transformation initiatives (eg Wick)	were underway. SRMC is a project based in the Highlands and supported by NHSH. (Raised by NHSH Director Sept 2019) NHSH issue.	(E) E4	*to use it to make real changes. We need to rethink about how we work more closely with HBs, PCIPS etc. Not sure which initiatives. We (the Joy) have had our own philosophy which = service which = support to practices. Earlier on it was more about getting (GP)'bums on seats' but we realised later that we could do more things.(PIO) explained comment had been made in Highland. Agreed, that perhaps the Joy scheme needs a better tie in to the health boards, otherwise how would the health boards know? Need to resolve this issue in future development. With Highland no link to the health board executive so no direct link. Good input to SG Primary Care Division.* *1033 E4 No clash with other initiative. Experience from the Joy is that it has provided continuity and stability and given other staff a breathing space, you don't have to pick up the pieces after breaks in cover etc.* *1039/1040 E4 It probably doesn't fit into other local initiatives but really there is not a clash because the root problem is that there are too few GPs.*	*Highland aware of the benefits of scheme at the higher levels.. The island boards (Orkney, Shetland and Western Isles) have direct representation in the Joy management team, as do the Scottish Government. However there is less of a direct connection with the much larger NHS Highland organisation. 1039/1040 raise the question of how serious an issue is this? The way NHSH operates managerially means there also may be less visibility of what the Joy program is doing.* *Recommendation (R32): New models and the benefits of the Joy proposal needs to be shared more widely with NHS Highland senior teams to improve buy in, support and operational effectiveness.*
19	We didn't know	Ability of Joy GPs to be effective business diagnostic ians and deliver a constructive message	Experience from a 2 x Joy GP placement (Sept 2019) 2 GPs diagnosed a number of practice problems on prescribing and other issues. They were also able to deliver, more objectively, constructive criticism in a supportive way to the Lead GP, probably better than if it came from AMD direct. Discussions from Joy GPs on VC and experiences. AMD protocol (7/10/2019) on raising the issue of challenges in practices was created (see issues #9 practices with a high workload, #30 Support for practices with problems, #26 When a Joy GP sees problems in a practice).	Interview Test – Marketing (A) A7 We Didn't Know (E) E7 E8 Limits of The Joy (F) F6	*1030 F6 As a model, sensible, innovative, safe and plays to the strengths of those attracted to these jobs. Looking for a model with different leaders in different tranches, modular approach to developments for success and to motivate the next generation. Matching behavioural expectations - keeps some GPs sharp and at the top of their game. Positive in an infectious way.* *1031 E8 It is an expectations issue on what the Joy means, the roles have developed now and there are 2 distinct aspects of the project/job a) A steady rural practice job, empowered as far*	*Evidence* *Evidence comes from two examples during Autumn 2019 and the discussion at a Joy VC (#8). Discussion arose around Joy GP's ability to become practice management consultants. The discussions were inconclusive, but several Joy GPs later expressed reservations about their ability and confidence in raising good practice issues with local GPs, a learning point, (see 1046 comments opposite).When Joy GPs raised issues with practices in the form of peer*

					as patient care is concerned. b) A role helping with difficulties in practices, a more empowered role to make change, help with flow and system building, facilitate change using skills. These improvements won't just happen by people walking in there (to practices), it will need to be facilitated and structured. Looking at a session on this at the development weekend in March. The really important thing is that GPs won't be forced to undertake the second aspect of the job (development and wider support of practice) but we need to make the structures to allow this to happen, if they want to. *1046 E8 (Providing critical opinion)… but only if asked. Is it appropriate to provide critical opinions on the way practices are run if you are only on a short placement? Will probably be received critically. Would personally be hesitant with this role unless opinion had been sought.*	*group support to the local GPs this seems to have gone down well and was sensitively handled.* *PIO - Clear that this is a very sensitive area and possibly not fully a role that Joy GPs originally expected. Discussions around practices with challenges led to the `Wanderers and Adventurers' Scheme (see issue #23 being tested during 2020 whereby GPs are recruited specifically for this type of diagnostic and practice improvement role. It may require GPs who are undertaking this role to be given consultancy or clinical governance type training to help (also see discussion on issues #9 practices with a high workload, #30 Support for practices with problems, #26 When a Joy GP sees problems in a practice).* *Recommendation (R33): Training/ professional development needs need to be considered for GPs recruited under the Wanderers and Adventurers scheme for practice development roles.*
20	Operation and management of the Joy Limitations of the Joy	Problems for HrHub in filling short term placements.	Short term placement request can't be filled as (under 5 days typically) as GPs unwilling to travel to North of Scotland for just a few days (though some will do multiple short placements with lots of associated travel). Limitation of the model really, culturally the practices more used to dealing with shorter term locums culture and tend to fire off requests	Interview Test – Limitations of The Joy (F) F3 F4	*1034 F3 One to two day placements - Doesn't suit all Joy GPs, HrHub can cope with, but more a challenge on cost and accommodation for practices involved. Practice specific but is popular for some.* *1037 F4 Possibly if word gets around hence bad reputation. Don't think it would happen, there should be enough flexibility in the current*	*Evidence* *There have been regular requests for very short term placements, often from NHS Highland practices. A sample taken from the latest vacancies list (3/4/2020) indicates that approximately 6 out of 21 placement requests are for 4 days or less (28%). Short term placements*

			when they have a crisis. Doesn't always go down well with Joy GPs who tend to blame the HrHub. Efforts to correct this at Joy GP VC's. (also see opposite issue #6 Practices are putting in very long range requests)		*system to cover (they did it in Unst at Xmas!). Joy fits the bill for small and rural, may be more problematic for urban/ larger practices where less attractive.* *1047 E3 For Orkney it is there to fill gaps. In the (Orkney Islands) we have our own model and pool of regular locums so only the occasional need to put in a vacancy request to The Joy. Problem also in that the Joy has difficulty with short notice requests, understandably so locum agencies more responsive.*	*can prove expensive in getting a GP up from England with travel costs for just a few days cover. Joy GPs when in the H&I can move around between short term placements and it was done successfully in December however it is not always easy to get placements to line up conveniently and travel between different parts of the H&I (eg Shetland to the Western Isles) can be tortuous and expensive.* *PIO – Its was not particularly an aim of the Joy to fill very short term placements. Fixed travel costs make it prohibitively expensive to get GPs up to the H&I however if the practices want to pay and feel there is value it is not a particular problem for the Hub to administer the placement .It might be very useful where a practice needs urgent cover but would be better if a GP who is familiar with that practice/ community.*
21	Clinical Governance Operation and management of the Joy	Improvements to the GP/Practice Feedback form	Comments from a Joy GP suggested that the feedback form was a bit basic. Revised form out to Hub management team for comment 27/9/2019 Forms seem to be practices to Hub, Joy GPs complaining of not getting feedback (7/11/2019) Joy GP VC #10 (see main discussion at GE22).	Interview Test - Management and Operation of the Joy (D) D9	*1030 D9 (Feedback forms) Don't know, no visibility. I know they exist and assume that they are being acted upon appropriately.* *1031 D9 (Aware) Yes, I think so. HrHub had not been passing them on. This was discussed at the December meeting and the decision made that feedback would be passed on - I am not sure if this is happening.* *1032 D5 D9 We originally wanted to cascade a small newsletter and needed input from clinicians and an understanding of what individuals wanted to know about so part information, part interest stories, part focus on*	*<u>Evidence</u>* *Joy GPs feel that not much constructive feedback has been given back to them, judging by the comments made as part of the evaluation (see opposite). Feedback from the practices to HrHub has not been spread widely either. The evaluation is not aware of any review of the feedback process other than by comments from 1031 on Dec 2019 workshop. Having good feedback is a necessary and valuable part of both management and clinical governance.*

					a clinical topic etc. There was a plan to discuss this at the development weekend earlier this year (cancelled due to Covid19 shutdown). We could spotlight individuals or practices; we aimed also to get the input from the new GP clinical co-ordinator. Needed to understand what would/wouldn't be helpful to people could merge it with GP practice vacancy bulletin. *1033 D9 Seen some - specific to Shetland only. Observation that people only fill the form in when they are unhappy or there is a problem so positive aspects appear less. Don't have visibility of the whole scheme feedback.* *1034 D9 - Practices Feedback -Form/process designed by clinicians and Hub don't get 100% returns back. They do get to look at the forms straight away before passing on to Med Directors. One or two issues highlighted on which they have acted. Form needs to be reviewed but really it is a clinician's form and there is a lot of sensitivity over comments made on practices or Joy GPs. Challenging area.* *1036 D9 Feedback forms have been reviewed, but not in the way that was anticipated. Seen by med directors when there is an issue. Now realise there are sensitive issues with HR and GDPR aspects that need to be managed sensitively, complex. If it is sensitive perhaps should not be written on a feedback form?* *1037 D9 Feedback - Don't routinely get it, the Hub should though. Would be useful if Hub shared because we could use it to improve on things. Would like feedback on general issues (eg referral policy)*	*PIO - Following the discussions at GE11 and GE22. A way needs to be found whereby feedback, probably summarised, needs to be made available to the Joy team, primary care leads and AMD's so improvements to performance and systems can be developed (eg newsletter, summary report, regular meeting etc.). Consideration also needs to be given to the feedback needs of Joy GPs and their requirements for appraisal and ongoing professional development.* *See Recommendation (R14) (GE22) A discussion needs to be held on the best way to use feedback within the Joy. Effective feedback systems on performance, challenges and success, both clinically and managerially, need to be worked out.*

					1039/1040 D9 We would want to know (what the feedback is). There are issues that maybe we are aware of and could help with practice management or staff at practices where there are issues, *1041 D9 Feedback - Not aware that this was going on.* *1043 C4 No feedback received yet so couldn't say anything about it. In practice not a big problem personally but should get some. Nothing to discuss at appraisal as no feedback from the Joy.* *1044 C4 (Performance linked to feedback forms) Linked to some extent, revalidated Nov 2019 so useful to reference. Would be good to have some feedback from practices. Feedback at recruitment weekend good.* *1045 C4 I have to provide evidence of my own performance and reflection as part of my own appraisal. I got spontaneous feedback from one H&I practice and on asking the hub got some feedback from mid-2019 from another in Shetland. Did complete the feedback form provided by the practices at the end of placement.. Could have been better – I think it should be routine to give feedback if at all possible – little things can then be managed before they become big things.*	
22	Recruitment and Induction	Suggestion of a help Video by an experienced	Suggestion at a Joy VC (#6), passed back by AMD.	Interview Test – Induction & Recruitment (B) B3	*1031 B3 No, didn't surface. Real problem is we need to create a document of ideas and concepts. Question should perhaps be `Do you feel that ideas and suggestions are readily reviewed and assessed with prioritisation? We need to think about that.*	*Evidence* *This, probably useful solution, to the problem of inducting first time GPs to the H&I was raised at Joy GP VCs but was never acted upon. It was also used as a test issue as part of the*

		practice manager on how to use practice PC IT systems.			*1033 B3 Heard of mentioned by DP originally, have an idea that CS knows more. Never saw anything.* *1034 B3 - GP IT Induction Video - She was aware of the idea but thought that Ian Blair (IB) leading on it. Thought that older GPs having trouble with Scottish systems, there have been no recent problems reported.* *1039/1040 B3 Not aware of this but would be useful though complex to do as there are several systems being used.* *1041 B3 Good idea but not heard of this initiative before.* *1045 E9 Can't think of any ideas. We did discuss help video for EMIS on induction. Yes, there is not a complete feedback loop here to the Joy GPs, if you raise an issue or an idea , you don't always get a response. In hospitals in England there is often the wall chart saying `You asked, we did' in relation to staff surveys/ patients etc. If we just had some regular e-mail updates sometimes, as a group, it would help.*	*evaluation to look at the point, occasionally raised, that communication to and from the Joy management team.* *PIO - good suggestion yet no forum or way that this could be communicated acted upon by Joy team. Most people think it's a good idea but there is no one to take a lead as it falls between the Joy and primary care and not sure who takes the lead. Given that the Joy as a team operates disparately (GPs and management) then perhaps more imaginative ways of using online conferences, MS Teams videos should be considered for professional development. Not so much evidence that this has been thought about during the first round of the Joy (see also GE8 and GE29 on bringing ideas forward)* *See recommendation (R4): A system needs to be developed to discuss and review ideas that surface.* *See recommendation (R28): The practicalities of producing a help video with or by an experienced H&I user for practice IT systems (eg EMIS and Vision) need to be explored*
23	We didn't know Limitations of the Joy	Proposal to develop the Joy scheme with `Wanderers &	The proposal for new scheme was brought forward at short notice by one person for launch at the UK RCGP 2019 Conference – leaflets were already put on order for printing. This had not been done particularly in conjunction with the other joy project management members. Oct 2019 - Discussions ongoing from a meeting	Interview Test – We didn't Know (E) E1, E7, E8 Limitations of The Joy (F) All	*1030 23 Yes, lessons were actively taken on board. Real lesson was unrealistic expectations of the work that would be required to develop a brand new project. Better process now in place and an accepted methodology for bringing new initiatives forward developed.* *1030 23 (See also D1) (Bigger Joy) Yes, more*	*Evidence* *The evidence for this issue is in the notes of meetings and e-mail trail around bringing W&A forward, originally to be launched at the RCGP 2019 Conference. The response to the issue was a key discussion held in Inverness on 1/10/2019 and the*

		Adventurers' (W&A) project.	with Joy/ SRMC Team / AMD Highland on 1/10/2019. SRMC `Sense Check' e-mail 4/10/2019, issue not that the initiative is not a good idea but approach to developing a new promotion needs to be worked through. Capacity of the Joy team/HrHub needs to be considered if the initiative was successful in bumping up recruitment. Subsequently ; 1) Workshop planned for SRMC Programme Board meeting (Nov 2019) 2) HrHub to meet MS for a workshop (Edinburgh, Dec 2019) (see also discussion in issue# 9 Practices with High Workloads, #19 Origin of W&A scheme,)		*delegation will be involved, clinical leadership will be shared. It will be built as a modular, repeatable model. Will look at economic efficiencies of a larger model.* *1031 A12 Flexible contracts not the main success factor, would put it as; 1) Strong vision - the strong core vision and values of the Joy excite GPs, allows people to feel hopeful and joyful when the vision and values ae strong. 2) Being part of a team - involving individuals to develop a team looking at underlying problems in a systematic way and help develop solutions 3) The flexibility that the contracts provide.* *1031 F11 Joy is developing into different programmes, important now to think about how to use the skills that we have with the GP team and how that can be used. Important now to think about creating an appropriate structure.* *1034 F1 -(Hub) Capacity - OK for current level of activity, not unmanageable. Some small delays, but mostly they can cope. Don't really know where lack of capacity becomes a serious constraint could cope with a 100 GPs if there were not other pressures. Challenging on time when a recruitment exercise is underway.* *1037 J12 Don't know how phase 2 of the Joy will work. Big driver and attractant - remote rural, small, rediscover the Joy. Expanded project becomes less different and not sure how it will work. Pleased where the existing model has got to, particularly for Shetland. A lot of work to set up, but met great GPs, covered a lot of work, great to be part of it. …Also bear in mind Cohort 2 of Joy GPs (Wanderers & Adventurers) may have different skill sets and attitudes to first cohort and we*	*resulting agreement on how the Joy should bring new project developments put forward by MS. This was later discussed more widely at the SRMC programme board meeting (Nov 2019) leading to a more formal and inclusive agreement that W&A should be brought forward as part of the 2020 Joy initiative with others to follow in later years. Clear from interview responses that Joy GPs not always aware of what W&A is and something has been missed in of team communications.* *PIO - This has resulted in two key learning points for the Joy project team;* *1) In the way that the management team now works through development proposals as a team in a structured way.* *2) Where a rough framework has been established as an overarching strategy for Joy programme development.* *The future of the Joy programme is being discussed during Spring 2020. Joy strategy needs to be agreed, in advance but with the whole management team. This is understood now. The initial funding arrangements (annual renewal) have made it harder to think in terms of a longer term Joy strategy. It is also true that strategy sometimes has to be developed quickly or changes in response to outside influences or*

					may have to review how we work. *1045 D2 No. Quite odd, meant to be a coherent team but experience is that new people get added and you don't know here they've come from or much about them. Start to query if there is enough work around? Some worries that scheme is expanding but don't have much information (on that). I have not heard about the new practice improvement scheme (DP says it's called `Wanderers and Adventurers') and find it slightly surprising that we weren't advised about it.*	*dealing with unknowns but, to get the benefits of the expertise and skills of the whole Joy and SRMC teams' wider consultation and buy in is required (also see GE8 and R4 on bringing ideas forward, R41 on funding arrangements).*
24	Marketing Recruitment and Induction	Concerns that Joy GPs were being sold a very upbeat message on recruitment but in reality some practices were hard work.	Comments from AMD Highland on discussion of an experience of a practice with challenges raises the concern that what we (the Joy) were selling may not be the reality – there could be reputational damage and problems stemming from mis matched expectations. Per Joy VC# 10 (7/11/2019) some Joy GPs also concerned that un-briefed GPs going into one particular practice were being sold a pup (though interestingly not necessarily the GPs who had worked there). See also issue # 2 Induction problems, #9 Practices with workload problems, #10 GPs Differing Expectations.	Interview Test – Marketing (A) A7 Induction & Recruitment (B) B8	*1031 E8 It is an expectations issue on what the Joy means, the roles have developed now and there are 2 distinct aspects of the project/job a) A steady rural practice job, empowered as far as patient care is concerned. b) A role helping with difficulties in practices, a more empowered role to make change, help with flow and system building, facilitate change using skills.* *1034 A7 - Practices with challenges - No, Joy GPs were not briefed and HrHub not aware of any issues early on, would have to check with PC leads. Most GPs going in blind to the way practices were.* *1036 A7 Didn't spend enough time thinking about this issue. We were up front with candidates at the recruitment weekend (Mar 2019) about the way things were in rural primary care in Scotland and sustainability issues. … Clear that there were sustainability issues in some practices but from AMD level we don't always know who has what issues. Clear that with English based GPs who have worked with CQC they might find it very different because in Scotland that work is only just*	*Evidence* *Discussed in other issues, see response to issues #9 False Expectations and #10 GPs differing Expectations.* *PIO –Discussed in other sections but this point does emphasise the reputational damage aspect to this problem and the possible knock on to future recruitment.*

					evolving. *1037 E8 Discussed the expectation of the Joy remit and partly the way that the scheme had been sold to the Joy GPs. Clear that some Joy GPs have the ability and have taken this role on to a limited extent but not originally what they were expected to do.. clear that there was a real patchwork of practice quality and development across Scotland.* *1039/1040 B8 Wick experience was a good example of this early on but feels that problems over expectations have resolved now .* *1043 A7 (Practices with problems) Thought there probably would be because we knew that there were GP recruitment problems in the Highlands.* *1044 A7 (Workload challenges) All practices have to some extent. Surprised by (the practice), didn't expect these sorts of challenges. Problems were the systems, Docman, prescribing etc. Time consuming, but you did get 15 minute appointments. Had to work as if I was a partner really. Remain open minded, it was fine really. ….The way the Joy was advertised did set a high bar and expectations so this could be a problem.* *1045 A7 No awareness in advance, aware of the problems 1044 was having in (the practice) from the Joy GP VC. (Practice) was an outlier possibly.*	
25	Induction and recruitment	Very important to work with practices	Important to settle new Joy GPs in and help retention. Working with PC Leads & practices (also see issues #1 GPs seen only as locums #2 Induction quality variable)	Interview Test – Induction & Recruitment (B) B2 B3 Clinical Governance (C)	*1033 B2 (Good inductions?) Yes, they have now. Practices and GPs have different views as to what should be in an induction. Experience from early on in the scheme resulted in the creation of a template by KB (Sept/Oct 2019),*	*PIO - See response to issues 1 & 2 and earlier recommendations (R25) (R26). Area needs development through clinical lead role (1046), see Further work section.*

		and improve welcome and induction quality.		C7	*this went out to all practices in Shetland and was well received (trialled in Broadbay). There has been no negative feedback from Joy GPs since.* *1034 B2 GP Induction - Not directly a hub issue though they know that quality varies amongst practices. They have been working on a standardised induction sheet with KB and trialling in the Western Isles. Not actually received specific complaints themselves.* *1036 B2 Induction - Process of evolution. Different understanding of what it means between med dirs./ hub/ practices. Appreciate now the wider induction requirements that the Hub consider, a full detailed checklist covering the duties as an employer. For C2 practices and locum arrangements , induction much more about quickly orientating a GP to get them working- basics of what you need to know to do the job. What has this meant for the joy - an iterative process, but we did actually point this out at the recruitment weekend and Joy GPs asked if they could help and the reaction was OK. The GPs wanted it to be better and some engaged later on tasks to help improve it.* *1037 B2 No, but can't speak for everywhere. Saw the problem first hand at Lerwick recently with a Joy GP and induction pack not ready, would hold hands up here.GP had actually worked on a pack that they had developed at Brae so she understood the issue. Resolved her support by spending time with her on first day and that was best practice. Have somebody from management sit down with a GP and establish induction needs. Practices should really have a generic induction pack with local add your own bits.*	*See Recommendation (R25): Good quality induction guides need to be available at all practices and Recommendation (R26), Joy GPs will also need time to orientate, support getting into accommodation and a good handover, support from an experienced user working with the primary care IT systems.*

					1039/1040 B2 Difficult for us to say, not aware of how good induction is at different practices or any marked improvement. Discussion as to how much induction GPs actually need and difference between quick orientation for short term placement and more involved induction with HR aspects etc. *1043 K6 (Good Induction) No not everywhere, a bit patchy, but some practices really good (South Uist, Glen Elg). Some locum packs not brilliant.* *1044 K6 (Induction quality) Variable. Wick - in at the deep end, didn't know Vision so a difficult first day. Better with others but, so long as you took your time, you could get there. Carbost - particularly good. Dr there did very well with a book. Overall, was sufficient.* *1045 K6 (Induction quality) Varied enormously, Scalloway Ok, Unst fantastic. All had some things in place but there are definitely ways to improve what is there. Key problem is the antiquated nature of Scottish EMIS, very difficult to work with when you first come from England. Good practice in Unst was EMIS screen shots to help. It gets easier each time and I have a standard list of questions I ask by email or on arrival now.* *1045 K7 (Appreciated) Yes, but a bit of wariness on both sides. Patients because of having to explain themselves regularly to locums. Practices for having to deal with a lot of temporary doctors, possibly sometimes with issues. Seemed to be appreciated personally and several places asked me to go back. Think you make your own appreciation sometimes – you can't expect to just walk in and for everyone to think you're fantastic.*	

					1046 C7 This area needs development through clinical lead role.	
26	Clinical Governance	Challenges when a joy GP sees challenging quality issues in a practice and how to raise it.	Discussions on Joy VC #7. GPs have seen 2 issues on a) Prescribing b) Lab results. Joy GP discussed with AMD and raised issue directly with the practice. SEAs reported for lab results through Datix and NHSH systems. KB issues a protocol for discussion (Oct 2019) Although there are risks, potential advantage as the Joy GP will be seen as a less threatening peer – if the Joy GP has the necessary skills to deliver a challenging message.. This approach was effective in the prescribing example. KB issues a (draft) protocol for Joy GPs to raise concerns for discussion (10/10/2019) (see also issues #9 Practices with Workload Problems,# 19 Ability of Joy GPs to be effective business consultants #21 Feedback forms, # 30 Solutions)	Interview Test – Clinical Governance (C) C1 C8 C11	*1036 C1 Robust, as professionals GPs shouldn't need managing, certainly not on admin.CG is evolving in Scotland and we will need to define what it mean, very much about how teams perform in Scotland. The CG offer for the Joy has been the GP VC which has moved on to discussing GP experience in the H&I and SEAs. More quality improvement issues need work at the moment and this awaits the new clinical lead coming into post shortly. The Joy VC will continue to be a good vehicle for this.. Individually GPs still have to maintain their regular CPD. Key learning point.* *1046 E8 (Providing critical opinion)… but only if asked. Is it appropriate to provide critical opinions on the way practices are run if you are only on a short placement? Will probably be received critically. Would personally be hesitant with this role unless opinion had been sought.*	*Evidence* *Discussions at Joy GP VCs (Sept – Dec 2019) mentioned this issue quite a few times. Clear also in the W&A discussion (see also issue #19 Ability of Joy GPs to be effective business consultants) Joy GPs did have concerns about raising quality issues with practices and sometimes lacked confidence in this area.* *PIO – More development work is required on these skills for those GPs who will be more engaged in it. It is also a good example of quality benefits from the Joy GP VC, learning point.* *Also see recommendation (R33): Training/ professional development needs to be considered for GPs recruited under W&A for practice development roles.*
27	Operation and management of the Joy Limitations of the Joy	One Health board taking over recruiting and hosting the Hub Critical.	Special financial measures (k/a Grip and Control) in NHS Highland, particularly cutting down locum costs, would have made running the scheme unmanageable from Highland even though they have greatest need of the service (also see discussion under GE10 B6 and issue #5 Highland practices not aware of the scheme).	Interview Test – Management & Operation of The Joy (D) D1 D7 D11 Limitations of the Joy (F) F7	*1030 J2 (one of the) Critical success factors for the Joy.* *1033 F7 (Shetland) Don't see it as a problem,. Wanderers and Adventurers (W&A) is using contracts with local health board. Only risk is if other health boards stop using Joy GPs.* *1039/1040 F1 Challenge is also how do you keep the current good relationships if the Joy expands? One of the great strengths has been learning how to build the model, but the great*	*Evidence* *Evidence from1039/1040 and phase 1a evaluation report agrees that it would have been difficult for NHS Highland to run the scheme effectively. Under financial special measures imposed managed by external auditors, they may not have been able to recruit Joy locums without constraints that would have made the scheme inoperable.* *Evidence under GE10 (Challenges in*

					strength has been building a team that works well together, across 4 health boards. Problems with `Grip & Control' in NHS Highland and an expanded scheme incurring more T&A costs raises questions with (NHS Highland) finance team. They may not be able to keep providing free accommodation etc.	*setting up Employment Contract T&Cs) supports this. Management of the scheme by a health board under less of a constraint is seen as a critical success factor (1031) though they do also take on the subsequent financial risk if there is a low take up of contracted Joy GPs.* *PIO - Key operational success factor has been that;* *a) one health board has been willing to take the risk of employing Joy GPs. NHS Shetland takes the legal risk over contracts of employment and liability for providing the service. This avoids having to get support from other health board or have problems creeping in from contract discrepancies issued by different health boards. It also protects the scheme against funding restrictions and other constraints imposed on NHS Highland.* *b) Expertise in operationally managing the Joy (ie GP contracting and managing placements) can be built up into a small centre of expertise (the HrHub).* *Learning point – this factor will be important when deciding how the scheme expands. Joy professionals will have to be employed by a health board but, the employer has to take the budgetary and legal risks.*

						Also see GE10 B6 responses and discussion of the VAT issue (#52). *Recommendation (R31): The impact of special financial measures in NHS Highland needs to be monitored and AMD Highland supported if there is pressure to dilute the offer to Joy GPs or cutbacks on using the Joy scheme.*
28	Marketing Operation and management of the Joy Limitation of the Joy	Communications with Practices	The scale of NHS Highland and the independent nature of their GMS practices means that the health boards have less intimate relations with their practices - not in the same way that the island health boards do. They issue many things `one to many' and much harder to get the buy in from Highland GMS practices. Nov 2019 - Copy of agreed intranet page for NHS Highland released (also see issue #5 NHSH Practices not aware)	Interview Test – Marketing (A) A3 A4 A5 Management & Operation of the Joy (D) D4 D5	*1034 A3 Highland practices - Difficult to tell, not sure how widely information on the Joy has been disseminated. However clear that highland practices are responding g and this has increased gradually over time of 106 placement bookings 44 come from highlands (42%). There was a suggestion in the beginning that they did not know about the scheme? Much more in line with expectations now.* *1039/1040 A3 (NHSH practices) More aware now, people/practices do talk about it though they don't always understand how the scheme works. Not everyone sees the scheme as a positive and with the recent inclusion of VAT then it is more expensive for GMS practices. Not so much a problem for 2c practices but there are not many ways around that. They had a similar problem with a GP Fellowship scheme. Locum agencies were more competitive as VAT only charged on arrangement fees.*	*Evidence* *The health boards are different in nature geography and scale (see QA11 and 12 for practice and patient populations detail). NHS Highland, with a large primary care cohort of GMS practices tends to have less `hands on' management of primary care support. The scale means that communications are more `one to many'/ use of intranet etc.* *Awareness of the Joy has increased over time (per comments 1039/1040) but take up is possibly now more limited because of the VAT cost differential and the fact that many practices have their own existing stable locum arrangements.* *PIO - Because take up of the Joy in NHS Highland has been lower than expected does not mean that the Joy is unsuccessful or communications with Highland practices are poor. Discussions with new entrants practices from Highland were*

						underway in early 2020 (Mull, Ullapool) and it may reflect the ongoing instability of the traditional H&I primary care model. *(see also issue # 5 NHSH Practices not aware)*
29	Operation and management of the Joy We didn't know	Late production of invoices by NHS Shetland/ NHS Grampian	Will cause a problem with other health boards if invoices not produced promptly – particularly for organisation under special financial measures (k/a `Grip and Control'). VAT issue needs to be resolved. (also see issue #52 VAT)	Interview Test – We Didn't Know (E) E10 E11 Limits of the Joy (F) F11	*1033 D15 (Benefits) For NHS Shetland, yes because we don't have the VAT issue that other health boards do so we are not paying the £900 pw locum charges* *1039/1040 A3 (NHSH practices) Not everyone sees the scheme as a positive and with the recent inclusion of VAT then it is more expensive for GMS practices. Not so much a problem for 2c practices but there are not many ways around that. They had a similar problem with a GP Fellowship scheme. Locum agencies were more competitive as VAT only charged on arrangement fees.*	*Evidence* *2 issues;* *a) The slow delay in NHS Shetland being able to provide invoices for payment by other health boards – due to uncertainty over the VAT issue - was causing a problem budgetary wise, particularly for NHSH (Autumn 2019)* *b) The status of whether VAT should be charged by NHS Shetland to other health boards or GMS practices needed to be clarified with HMRC. This took time (ruling late 2019)* *PIO – Delayed invoice payment no longer noted as a problem by NHSH for evaluation interviews (Feb 2020). VAT issue see issue #52), cash flow problems are a risk factor for health boards involved in managing the programme though.* *Recommendation (R35): VAT and invoice payment need to be considered as risk factors as part of cash flow modelling for future versions of the Joy scheme.*

30	We didn't know	Supporting a particular practice, Solutions – The Joy proposition	Discussion at Joy VC #8 around how best to support a practice with some challenges. Analysis from 2 Joy GPs who had worked there informed the debate (views were slightly different). Proposed solution asked for from Joy GPs about how best to cover. This is considered important in empowering the GP group.	Interview Test – We didn't know (E) E1 E7 E8 E9	.	*PIO - See response under discussion at GE 30 Difficulty Recruiting, Issue #9 Working with practices with challenges, #23 Wanderers and Adventurers, #45 Prescribing Management problems.* *Important not to lose the point of the idea that Joy GPs would advise management and be part of providing solutions, this was an important part of the scheme. In this example Joy GP opinions later fed into the debate that led to the development of the W&A scheme.*
31	Clinical Governance	SCI Store (Blood Test Result System) across the region log ins.	Is a problem as, bespoke login arrangement for each health board area so GPs will have to set up logins each time. No immediate solution.	SEA Evidence	.	*PIO - C8 Discussed at Joy GP VC (#7) – information point from an SEA discussion. Evidence that Joy GPs are taking part in SEAs but also highlighted a problem that primary care managers and AMDs feel they struggle to influence national IT plans and priorities. In this case SCI Store was not flexible enough to allow GPs a one sign login and bespoke arrangements continue to be made.* *See also Recommendation (R4a) on Scottish Primary Care IT systems.*
32	Recruitment and Induction Clinical Governance	Formularies different across regions.	An observation made by Joy GPs from England who were used to more tightly defined formularies. Discussed at Joy GP VC #9. Several GPs not aware there was a Highland formulary. Action to make Joy GPs aware of formulary. More development work on formularies.	Interview Test – Recruitment & Induction (B) B2 Clinical Governance (C) C7	*1033 C7 Each practice in Shetland has a locum pack and any new guidelines etc. are added to the pack (eg Corona virus). New guidance is sent out by e-mail to all substantive (and semi substantive) post holders eg Joy Gps. Also GPs are invited to a 4/6 weekly SWIDDER Group learning event for clinicians, to discuss best practice and new things. There is also a clinical portal on the intranet.* *1036 C7 Complex as each board area has its*	*Evidence* *There does not seem to be tight agreement in this area.* *1) (Per 1036) Each board has its own guidelines* *2) There does seem to be some doubt about how to find guidelines easily (some GPs not aware of intranet materials).* *3) (Per 1037) Environment for*

					own guidelines eg WI use the Highland formulary, Shetland & Orkney different. Difficult one for Joy GPs. CS working on emergency protocols, part of an ongoing programme. There is a big role for the practice in this, How do you deliver good protocols and induction? This is also what we are expecting practice to develop themselves. *1037 C7 Don't know, intranet? A lot of protocols in Shetland have been borrowed from Grampian. Really should have links to current protocols & procedures linked to induction materials. Formularies also a difficult area and a bit of a hash as different parts of the H&I do different things. English based Joy GPs not so comfortable with this as there are lots of constraints on their prescribing in England but free-er here to refer to BNF and make their own decisions and allowed flexibility. Constrained in some dispensing practices due to limitations of available stock and longer times for re supply. Should be an induction point though.* *1039/1040 C7 Good question, how to H&I (primary care) keep up to date? Do Joy GPs know about `Treatments and Medicines App' on NHSH intranet? Key question on the grid for development of an induction pack by health boards.* *1043 K5 (Aware of clinical guidelines and protocols?) to some extent yes, some information available on the board intranets, some material on inductions, you get better at looking and sometimes you just have to ask.* *1044 C7 – Discussed at K5. Joy repository would be a good idea. Would have helped with*	*English based GPs is probably very different from what they are used to. Less controlled and decentralised in the H&I.* *PIO - Arose as a point from a Joy VC as a good learning point, how are primary care managers assured that GPs are getting good inductions and access to agreed protocols, guidelines, formularies etc.? AMDs probably want to consider the question on how the formularies are reviewed and should they be harmonised between health boards? In England, tight formularies have arisen to link to good evidence based prescribing practice but also to save costs at the cost of restricting GPs control of prescribing. Is this approach necessary in the H&I? How and when are H&I formularies reviewed and updated?. A key point will also be to reduce uncertainty and help induction for Joy GPs, further work for clinical lead role? (see issue #41 on Access to guidance).* *Recommendation (R36): Guidance on how to access H&I clinical guidelines and formularies needs to be made more explicit on GP induction.*

					anxiety over `once in lifetime' type situations where you are facing serious problems on your own in a rural area. Had a problem in one practice with Evac procedures and wrong contact number was on the guidance? *1044 K5 (Aware of local guidelines and protocols) Maybe, pre-loaded T&Ms App before I arrived because anticipated poor broadband. Practice intranets also had guidance, if in doubt asked the practice; Highland formulary was a bit restrictive. Could think about a Joy repository for guidance, e-mail addresses, links etc.?* *1045 K5 (Aware of local guidelines and protocols?) No, not generally, apart from Unst. Asked in Stornoway (`Ask if you need to know'), didn't always work. Did dig out the Highland formulary. Conflicting information on mental health referrals in one island practice and did the wrong thing so felt a bit daft with the patients when you do something like that. not aware of local intranets.* *1046 C7 (Kept up to date?) Not much at present, this area needs development through new clinical lead role.*	
33	Original philosophy and values	Will Joy GPs develop a longer term relationship with practices?	Expectation that some Joy GPs would develop a longer term relationship with practices and provide longer term cover etc outside of the Joy arrangements. Raised by CS at Joy GP VC#9 and previously. Evaluate longer term if this is the case.	Interview Test – Limitations of the Joy (F) F10	*1033 Nothing yet, but one joy GP has been offered a substantive post, so the role has been an introduction to the area.* *1037 F10 Could happen, often the availability of a substantive post.* *1039/1040 F10 Has happened (eg Gareloch), prospective Joy GP became a partner.* *1041 F10 No evidence.*	*PIO - It is probably a little bit too early to tell yet but there are some encouraging signs (per 1033/1039/1040 comment). Dilemma may be that although Joy GPs do develop more substantial relationships with practices many of them are in the retirement age category. Continue to evaluate, See Further work section.*
34	Clinical	Feedback	Raised by Joy GPs at VC # 8 & #9 (& #10)	Interview Test -	*See evidence at issue # 21.*	*See response to issue # 21*

	Governance Operation and management of the Joy	forms need developing and more widely disseminating	Suggestion of a form between GP and practice. Issue raised with Joy Management (12/11/2019) (also see issue #21 Improvements to the feedback form).	Clinical Governance (C) C4 Management and Operation of the Joy (D) D9		*Not much constructive feedback has been given back to Joy GPs, judging by the comments made as part of the evaluation. Feedback from the practices to HrHub has not been spread widely. The evaluation is not aware of any review of the feedback process other than by comments from 1031 on Dec 2019 workshop. Having good feedback is a necessary and valuable part of both management and clinical governance (also see GE22 Return of Feedback forms and issue #21 Improvements to the Feedback form).* *See recommendation (R14) (GE22). A discussion needs to be held on the best way to use feedback within the Joy.*
35	Recruitment and induction	Email from GP frustrated with The Joy recruitment processes and decided not to continue.	Problems with ; Getting GPs onto Scottish GP Performers list 3 week delay in getting interview result. Short notice vacancy listings. Contract T&C's unclear. What's App group depressing comments AMD call for clinical huddle meeting to discuss 10/11/19 (also see issues #4 and #43).	Interview Test – Induction & Recruitment (B) B4	*1034 B4 Frustrated GPs -Not aware directly from GPs that there was a problem. Setting up contracting process in early 2019 was difficult and time consuming as they had to create bespoke contracts and agreement on hours/ T&Cs etc. Took a long time to put in place. Clear they (HrHub) were sensing frustration from other Joy team members. This may have stemmed from a lack of awareness from clinical staff on what was involved in putting the contracts and robust process together. To help they (HrHub) prepared an FAQ to help GPs but don't think they ever lost a prospective GP because of delays. They did a lot to stay in touch with them.* *1036 B4 Frustrations were not necessarily around recruitment, but long delays getting onto the Scottish GP Performers list and other*	*See main response at issue #4.* *<u>Evidence</u>* *Only evidence of 2 GPs quitting the recruitment process, one blamed it on delays.* *PIO - This issue had a high profile during a period of difficulty in May/June 2019 when long delays in getting recruitment processing done was causing frustration all around. Root of the problem is getting the rest of UK GPs registered on the Scottish GP Performers list, this process is still slow but attempts have been made to improve the speed.* *Not too much evidence that the*

					delays around PVGs, occ. Health. Really time consuming and often cross border (Scotland/England), slow. Perhaps we didn't make that clear at the beginning. KB and CS went to Shetland (Aug 2019) to help understand the position and so that HR not acting in isolation. *1041 B4 Aware of some frustrations but also understands that recruitment takes time and there was probably an expectations problem in the beginning given the slow pace of the NHS.*	*scheme has lost potential Joy GPs because of delays appointing/ placing. Seems less of an issue now.* *See recommendation (R3): The first Joy recruitment campaign, following the date of the original BMJ advert in January 2019, to the first placement of Joy GPs in July 2019, took approximately 25 weeks. This time frame should be born in mind for a similar scheme or extension of the Joy*
36	Marketing	What are the lessons from marketing ?	How effective as the whole effort been and could it have been done another way? CS – Clinician Led marketing Team very operational so less thinking about the outside world. Did we consider all media, could we have done more? Spend some money? Time to re run BMJ advert?	Interview Test – Marketing (A) A1 A2 A11	*See evidence under GE1*	*See response under GE1; see also website discussion at issue#61.*
37	Clinical Governance	The need for a clinical lead post for The Joy	How the need for this role came about and why was there a long delay getting a candidate into post?	Interview Test – Clinical Governance (C) C10	*1032 D1..It has been confusing in the past as clinical leadership has got mixed up with operational management, as a consequence the wrong issues have been brought up in the wrong forums (eg What's App group) everything had been a bit confusing and sometimes bonkers. Need to split things into Clinical Leadership, HR management and strategic management. Lesson #1 had been the crossover of roles into different areas had been confusing. #2 It was necessary to put someone in a new role to link between clinical leadership (KB/CS) and the HrHub team.* *1033 J10 Work with the new clinical lead very closely, will review in 6 months, but this also means a long term commitment(see above)* *1036 C10 Have appointed to post now. Need*	*Evidence* *Need for post identified early on (see 1036) but workload pressure at the start of the Joy operation and the need to bid for funding meant that it took time to agree the funding, job description (circulated Sept 2019) and set up the recruitment process. The candidate started in post in Feb 2020. NHS Shetland took the responsibility and the risk as this post would also cover workload challenges for AMD Shetland.* *PIO – The benefits for this role fall outside of the evaluation period but it could be a future key success factor providing action, direction and reassurance around clinical*

					for post identified early (2018), just took a while to promote the case, write the paper (Aug 2019),	*governance in future (see main clinical governance discussion at GE11 GE12).* *See recommendation (R6) (GE 11, GE12).The activity and effectiveness of the Joy clinical lead role is assessed and reviewed.*
38	Operation and management of the Joy	Management group of the Joy not meeting regularly (Aug – Nov 2019)	Is management of the joy effective and robust? Are things uncoordinated or not happening as a result? Are there risks? (see evaluation of the effectiveness management arrangements for the Joy GE19)	Interview Test – Management & Operation of The Joy (D) D1 D4 D13 Joy GP Questions (K)	*1030 D1 Didn't know originally how the Joy would be managed as it depended on the number of GP candidates we would attract. We have, in retrospect, done very well. We had to organically grow the team and had to learn quickly, but in the end nothing was left undone. Sometimes things were done on a fairly ad hoc basis in the end, what we did was good enough and nothing foreseen that we couldn't manage. In future, the management team will need to be bigger with more delegation.* *1030 D3 In the early days it was hard to establish a routine and we were on the back foot a lot things were very disruptive.. Not a problem now. Things are now treated with the right amount of urgency and we have learned to be responsive when required.* *1031 D1 There is an aspiration for wider involvement but it is difficult for all the people to look at all the issues when we tried to do this with all 4 Primary Care Managers and AMDs we found that most did not have the time, focus and attention to the project to allow us to make decisions and move the project forward. We therefore created the Executive Leadership to drive the project forward. This has worked much better. I think the issue is in us ensuring that we communicate the developments to our partners.* *1031 D7 Executive meetings minuted, with*	*See main discussion on the effectiveness of the Joy Management GE19.* *<u>Evidence</u>* *Some symptoms that irregular nature of management meetings during the period May – Dec 2019, meant that there was a lack of co-ordinated direction and not much information coming out. This may not have created disruption in terms of Joy operation, but has created anxieties and a sense of a lack of inclusion by staff who felt they were very much part of it in the beginning but feeling less so later on (eg 1039/1040/1041) Also Joy GP responses (see 1045) would suggest that they feel out of the loop though this view is a bit subjective. Situation in early 2020 now compounded by Covid19 shutdown.* *PIO – In the later part of 2019 Joy management team were struggling to make time for hands on management of the scheme (though different initiatives were continuing). If this pattern repeats into 2020 then other dysfunctions could appear. A meeting was held in Edinburgh (Dec*

					actions, have used What's App and attend anywhere though some meetings cancelled. If no time can be found then the meetings don't happen, they do tend to get replaced by more (specific) functional meetings though (eg upcoming conference event prep meetings). *1032 D1 It depends on your definition of management and who you are referring to as management eg is it SRMC is it Clinical Management is the Hub itself and therefore you will get different responses depending on what individuals think is the management unless you have specifically said who or what you are referring to - and therein lies the issue - confusing landscape and so I am currently working on a wiring diagram to make it clear how the Joy is managed. It has been confusing in the past as clinical leadership has got mixed up with operational management, as a consequence the wrong issues have been brought up in the wrong forums (eg What's App group) everything had been a bit confusing and sometimes bonkers. Need to split things into Clinical Leadership, HR management and strategic management. Lesson #1 had been the crossover of roles into different areas had been confusing. #2 It was necessary to put someone in a new role to link between clinical leadership (KB/CS) and the HrHub team #3 The role of the Project manager was confusing and I think different folks thought that David was doing some feedback into the other areas! the Lead HUB GP is that interface and as such I (LH) have set up proper monthly meetings to keep people up to date and cascade information (both ways) correctly.MS understanding lessons document has been useful however capacity is required to spend time in pulling together the lessons learned. In 2020 the*	*2019) to discuss issues and try and improve management effectiveness with an agreement for regular future quarterly meetings to be held. With such a geographically disparate organisation, this effectiveness will need to be kept constantly on review. A cascade of information system (eg newsletter, see GE19) should also help.* *See recommendation (R11):* *The effectiveness, participation in and frequency of Joy management meetings, as well as the effectiveness of communications to and from the management team, need to be reviewed constantly.* *Also see recommendation (R12): If the joy is expanded and more people become involved, then, the management structure and meeting arrangements need to be fundamentally reconsidered.*

					landscape is clearer now and there are better ways of working. The earlier havoc used a lot of additional time and effort to manage.. lots of valuable lessons. *1033 D11 Need to draw the management in - who are the core management group? With potentially 14 health boards, med directors , primary care leads and other professions there is great risk of it all becoming unwieldy. Have to get it tighter and not too many chiefs. A real problem coming is who do I answer to? and the decision making process becomes confused.* *1034 D1 Felt not much of an appreciation of what the HrHub did early on. Comms have been much better since Edinburgh meeting (Dec 2019) but problems with earlier Hub meetings with poor attendance. Appreciate, quite a challenge over building a disparate team. New clinical role (recruiting Jan 2020) should definitely help.* *1039/1040 D3 (Problems) Sometimes, but aware that for a long time the HrHub were under pressure over contracts and recruiting the first GPs. They are very responsive when you make contact and single inbox gets used. 1039/1040 D13 (March 2020 Event) Not been involved with. Would like perhaps to have been given the option but commitment is high so possibly not. 2019 event was very rewarding.* *1045 E9 … there is not a complete feedback loop here to the Joy GPs, if you raise an issue or an idea; you don't always get a response. In hospitals in England there is often the wall chart saying `You asked, we did' in relation to staff surveys/ patients etc. If we just had some regular e-mail updates sometimes, as a group,*	

					it would help. *1046 D4 HrHub very helpful and responsive though they don't always have the answers straight away. They have had quite a workload with teething issues on admin and still some delays on expense payments.*	
39	Limitations of the Joy	GPs negotiating their own arrangements with practices	One GP had been talking to practices to negotiate his own engagements/ pay rates etc. This was much more in locum mode and created a little bit of confusion but more an issue on the concept of what a Joy GP was and the difference with locums. HrHub not averse to GPs making longer term arrangements with the practices, that was a longer term Joy aim but, GPs using placement opportunities to market themselves as a locum muddied the water and caused confusion to the practices (see also #33 Longer Term relationships)	Interview Test – Limitations of the Joy (F) F10		*PIO - F10 Quite possible and an example in Highland area. More likely in parts of the Highlands and Orkney where long running established locum arrangements run alongside the Joy. The VAT issue means that, at the moment, in non-Shetland GMS practices the Joy scheme is at a cost disadvantage when compared against locum agencies (see issue # 52 VAT).*
40	Recruitment and induction Operation and management of the Joy	Issue of introducing GP timesheets	Problems sometimes emerge from the placement requests that practices make, some obfuscation over whether payment is by session or by hour and practices have very bespoke arrangements whereby GPs are not sometimes working all the hours they are contracted to. Root problem that GPs are sometimes not working sufficient hours. Timesheet completion is not liked by some of the GPs who feel that they are being treated like a locum.	Interview Test – Induction & Recruitment (B) B7	*1034 B7 GP time Sheets - In the end no (not a problem), most GPs now complying, though not always on time.* *1041 B7 Timesheets - No, not a problem. Timesheets are standard practice and necessary to prove hours worked. Did need a conversation on expectations with practices though sometimes felt that the hub resort to e-mail rather than having a more effective conversation.* *1046 B7 Time sheets not a problem but they never reflect the full, above and beyond contract, work you have to put in so not really accurate and feels a bit pointless.*	*Evidence* *Some unhappiness from Joy GPs when timesheets were introduced in Nov 2019 and several did not comply originally. System working OK by February 2020.* *PIO - Not really a problem now though some Joy GPs doubt the value of a timesheet (see 1046 comment).*
41	Clinical	Joy GPs	Raised by Joy GP at VC (#12 Nov 2019). GP	Interview Test –	*1033 C7 Each practice in Shetland has a locum*	*Evidence*

	Governance	are out of the loop for getting up to date clinical protocols/ guidance/ SOPs etc.,	attended a BASICs course. Scottish Ambulance Service (SAS) tutor explained protocols and provided them but GP not sure these are available in practices. This is something that would come from a CCG in England but no equivalent in Scotland. Should be something practices hold, but many often don't have them (see discussion at GE11 and issues # 1 & 2 on Induction, issue #32 Formularies).	Recruitment & Induction (B) B2 Clinical Governance (C) C7 Joy GP (K) K5	*pack and any new guidelines etc. are added to the pack (eg Corona virus). New guidance is sent out by e-mail to all substantive (and semi substantive) post holders eg Joy Gps. Also GPs are invited to a 4/6 weekly SWIDDER Group learning event for clinicians, to discuss best practice and new things. There is also a clinical portal on the intranet.* *1034 B2 GP Induction - .know that quality varies amongst practices. They have been working on a standardised induction sheet with AMD and trialling in the Western Isles. Not actually received specific complaints themselves.* *1036 C7 Complex as each board area has its own guidelines eg WI use the Highland formulary, Shetland & Orkney different. Difficult one for Joy GPs. CS working on emergency protocols, part of an ongoing programme. There is a big role for the practice in this, How do you deliver good protocols and induction? This is also what we are expecting practice to develop themselves.* *1037 C7 (Access to guidance) Don't know, intranet? A lot of protocols in Shetland have been borrowed from Grampian. Really should have links to current protocols & procedures linked to induction materials. Formularies also a difficult area and a bit of a hash as different parts of the H&I do different things. English based Joy GPs not so comfortable with this as there are lots of constraints on their prescribing in England but free-er here* *1039/1040 C7 Good question, how to H&I (primary care) keep up to date? Do Joy GPs know about `Treatments and Medicines App'*	*See comments by Joy GPs (opposite), there are variable responses. Some GPs have not looked at intranet resources; some have done advanced work before coming to H&I to understand the systems and guidance that is in place. Clear from some responses that regular NHS not always quite sure where information resources are. NHS Highland Treatments and Medicines App (TAMS) is available on their intranet and appears to be fairly comprehensive.* *PIO – Joy GPs are responding in different ways so it is not a universal issue. This is something that should be dealt with at induction pack level (see also issue # 1 and #2 on induction and #32 Formularies).* *Recommendation (R37): Induction guides need to be clear show GPs where current clinical protocols, guidelines, formularies, treatments and medicines app and SOPs are held, on paper or online (also see R27 on Induction Packs).*

					on NHSH intranet? Key question on the grid for development of an induction pack by health boards. *1043 K5 (Aware of local clinical protocols and guidelines) To some extent yes, some information available on the board intranets, some material on inductions, you get better at looking and sometimes you just have to ask.* *1044 K5 (Aware of local clinical protocols and guidelines) Maybe, pre-loaded T&Ms App before I arrived because anticipated poor broadband. Practice intranets also had guidance, if in doubt asked the practice. Highland formulary was a bit restrictive. Could think about a Joy repository for guidance, e-mail addresses, links etc.?* *1045 K5 (Aware of local clinical protocols and guidelines) No, not generally, apart from Unst. Asked in Stornoway (`Ask if you need to know'), didn't always work. Did dig out the Highland formulary. Conflicting information a on mental health referrals in one island practice and did the wrong thing so felt a bit daft with the patients when you do something like that. See C7, not aware of local intranets.* *1046 C7 (Keeping up to date) Not much at present, this area needs development through new clinical lead role.*	
42	We didn't know Limitations of the Joy	Reluctance of some Joy GPs to become involved in `Flying Squad' concept of	Raised at GP Joy VC # 12 (28/11/2019). Older GPs feel it is challenging, requires energy and may involve confronting local GPs. Review as Joy 2 developments are brought forward (see also GE 30 Difficulty Recruiting and issue #23 Wanders and Adventurers).	Interview Test – We Didn't Know (E) E1 E7 E8	*1031 E8 It is an expectations issue on what the Joy means, the roles have developed now and there are 2 distinct aspects of the project/job a) A steady rural practice job, empowered as far as patient care is concerned. b) A role helping with difficulties in practices, a more empowered role to make change, help with flow and system building, facilitate change*	*Evidence* *The Wanderers and Adventurers scheme was being formulated in Oct/Nov 2019.This planned to recruit GPs for larger blocks of time (typically over 12 weeks) to work intensively with practices, as part of a GP team, to help them develop and overcome*

		providing solutions for practices with challenges .			*using skills. These improvements won't just happen by people walking in there (to practices), it will need to be facilitated and structured. Looking at a session on this at the development weekend in March (2020).* *1031 #9 W&A just one solution, trying to create part of the solution, just a concept really. Shows different ways of working, helps with support for individuals and a opportunities of working in a pool. Would make a good case study, really good example of different ways to find a solution. Breaks away from the problem of trying to fit round pegs into square holes, different way of thinking and working. Not doing the same old thing and getting the same old results.* *1037 E7 Initial thoughts cam at the time of the first recruitment weekend (March 2019). They only realised then the high quality and calibre of GPs that would be available.* *1037 E8 Discussed the expectation of the Joy remit and partly the way that the scheme had been sold to the Joy GPs. Clear that some Joy GPs have the ability and have taken this role on to a limited extent but not originally what they were expected to do. Joy GP feedback was useful eg at Wick where problems were highlighted, but this should really trigger management action in Highland to come up with a plan to provide solutions rather than the Joy GP carrying on as a management consultant for practices.* *1046 E8 Motivation and confidence, yes, but only if asked. Is it appropriate to provide critical opinions on the way practices are run if you are only on a short placement? Will probably be received critically. Would personally be*	*particular backlogs or other quality related issues. The idea originally came from the fact that in the first round of recruits for the Joy, some of the GPs were very experienced and very capable. When Joy management became aware that there were practices with development problems it seemed logical to see how Joy GPs could be deployed to help. This idea was explored at several Joy GP VCs* *The specific idea of a `flying squad' was discussed at a Joy GP VC (Nov 19), but some GPs had reservations that this was not really what they had come to Scotland for.*  *Per GE30 , some the of the reasons Joy GPs have come to the H&I is for the `great locations' (1043) `looking for a way to go back to Shetland' (1046)`interesting locations' (1044). No evidence on whether the GPs would be willing to go to other parts of Scotland, or those with deprivation and other problems. Also 1046 points out that opinion may be taken critically by local GPs and this may be an uncomfortable position for a Joy GP to be in.* *PIO – Clear that the W&A type practice development role may not be suited to Joy GPs generally, who tend to be older and looking to get away from the pressures of practice management. However it may suit some GPs to do this. This role is being made explicit as part of the 2020 Joy*

					hesitant with this role unless opinion had been sought.	*GP recruitment campaign. Ultimately how this development role is set up with the practices may be the real test (see also, discussion at GE 30 Difficulty Recruiting and Issue #23 Wanderers and Adventurers, #24 Concerns Joy GPs being sold a too upbeat a message).Further work would be a separate Evaluation of W&A (see Further work section).*
43	Recruitment and induction	GP applicant frustration	GP interested in The Joy. Frustration at not hearing things and performer's list issues (also raised as an issue(#35) Email from a frustrated GP and # 4, reference also discussed under Phase 1a evaluation report).	Interview Test – Induction & Recruitment (B) B4	*1034 B4 Frustrated GPs -Not aware directly from GPs that there was a problem. Setting up contracting process in early 2019 was difficult and time consuming as they had to create bespoke contracts almost and agreement on hours/ T&Cs etc. took a long time to put in place. Clear they were sensing frustration from other Joy team members. This may of stemmed from a lack of awareness from clinical staff on what was involved in putting the contracts and robust process together. To help they prepared an FAQ to help GPs but don't think they ever lost a prospective GOP because of delays. They did a lot to stay in touch with them.* *1041 B4 Aware of some frustrations but also understands that recruitment takes time and there was probably an expectations problem in the beginning with the slow pace of the NHS.*	*See response under issue #4 & #35.*
44	Clinical Governance	Is the nature of the VCs changing? Where should they be going?	Originally , VCs very driven by GP contractual terms and frustrations issues. Nov 19 - Since 7/11/2019 (VC#10) there has been much more emphasis on case histories and significant events and although administrational issues come in, usually now, about 50% of a meeting is talking about clinical cases. There have been references to providing CPD through	Interview Test – Clinical Governance (C) C11	*1031 E9 Need to think about Joy VCs, keeping a lessons learned log, action minutes or quality ideas and improvement spreadsheet. VC need to be re-thought out. Important for us to recognise that we need to empower people to be able to raise ideas and innovations and take them through to solution stage, this needs a structure putting in place. Clinical lead needs to be empowered to take this forward. Important*	*See main discussion under GE18a on the effectiveness of the Joy GP VC.* *<u>Evidence</u>* *From Joy GP notes of meetings, the emphasis of the meetings do clearly change after around Oct 19. There is then much less emphasis on discussing GP terms and conditions*

			the VC meeting (see discussion under GE18a)		*to recognise and record what we are doing to improve quality and feed that back to health boards.* *1036 C11 Joy VC- has been a start. Needs iterating now and be owned by the Gps and the clinical lead. Change in format might be necessary. Good time for a review.* *1043 C11 Joy VC very good, despite the technology, they were effective in discussing issues and a way of providing support when you were out there in placement. You got some feedback about how the whole project was working etc. They were much appreciated.* *1044 C11 Useful, excellent way of supporting (personal) reflective practice, having the minutes of the meetings was helpful. Feel it helps when on placement for the Joy and useful to patch in, need about 5/6 on the VC to make it work. Appreciate the efforts to try and get round the technology.* *1045 C11 To be honest, didn't really enjoy. A problem when you raise clinical cases and what you thought were pertinent issues, but other GPs didn't always seem interested and could be a bit dismissive. Also, light hearted comments look odd out of context in the minutes. It made me anxious about speaking although I was interested in what the others had to say. Don't really want to contribute now as a little bit anxious. Connectivity awful so had a lot of problems. Thought the concept was good though. What's App group quite good and positive, but not often clinical.* *1046 C11 VC not bad but challenging as trying to 1) Provide support to working GPs 2) provide*	*(prevalent July – Sept), management and practice issues (Oct). By November there are interesting case and SEA discussions which continue through to Feb 2020 (16 in all).* *See recommendation (R10)(GE18a) Joy GP VC format and agenda needs now to be reviewed by the Joy clinical lead.*

					some link to professional development and CPD and can't do both. Looking at new models.	
45	We didn't know	Prescribing Management problems	Issue first raised VC#6 (19/9/2019) in relation to two practices where it was clear that they had not had the time to keep up with patient medication reviews. The knock on problem was that GPs had to take a long time with patient appointments in order to search patient records for the medication history. Covered in more detail at Joy VC VC#8 (24/10/19) and likely a consequence of practices being dependent on locums over a long period of time. There is also a potential opportunity, if medication reviews can be updated, it would make workloads easier providing headroom for development work and destressing the experience for GPs (see main discussion at issues #9 Practices with a High workload & #30 Practice Support).	Interview Test – We Didn't Know (E) E1 E7 E8	*See interview evidence under issue #9 and # 30.*	*Evidence* *A backlog of medication reviews appears to be a symptom that a practice has workload challenges. At Joy VC VC#8 (24/10/2019) 2 of the Joy GPs who had come across the problem, felt that, if the medication reviews could be brought up to date, that would give the practices good capacity to catch up on other development work. This point led to thinking about solutions in the form of a dedicated team of GPs working for a temporary period to get practices `caught up' and perhaps look at other development issues.* *PIO - E1 This has become a learning point for the Joy. Although the Joy has enabled visibility of the problems, and can suggest solutions, the responsibility for management is the relevant primary care team and health board (also see discussions under issue #9 Practices with a high workload, #30 Practice support).*
46	Original Philosophy and Values	Only now am I reflecting on how busy I really was in urban general practice	This was a comment made by a Joy GP at Joy GP VC # 13 (5/12/2019) – this led to consideration of capturing the reflections on the experience for Joy GPs. In part, this led to the formation of the Joy GP experience test questions in the evaluation.	Interview Test – Clinical Governance (C) C11, Joy GP Experience Section (K) K1 K3 K6 K7 K8 K8a	*1043 A9 Retiring from surgery after 35 years, I wasn't necessarily ready to give up work but I did need a different challenge, looked at Australia/ New Zealand, but very money culture which is different. Liked the idea of Shetland and the isles, ideal opportunity. 1043 J122 K8 Overriding thoughts; As a retired GP wanted to do the Joy, and didn't mind working hard but wanted some time to take in the great locations. Part of the Joy is living in a different community and it has been great for*	*Evidence* *Comments opposite illuminates why the GPs came to the Joy and whether they got satisfaction from the experience. In general, eventually, they did all get `the Joy' and, on a small sample size, tends to prove the original concept and likelihood that the Joy programme can provide some solutions for making primary care service provision more sustainable in*

					that. Good, relevant accommodation is necessary as well as a work car, important for us was that I brought my wife to some placements and you have to think about the couple, what will the partner do? Having said that great experience, a lot of colleagues jealous in England, not just GPs. Remoteness - A little scary to be honest, particularly with sick patients in remote places. Chances of a call out remote, but when you were, it could be serious. BASICs training came into play but still worry a little bit before going out on placement at the start (& perhaps a doctor should?)… Experience wonderful, got the Joy, loved it, helped me carry on being a GP. *1044 A9 Something different, west coast of Scotland, would like to try a wilderness (had worked as a medical student in Labrador). Great experience at the end of my career.* *1044 K8a (The Joy?) Yes I definitely did. Was a bit nervy on what to expect after BASICs week. Even after first attachment felt good and it got better each time.* *1045 A1 Did the job for me. Applied for a job I wasn't even looking for! Thought about doing locum work in Scotland a long time ago but put it to one side as too difficult for lots of reasons but then the advert was there. Key phrase was `One last challenge' thought it was now or never'.* *1045 K8a Absolutely loved it. Difficult start at first practice and I had some health problems of my own when I came so any negativity was mine. Am much more able to appreciate things now. Love it more and more. Very important to bear in mind that I come with my partner and he has to enjoy it plus important to be able to*	*the H&I.* *There are a number of similar themes arising;* *a) GPs, approaching retirement from arrangements in England wanted to do something different for an end of career challenge.* *b) They were all a little apprehensive as they started partly the change but also the thought of being responsible for providing care in some very remote and rural places without, perhaps the support that they were used to in England.* *c) The location and scenery are important as well as the experience for their partners.* *This evaluation has only taken opinions from 4 of the 16 Joy GPs working placements during the period of the evaluation.* *PIO – Support and attractants for Joy GPs are critical success factors. Future evaluation should continue to look at this theme to see if there are different experiences or if an experience change over time as the Joy develops (see also Joy GP evidence section).*

					have some time off and go and look at the area, not really in for a 10 session week in the busy town practices as you seem to lose some of the point of being here. Can't believe I get paid for it sometimes. Privilege to spend time with patient and families and have done things I haven't done for a long time in England (terminal care etc.) It gets better as you go on.	
47	Operation and management of the Joy vdzl·yűńűl·úńØŜ Analysis	How much time and resources has The Joy used up?	What needs to be understood in terms of the change in use of resources in using the Joy programme instead of usual or default operational arrangements. This area raises the need to understand the costs of the Joy and the efficiencies of the Joy solution compared to the likely scenario if the Joy programme had not been used. Also, it may be that Joy costs change over time and any ramifications need to be understood for future developments of the Joy.	Not interview tested, financial and efficiency analysis	*Relevant comments provided through interviews;* *1033 D15 For NHS Shetland, yes because we don't have the VAT issue that other health boards do so we are not paying the £900 pw locum charges and they are getting a GP at standard rates. Other efficiencies - not much else, perhaps some small savings of practice manager time, HrHub takes over all the actions. Big improvements are in qualitative level, greater consistency.* *1039/1040 D15 (Efficiencies) Not really aware, may have been some efficiencies for practice staff in not having to recruit locums, but locum arrangements in Highland very stable with experienced locums so not a lot of hassle saved.*	*PIO – Full financial analysis for the Joy not available however, see discussion at section GE 28 on efficiencies and Ijdzl·yűńűl·úńØŜ analysis and some conclusions. This is also an area to be considered for future evaluations (see section, also Phase 1a evaluation report and future evaluations summary and issue #48 Further work).* *<u>Evidence</u>* *NHS Shetland used 48 weeks of Joy GP time in 20 placements.* *Av. Cost of a Joy GP pw £85k ÷ 52 weeks = £1,600 pw, Locum cost (incl. agency charges c £2,400 pw) saving therefore is c £2,400 - £1600 = £800 x 48 weeks = £38,400.* ***Caution****, this is a very rough figure and actual locum charges may have been lower using direct recruitment of individuals.*
48	Evaluation Process	Additional outputs required from the evaluation .	Raised in discussion with Joy management team members; *a) Toolkit/ format for future evaluations something very basic. Use from an informed position to create a shell of an evaluation tool.* *b) Toolkit / format for other hubs Shell*	Discussion on interview with Joy management team members	*See report sections on Further Evaluation and Further work.* *No financial spend or efficiency analysis has been done in this evaluation as financial information has not been available. To understand the costs and efficiencies the following information would be useful ;*	*PIO - See sections on recommendations and further work, in answer to outputs raised by management team members opposite;* *a) Future Evaluation shell toolkit considered in*

			toolkit for another hub). *c) Good practice guides- Probably best as a case study preparation after the evaluation, some collaboration we can do with UHI.* d) *Create a charter - Recommendation for a separate piece of work for new joy.* e) *Accountability framework for future - a roles and responsibilities model and governance framework in future - Recommendation for a separate piece of work for new joy.* The management team also need to understand the costs of the Joy and the efficiencies of the Joy solution compared to the likely scenario if the Joy programme had not been used. Also, it may be that Joy costs change over time and any ramifications need to be understood for future developments (of the Joy).		*a) Spend on the Joy scheme since inception for the period of evaluation, breakdown of what that spend, was used for. Principally from the funding provided by the Scottish government.* *b) Estimate of savings that any health board or practice has made during the period. This could be on locum costs or saved staff time.* *c) Any extra costs that health boards or practices will have incurred (accommodation or travel).* *d) An estimate of management time and cost engaged on the Joy programme.*	*separate section under recommendations for further evaluations* *b) Further work - HrHub Toolkit needs to be scoped as a project.* *c) Good practice guides required need to be scoped what is required?* *d) Charter creation – future work, required to scope this requirement, does the charter set up the basis of a contract between the Joy and other NHS organisations?* *e) Recommendations on a future accountability framework for new Joy structures. This would be a separate but related project and linked to the new organisational diagram. The framework will need to be adapted to the professions and geography that a future Joy is supporting.* *What additional work could be done?* *<u>Financial and Efficiency Analysis</u>* *It will also be useful to establish some useful ratio analysis that may be useful in future evaluation ie;* *The number of Joy GP weeks cover provided, by practice, month, health board area, Joy GP (available see QA*

						section). Analysis provided here could include; *I. Total costs per Joy GP* *II. Total costs per weeks cover provided* *III. Analysis of unfulfilled placements by practice and health board area* *IV. Analysis of the cost of unfulfilled placements by health board area.* *<u>Quality Approach</u>* *Consideration could also be given to whether the Joy would benefit from working with a recognised quality governance framework (eg ISO, CHKS) This is generally not the trend in NHS Scotland for primary care but would reference joy progress against best practice UK standards, has been used by acute trusts in the UK).(Optional, the workload would be high).* *<u>Clinical Outcomes for patients</u>* *See discussions at GE28, the impact of the Joy on patient clinical outcomes, other services and public health of communities would be a major work and should be part of any future evaluation of the Joy.* *See Recommendation (R17): Future evaluation of the Joy programme need to consider the social and clinical outcomes of the scheme for patients and the public health*

						on communities.
49	Project Methodology Original philosophy, values and intentions	Would a more formal project methodology (Prince2, Agile) have been useful?	Has the agile approach helped the project to succeed?	Interview Test - Operation of the Joy (D) D14	*1041 D14 No methodology employed, but project might have been better if it had. Speed, at which things happened caught everybody out, very surprised and it has been wonderful that it happened. But could only contribute a little in the beginning. Time pressure meant hard to keep up a significant level of support.*	*PIO – The programme had a very simple methodology and used an Agile type approach. Anticipated and unanticipated issues were effectively worked on as small projects paralleling `timeboxing' in Agile ™ methodology. Other methodologies (eg Prince2 ™, Waterfall) would not have been suitable given the need for most project costs and activity to be clearly understood before the project started.* *Because there were so many unknowns (eg what would be the response to the original advertising?, what placements would be available , when and where?, then Agile is probably the only approach that could have worked. Essentially this meant that the project had room to evolve and test new things as it evolved. The ability to use the project budget flexibly (see and the Agile approach were both key success factors in helping this to happen* *Logically the Joy could not have moved to deployment phase (July 2019) without the evolutionary development (recruitment, selection, employment contract agreement) being resolved. Unfortunately project evaluation was a late prioritised requirement only added when earlier evolutionary work had been completed (May 2019) hence the need for the Phase 1a evaluation to be retrospective and perhaps missing*

						an opportunity for a clearer assessment of the `test of change'. *Recommendation (R38): Future developments of the Joy programme need to be evaluated from the beginning to allow comparative analysis of future expectations and other models.*
50	Project Methodology			Reference only.		*This issue not developed.*
51	Effective Marketing Limitations of the Joy	Joy is recruiting middle aged white GPs, does this reflect a diversity challenge ?	A question that arose through the round of evaluation interviews. The assumption would be that the correct attitude to compliance with equality legislation would be ensured by recruiting through NHS Shetland oversight and established procedures. However has the Joy unconsciously built in a bias towards one particular demographic/ social group?	Interview Test – Marketing (A) A3 A4 Limitations of The Joy (F) F11	*1031 J13 Not an issue for me. We targeted the market for GP's approaching retirement so the demographic we got was reflective of that group. Can't think that any group has been excluded.* *1032 J13 No that is the nature of the demographic expected in phase 1 of the joy - this is part time posts and therefore will appeal to a higher percentage of those at a particular stage in their career. The Equality aspects are not an issue when you think that the Medical Director is Female the GP Lead is Female and a proportion of Phase 2 are female. We monitor all equalities data as we are legally obliged to do so and we would amend campaigns to look to attract specific types.* *1033 J13 Don't think it's a problem (probably)? Our original marketing aimed at O50s anyway and we are only reflecting the demographic of UK GPs anyway. Majority O50 are male, majority U40 are female. There were some candidates from other backgrounds for the scheme but they didn't have GMC registration and so had to be screened out.*	*<u>Evidence</u>* *Most accurate comment is (1045)" it reflects the nature of the GP demographic group who would apply for this sort of role. Not a big issue as the demographics of this group reflect the demographics of the communities they are serving and often the demographics of the practices they are replacing. Some places very grateful to have a woman GP. We are serving a very disparate population and I suspect not many younger doctors would have the experience to deal with some of the issues you face in the H&I.."* *PIO –Very unlikely that the Joy non-compliant in terms of equality and diversity legislation so long as a health board HR department has oversight and management of the recruitment and employment contracting process. It is a question that by advertising in the way that the scheme was advertised, was*

					1039/1040 J13 (Diversity) Good question - Perhaps places would benefit from a more diverse approach. *1043 J13 Can only attract people who apply; the marketing targeted the demographic so that's what you got in the end. Not an issue.* *1045 J13 I think it reflects the nature of the GP demographic group who would apply for this sort of role. Not a big issue as the demographics of this group reflect the demographics of the communities they are serving and often the demographics of the practices they are replacing. Some places very grateful to have a woman GP. We are serving a very disparate population and I suspect not many younger doctors would have the experience to deal with some of the issues you face in the H&I. Modern GP practice in urban areas does not necessarily give the skills or independent frame of mind to cope with some of the situations you face. Also younger people with families wouldn't necessarily want this sort of role, I couldn't have taken it on when my children were younger.* *1046 J12 Inclusion - Just some concerns as GPs so far recruited are all quite similar, white , middle aged, middle class , perhaps 2/3 men. Not as this is a problem but it is not a diverse mix and it may mean The Joy is seen as not so inclusive or open. Noticeable coming from England.*	*there not an in built bias to recruiting the gender and age of GP that the Joy did?*
52	Operation and management of the Joy	The Joy is expensive – extra VAT and costs	From Joy Evaluation interviews (Orkney) and VAT issue as well as problems recruiting in Highland region (see GE10 Challenges setting pay etc., issue #5 Highland Practices & #29 Invoice production).	Interview Test – Marketing (A) A3 A4 Limitations of The Joy (F) F11 E10	*1032 iss52 The VAT charges has been an issue and we need to be up front with practices about how and what we charge. Important that the whole offer of what the Joy can provide - eg a managed service whereby there*	*Evidence* *The question as to whether NHS Shetland should add VAT on to invoices to GMS practices or other health boards for providing Joy GPs,*

	Limitations of the Joy	much more expensive than other locum agencies..		LW, EB, FM Interview Question	*is a higher quality and control over the GPs that are provided - is made clear by AMDs ie `more bangs for your buck'. VAT problem only an issue for GMS practices who are not (VAT) registered, many are and more so in urban areas.* *1033 D14/ E10 (Efficiencies) For NHS Shetland, yes because we don't have the VAT issue that other health boards do so we are not paying the £900 pw locum charges and they are getting a GP at standard rates. Other efficiencies - not much else, perhaps some small savings of practice manager time, HrHub takes over all the actions. Big improvements are in qualitative level, greater consistency.* *1039/1040 E10 Yes, definitely, the Joy now not so attractive for GMS practices. Less of an issue with 2c.* *1047 .but cost for practices is very high for the Joy. Regular locum on their books is £4620 pw, HrHub (The Joy) charge £5674, quite a big difference. Probably why Orkney have not used the scheme too much.*	*as a service, was under discussion as early as June 2019. Advice was secured from the NHS Shetland tax advisor late in 2019 that VAT would have to be chargeable to GMS practices outwith Shetland health board area. This increases the cost to them (by 20%). GMS practices may be able to reclaim if they are VAT registered (eg dispensing practices), but not all are.* *PIO – This may be a setback in trying to make the Joy more attractive to GMS practices outside the Shetland area and may possibly be part of why Joy take up has been less than expected in Highland and Orkney (also see discussion at GE10, issue # 5 Highland Practices,' # 29 VAT and Invoices, QA11 GMS practice data). For further evaluation work on reasons behind take up of Joy scheme across Scotland.* *Recommendation (R39): Future operation and iterations of the Joy programme need to consider having employment contracts issued by the relevant health board for the area of the practice being supported. This should be explored by NHS boards and relative HR and finance department (see also R35).*
53	Operation	Where	Capacity of the Joy – this question is relevant in	Management and	*1030 F1 The HrHub is a person dependent*	*Evidence*

	and management of the Joy	does the Joy HrHub reach capacity?	planning future capacity for an expanded Joy it is also relevant in assessing whether the current manning of the HrHub is correct.	Operation of the Joy (D11) We didn't know (F) F1 F11	*element that acts as a key constraint and this would need to expand if the Joy expands. It is noted that this small 2 person team has to cope with spikes in activity - typically recruitment campaigns. They have coped so far, but if the number of GPs increases or one of them is off work or leaves there will be an operational problem. We are looking at developing a planning for success modelling tool to help look at workloads. This will be considered in the new business case for the new Joy programme.* *1031 D1 Recruitment - This is a good testament to the joy we have managed to recruit 36 + GPs and organise recruitment events but how do you make this transparent? Need to be careful not to lose the agility of the Joy, but need to develop a good system of communications and management still.* *1031 D10 .this project has really expanded. I think we need to sit down and think about it and create a very clear structure to manage (it). I think what we have done this first year was OK (it could have been better) but we evolved as things progressed. We now have the benefit of hindsight and need to set this up so it functions smoothly and with clarity.* *1032 D15 F1 iss53 HrHub model has worked well and they are currently working with 19 employed people. There is capacity. There is a national e-Rostering system in development and if the Joy were to increase in size we would need to look to more technical electronic based tools to support administration and reporting which is currently very paper based. One of the major issues is around funding - year by year disables medium to long term planning SG supported funding runs out on 31/5/2020 and NHS Shetland already taking risk of employing*	*The Joy has operated with 1.6 WTE staff (grades 6 and 4 respectively) recruited in February/ March 2019 on 18 month contracts and in post just in time for the first recruitment weekend. The two roles are different with one full time HR professional to provide support to the Joy GPs on contractual issues and an admin role to process expenses and the placement process .The manning was an estimate by the NHS Shetland HR Director based on experience. Conclusion to the Phase 1a report looked at capacity briefly;* *"The hub has more capacity for an expanded programme now the initial process setting workload has been settled. Future work will be more around practice booking, matching and covering the system one off issues of GP administrational support. The current 2 dedicated Hub staff are engaged on an 18 month contract and so this will also need to be considered for the period after August 2020. Estimates are that now the legal and procedural administration is fully in place, the hub could take on a lot more work (certainly double) but there are further considerations if the present approach is rolled out to other MDT professions"* *This is supported by 1032 and 1034 opposite.* *PIO – In normal operation the current*

					hub staff with no guaranteed funding. *1033 D11 Need to draw the management in - who are the core management group?. With potentially 14 health boards, med directors , primary care leads and other professions there is great risk of it all becoming unwieldy. Have to get it tighter and not too many chiefs. A real problem coming is who do I answer to? and the decision making process becomes confused.* *1033 F11 Critical; a) Long term funding, the Joy cannot progress, needs a 3/5 year commitment at least. Getting to the limit now on what can be done with the existing funding. Year to year funding provides no stability for long term plans. b) Models need time to embed, need to let the W&A scheme settle, changing things every year is not helpful and perhaps need to think in terms of the PCIP framework of 4/5 year plans. Joy current arrangement is too short. If new funding is not forthcoming we need to be working on the exit strategy now.* *1034 F1 Capacity - OK for current level of activity, not unmanageable. Some small delays, but mostly they can cope. Don't really know where lack of capacity becomes a serious constraint could cope with a 100 GPs if there were not other pressures. Challenging on time when a recruitment exercise is underway.*	*model seems to be adequate however;* *a) Should either one or two of those 2 key staff be away or leave suddenly the Joy will have a serious short term capacity problem Key learning point. 12 months into the role , they have built up a high degree of knowledge, practice and GP networking and skill.* *b) Workload is not evenly spread. The two staff are extremely busy during any recruitment campaign, as they have been during March/ April 2019 and 2020. But otherwise the work is evenly spread. This part of the job could be relieved by help from local HR departments.* *The other key critical success factor has been the funding provided by the Scottish Government which, so far, has been agreed annually. However, this model has the side effect of insecurity in terms of;* *a) Making employed Joy staff insecure, and the model unstable, particularly towards the end of temporary contracts.* *b) Strategy short term and harder to commit to future initiatives (see issue #23 Wanderers and Adventurers).*

						The longer term problem being that the HrHub's own employment contracts have only been temporary (currently terminating Sept 2020).This is unsettling for staff and risky towards the end of contracts as staff look for other work. A longer term funding arrangement is required for stability. *Recommendation (R40): The current HrHub model can cope with administering and managing perhaps double the number of current Joy GPs (c40) however they may require additional help during recruitment campaigns (see also R30).The whole capacity of the hub will have to be reconsidered if the scheme expands to additional MDT professions.* *For an expanded programme, different models of the Hub were discussed in the Phase 1a Joy Evaluation report, these are still valid but there are several different models that could be provided to suit different professions or geography. It is certainly possible that the current hub based in Shetland, could provide expert support to newer hubs but this will have a ramifications for capacity.*

						Recommendation (R41): Longer term funding arrangements will help keep the programme stable and allow more confident development of strategy and planning of RTJ initiatives.
54	Operation and management of the Joy Original Philosophy and Values	Has the Joy been successful and what are the benefits?	Benefits of the Joy – Need to sell the benefits if future funding to be secured or cannot be found (see also issue #17 No further funding available).	Values, Philosophy and Original Intentions (J2)	*1030 J2 (Joy successful?) Yes, in a big way (10/10) Achieved what it set out to.* *1030 J2 Success factors - a) Creative people running it, freedom to do creative thinking and applying that. B) Expertise, HR expert with experience of living in the islands, a great service visionary but also a willing ness to take responsible risks, also KB voice of reason and myself, experienced project manager that can bring some process and organisation. Team dynamic also very good. c) Initial SG funding, without prescriptive control and some freedom. d) NHS Shetland willingness to host Hub and take responsible risks, initial drive of RR and LH. e) Using evidence base to do what needs to be done. The Joy is not actually novel, ability to reference that has happened in the past.* *1030 17 (Benefits) would demonstrate the following benefits; Economies of Scale, Efficiencies, Connectivity, quality and on patient satisfaction.* *1031 J2 Yes, in terms of basic ambitions has been successful (say 6/7 out of 10), it has provided a workforce for rural practices in health board areas where there have been serious shortages.* *1031 J14 What they Joy has brought has been; a) To prove we could recruit doctors when prevailing belief was that you couldn't. b) Changed attitudes so that there has been more*	*<u>Evidence</u>* *The Joy programme now entering a critical phase in preparation for decisions about what the future model and scope of the programme. This is timely as Scottish Government normally considers funding bids during summer though, in 2020, this may be disrupted.* *PIO – It will be important to state the benefits of a new Joy programme to Scottish Government. For the sake of this evaluation, the benefits have been ;* *- 46 Joy GPs have been recruited 138 Placement weeks have been provide to 21 practices in; Shetland, Highland, Western Isles, Orkney at rural and remote practices equivalent to 3.53 x GP WTE. This replaces cover that would have been provided by casual locums or not filled at all. It has taken pressure off those practices involved.* *- It has provided hope to GPs in H&I (see1031) "a) To prove we could recruit doctors when prevailing belief was that you couldn't. b) Changed attitudes so that there has been more*

					hope that solutions can be found though we have to be flexible with what we can offer. ..challenging the old mind set. If no Joy - Would have lost a lot more GPs in the H&I, some of Joy GPs would have left health and retired/ been lost to the NHS. For SRMC it might have been critical, we would have been struggling to show what SRMC had actually done with GP recruitment and retention projects. *1032 J2 Successful, yes. We have achieved a test of change and made a model work and learn lessons from.* *1032 F11 Will need to work towards better outcomes for patients; 1) The Joy needs to expand to Multi-Disciplinary Roles and widen the offer. 2) How do we support practices in crisis/struggling We need to think about a crisis team and perhaps a different financial model where they Joy is paid directly by SG to provide that support with a team intervention. We have excellent skills; model could be adjusted/funded to work in areas of high deprivation, remote and rural etc. More of a team approach to failing practices etc.*	*hope that solutions can be found though we have to be flexible with what we can offer. ..challenging the old mind set. If no Joy - Would have lost a lot more GPs in the H&I, some of Joy GPs would have left health and retired/ been lost to the NHS."* *- Proven the test of change that the Joy model can work and there is validity in the concept, the model can be developed and extended to other areas and professions.* *- Provides a platform on which to develop the model for other primary care professions and parts of Scotland.* *- Improved knowledge of issues and challenges within primary care.* *- Joy GP satisfaction is high; they are a motivated, experienced team who will spread confidence.* *- Learning points and success factors are known*
55	Operation and management of the Joy Original Philosophy and Values	Agility as a success factor	The Joy has been successful because it has developed quickly and has not been bogged down. Collaboration between health boards is a key success factor. It has also arisen independently of health boards to some extent (also see issue #49 Agile approach).	Values, Philosophy and Original Intentions (J2)	*Key success factors* *1030 J2 (Successful) Yes, in a big way (10/10) Achieved what it set out to. 1030 J2 Success factors - a) Creative people running it, freedom to do creative thinking and applying that. B) Expertise, HR expert with experience of living in the islands, a great service visionary but also a willing ness to take responsible risks, also KB voice of reason and myself, experienced project manager that can bring some process and organisation. Team dynamic also very good. c) Initial SG funding, without prescriptive control and some freedom. d) NHS Shetland willingness*	*<u>Evidence</u>* *This point is not rigorously tested through interviews. There are no obvious NHS projects by which to compare it so it is difficult to benchmark progress. Key success factors have been collected through the whole valuation process (see Evidence section). Discussed as part of Phase 1a evaluation under `can do attitude'.* *PIO – This point was suggested by*

					to host Hub and take responsible risks, initial drive of RR and LH. e) Using evidence base to do what needs to be done. The Joy is not actually novel, ability to reference that has happened in the past. *1031 E4 We (the Joy) have had our own philosophy which = service which = support to practices. Earlier on it was more about getting (GP)'bums on seats' but we realised later that we could do more things. Agree, that perhaps, the Joy scheme needs a better tie in to the health boards, otherwise how would the health boards know? Need to resolve this issue in future development. With Highland no link to the health board executive so no direct link. Good input to SG Primary Care Division.* *1037 D1 Skill sets ae very good, CS is a great innovator based on Orkney and experience.*	*many interview participants but not actually iterated in a response. During preparation of the phase 1a evaluation the feeling was that the project would be successful because of the agile response ie, the programme had a `do it yourself` approach and wasn't health board driven, it moved quickly (although this caused frustration with the slower paced recruitment process) and (importantly) there was room for the programme to adapt process or develop its own initiatives (eg Wanderers and Adventurers).The agility point is also matched with the success factor that Scottish Government funding was not too prescriptive and gave license for the Joy team to develop flexibly (see 1030 response opposite).The agility – as a key success factor -perhaps will relate to further development of initiatives and this has not yet been fully tested yet.*
56	Philosophy and Original Values Operation and management of the Joy	Success factors	Joy management leaders have been quite inspirational in identifying the opportunity, agreeing on scope and speed of the project.	Philosophy and Original Values (J) J2	*1030 J2 Success factors - a) Creative people running it, freedom to do creative thinking and applying that. B) Expertise, HR expert with experience of living in the islands, a great service visionary but also a willing ness to take responsible risks, also KB voice of reason and myself, experienced project manager that can bring some process and organisation. Team dynamic also very good. c) Initial SG funding, without prescriptive control and some freedom. d) NHS Shetland willingness to host Hub and take responsible risks, initial drive of RR and LH. e) Using evidence base to do what needs to be done. The Joy is not actually novel, ability to reference that has happened in the past.*	*<u>Evidence</u>* *Hard to test `inspirational', the programme appears to be fairly unique in NHS Scotland though not novel (per 1030). The idea of having flexible employment contracts for multi locational working will certainly not be new.* *PIO - Difficult to define the term inspirational here but context is all important. The NHS does not always find it easy to re-invent itself and is more a defined service organisation (as in the name) that tends to `tweak'*

					1031 J14 What they Joy has brought has been; a) To prove we could recruit doctors when prevailing belief was that you couldn't. b) Changed attitudes so that there has been more hope that solutions can be found though we have to be flexible with what we can offer. Challenging the old mind set. If no Joy - Would have lost a lot more GPs in the H&I, some of Joy GPs would have left health and retired/ been lost to the NHS. For SRMC it might have been critical, we would have been struggling to show what SRMC had actually done with GP recruitment and retention projects.	*its services and support functions rather than consider `inspirational' wholesale adoptions or models from outside itself. Generally the NHS will accept radical change if a threat or disturbance is large enough (hence the recent fast paced Cvoid19 service changes) and it may be that the threat of the current model of primary care becoming unsustainable is providing that stimulus.* *To GPs and practice, out in remote and rural areas, who are having to deal with the consequences and stresses of a model that may be struggling then, the Joy perhaps has been inspirational (see issue #60 on practices view).*
57	Philosophy and Original Values Operation and management of the Joy	Success Factors	SRMC Support – Has support provided by SRMC helped?	Philosophy and Original Values (J) J2	*1030 J2 Success factors - a) Creative people running it, freedom to do creative thinking and applying that. B) Expertise, HR expert with experience of living in the islands, a great service visionary but also a willing ness to take responsible risks, also KB voice of reason and myself, experienced project manager that can bring some process and organisation. Team dynamic also very good. c) Initial SG funding, without prescriptive control and some freedom. d) NHS Shetland willingness to host Hub and take responsible risks, initial drive of RR and LH. e) Using evidence base to do what needs to be done* *1030 57 Has been a critical factor. Website presence, media support, smoother surfaces and interfaces, project officer time for the evaluation.* *1032 57 Relationship and role of the SRMC has been confusing. The Joy doesn't have a project*	*<u>Evidence</u>* *SRMC is a programme, established in 2017, to develop ways to support GP recruitment and retention in rural areas in Scotland. There is a 5 person team who work closely with a wide range of agencies including the Joy team, to pursue these objectives; they are also funded by the Scottish Government. Support provided by SRMC has been;* *a) Support and advice provided by SRMC programme manager who sits as part of the Joy management team. Support here has been to help with programme facilitation, strategy and ideas on wider resources/ links.* *b) Formal board*

					manager the role of (DP) was confusing and lack of clarity around (the) role initially and it's interactions with the HUB and the GPs - what and why information was being requested and how it was to be used caused additional work as it didn't dovetail into the reporting cycle for either the Health Board or the Scottish Government. Again this is because it was an evolving and agile programme looking to showcase in some areas how good it was. The support around widening the knowledge of the Joy has been hugely supported by SRMC and sharing that at events (was) hugely positive. Along with website presence. Since December greater clarity around engagement and understanding has happened. *1032 D1 …The role of the Project manager was confusing and I think different folks thought that David was doing some feedback into the other areas! the Lead HUB GP is that interface and as such I have set up proper monthly meetings to keep people up to date and cascade information (both ways) correctly.MS understanding lessons document has been useful however, capacity is required to spend time in pulling together the lessons learned. In 2020 the landscape is clearer now and there are better ways of working. The earlier havoc used a lot of additional time and effort to manage.. lots of valuable lessons.*	*arrangements to oversee and ensure accountability of the work of the Joy programme, as part of the SRMC programme board arrangements.* *c) Project officer support to facilitate Joy GP VCs (July 2019 – Feb 2020)* *d) Project officer support to undertake the Joy Evaluation (Phases 1a and 1b).* *In Sept 2019 the SRMC programme manager became a member of the Joy management team as an experienced project manager to bolster these skills.* *PIO – SRMC has not been critical to the Joy, but it has been used for important support See response by 1030 for a general idea on success factors. 1032 is more critical of the SRMC role and feels that the project manager role was confusing.* *The SRMC has provided useful advice and facilitation for the Joy. Key is the `critical friend' role that has on several occasions helped resolved complications and given clinicians key management input. SRMC input has also helped in clarifying strategy (eg W&A) and providing tools to help decision making.* *The SRMC role may be more critical in ensuring the ultimate development of the Joy programme is successful.*

58	Philosophy and Original Values	Success Factors	Scottish Government Support -If SG had not put the initial money up the project would not have happened because the HrHub could not have been funded.	Philosophy and Original Values (J) J2	*1030 J2 Success factors - . c) Initial SG funding without prescriptive control and some freedom.*	*Evidence* *In response to bids, discussions with the SG advisor on primary care (also a Joy management team member) and discussions at SRMC programme boards, Scottish Government has allocated the following funding to SRMC).The funding was critical in funding the initial advertising, 2019 recruitment weekend and employment of the two hub staff.* *PIO - Without the funding it is hard to see how the Joy could have operated and it would have been difficult to find appropriate funding from the 3 small Island health boards and NHS Highland under special (financial) measures. This has been a critical success factor. However, see issue #50 on problems with the annual short term funding model which;* *a) Creates an instability and risk for HrHub manning (issue # 50)* *b) Provides risks for NHS Shetland as the employer of Joy GPs (issue # 17)* *c) Absorbs a lot of valuable (& more expensive) management time in preparing annual financial bids for the Joy (& SRMC).* *See also recommendation (R41): Longer term funding arrangements will help keep the programme stable and allow more confident development of strategy and*

						planning of RTJ initiatives.
59	Operation and management of the joy	Resilience	Is management burn out potentially a problem?	Management and Operation of the Joy (D)	*1030 57 Still a risk, but has been acknowledged. Some changes have been enacted to reduce.* *1032 59 Don't really think so though a lot of work does fall on a few people. Covid 19 shutdown has disrupted a lot of ongoing work in 2020 and workload for some individuals has increased and is causing capacity issues. Lots of boards expressed an interest in supporting but dropped out by Feb 2020. Leads on to a question sometimes about how really invested are other areas? Since the shutdown the Joy have fallen back on the core team. But is clear that some boards want more from the project than they are willing to put in and this may be a lesson for the future. Sometimes the passion and pace of some individuals is more than a small tem can cope with and sometimes you have to say no.* *1032 D11 Problem is nature of the expanded Joy program not yet known. For example, my time on the Joy (on average 0.5days pw over the last 3 months has actually been more that 1day per week on average) is given as goodwill, it's necessary but not funded, this is an example of where they Joy is heavily reliant on goodwill…. More admin support will be required, if the Joy includes other professions (eg more interaction with professional leads, NMC (Nursing and Midwifery Council). ..Generally the amount of traffic, communication and necessary support for staff will increase and this will require administration.*	*Evidence* *Formation of the Joy and bringing it through to operation and then bringing forward Wanderers and Adventurers represents a lot of work by a team of engaged health professionals. This has been done, largely in addition to their normal roles, some very demanding. There is not direct evidence of burn out or analysis of sick days or days lost but there is casual reference to the workload and time put in. This has been discussed at Joy management meetings (see 1030).* *PIO –This may be something to consider on any future risk register, the Joy management team must look out for the welfare of the team and though most members are employed by their respective health board there is a duty of care.* *Recommendation (R42): Expansion and restructuring of the Joy will have an effect on the stress levels and capacity of the management team particularly. This needs to be considered as a risk factor and appropriate mitigation considered (see also R15) (GE23)*

60	Philosophy and Original Values	Impact on patients and communities	The impact on patients - something missing (also see GE28 Local community Awareness) .	We didn't know (E) E6 Philosophy and Original Values (J)	*1032 F11 Will need to work towards better outcomes for patients; 1) The Joy needs to expand to Multi-Disciplinary Roles and widen the offer. 2) How do we support practices in crisis/struggling We need to think about a crisis team…. We have excellent skills, model could be adjusted/funded to work in areas of high deprivation, remote and rural etc.* *1036 J12 If you want to do something effectively you have to involve the people who are doing it. Coherent involvement needs to include respect and care for the patients. Perhaps, along with practices, this has been a neglected part of the Joy it has been a little bit (only) 2 sided at the moment.*	*Evidence* *(From GE28) Not too much evidence that communities are aware of the scheme…* *PIO – The impact on patient care directly has not featured highly in answers around how successful the Joy has been, largely as the `test of change' or trial of the model has predominated in people's minds. Also, possibly, because clinicians feel comfortable in acting as the patient's proxy. The point made by 1036 means that practices- as being part of the community – have not been heavily consulted, only made aware of the scheme as a service. They may have other views that have not been represented here (see also methodology section and challenges).* *While it may have been challenging to expect this evaluation report to cover the impact on patient care outcomes in such an early phase of the Joy, it should be a high priority for future evaluation (see also Further evaluation section and discussion at GE28).Learning point.* *Recommendation (R43): Practices are consulted on future Joy initiatives and their opinions, along with those of patients, are considered.* *See also Recommendation (R17): Future evaluation of the Joy*

						programme need to consider the social and clinical outcomes of the scheme for patients and the public health on communities.
61	Marketing	The Joy web presence	Concern that current Joy web page(s) on the SRMC website https://www.srmc.scot.nhs.uk/ not as clear or as effective as they could be in recruiting Joy GPs or promoting clearly the benefits of the Joy programme.	Interview Test – Marketing (A) A1, A2, A5, A6	*No direct responses on this issue but referenced as part of SRMC Website Review (5/2020).*	*PIO – This is not a point tested at interview during the evaluation but came from a review instigated by the SRMC into the effectiveness and redesign of its own website from Jan 2020.* *Most comments have been complementary of the content and appearance of the website pages comments have been;* *a) Everything in this section is well laid out, the colour of text is nice and works well. The information is presented very well and easy to read and seems to be very relevant and forward.* *b) Not easy to understand how the project came about from the pages, the story.* *c) W&A page a little hard to understand as the picture dominates and pictures only load slowly which is distracting.* *d) Text arrangement is clear and easy to follow.* *e) Pages nice clear and uncluttered.*

						Longer term, development of the Joy web pages will have to consider how expansion into other MDT professions or geographical areas will need to be emphasised. This will take management time and attention to focus and develop the offer for each profession. Key opportunity. *Recommendation (R44): Future developments of the Joy scheme will need to be reflected in the Joy webpages. Additional pages and emphasis on other professions will require the input of the relevant professional lead in expressing the benefits to those professions.*

Joy GPs evidence

Joy GP Experience Questions					
Additional questions were added to the evaluation controlled question list on 17/2/2020 to help with Joy GP interviews and look at issues from their perspective (questions K1 – 8a). The responses are provided as information.					
Ref.	**Issue**	**Background**	**Question Rationale**	**How Tested/ Interview Question**	***Comments from Joy GPs***
GP1	Joy GP Experience	Did your Joy placement experience live up to expectations?	General impression to highlight issues with themes (a) – (e)	K1	*K1 Absolutely, great fun, worked for the joy in different places, not too onerous and in some places workload a bit too quiet, uncomfortable being paid for on-call when this happens.* *K1 Yes, for me. Wick not quite what I expected but would go back, other places better. Love the West coast, idyllic, but Wick had similar issues to other places I had worked in England* *K1 Not sure what my expectations were? (in the beginning) It was interesting, different, but got the Joy over time. Interface was difficult to start with, Scotland and Scottish NHS IT systems very different and I didn't know what I didn't know when I came. Had worked in Shropshire for 25 years before that. Last 3 placements were lovely, even good working through the grey winter..* *K1 Yes, definitely, atypical experience as had worked in Shetland before and was looking for a way to go back on a stable contract that allowed for work elsewhere.*
GP2	Joy GP Experience	What did you think of the GP Video the SRMC Website?	Interview Test – Marketing (A) A5 A6	K2	*K2 Yes, I was in it!. Agreed though not sure how many people have got to see it.* *K2 No, not at the time (of recruitment), vaguely aware when it was made. Not mentioned on What's App etc.* *K2 Saw it, as sent by 1043, not aware of it anywhere else or SRMC website.*

					K2 Yes, aware of it, not useful for me personally so difficult to evaluate the effectiveness, certainly of some value though for information purposes.
GP3	Joy GP Experience	Were you treated and supported well by the practices?	Interview Test – Recruitment & Induction (B), B2 Clinical Governance (C) C3 C11 Operation of the Joy (D) D8	K3	*K3 Generally pretty well, difficult for practices because they see a lot of strangers coming through. Not getting any feedback from practices which is a bit frustrating..* *K3 Different for each practice. Wick busy and lots of part time staff/clinicians, I was the only one there every day. Not treated badly but not much camaraderie, not anyone's fault. The others were very good, great welcome at Broadbay and Acharacle, enjoyed being alone at Carbost.* *K3 Some initial teething problems on both sides. It would have been a good idea not to have been put on call at the first practice on the first day as no idea where everything was or how IT worked, wasn't thought through by practice. Later practices were all fine and accommodating, invited to meetings etc. Unst had an outstanding hand over package, head and shoulders above others; the regular doctor/PM had really thought it all out even down to the useful everyday tasks/ routine. Helps to plan your day very efficiently, the model induction.* *K3 Brilliant, fantastic, treated really well.*
GP4	Joy GP Experience	Were the terms & conditions attractive enough?	Interview Test – Recruitment & Induction (B), B5	K4	*K4 Yes, not all about the money. Some irritating things are the mileage rate only being paid from Scottish border but not a major bug bear. Personally had some issues with the Medical defence subs. Learning point is to explain to them that you need `split cover' for England and Scotland, some societies don't like the idea of double cover, could save £700.* *K4 Less of an issue for me, didn't read into it too closely, personally interested in the job because a great end of career challenge in interesting locations. Might be an issue for younger doctors. Administrational Hub were fantastic in responding to queries and sorting things out eg Accommodation etc. Some hoops to get through including getting onto Scottish GP Performers list. No major issues.* *K4 Yes, not doing the job just for the money. Salary fine though couldn't do it for much lower as I Lose other work in my local county due to being in Scotland and also have to arrange cover for my charity work whilst I'm away* *K4 For me personally, excellent, replaced a locum and was a good deal, particularly with*

					free accommodation, travel from Scotland. Even annual and study leave built in.
GP5	Joy GP Experience	Were you able to access the clinical protocols and guidelines for the area in which you were working?	Interview Test – Clinical Governance (C) C7 C11	K5	*K5 to some extent yes, some information available on the board intranets, some material on inductions, you get better at looking and sometimes you just have to ask.* *K5 Maybe pre-loaded T&Ms App before I arrived because anticipated poor broadband. Practice intranets also had guidance, if in doubt asked the practice. Highland formulary was a bit restrictive. Could think about a Joy repository for guidance, e-mail addresses, links etc.?* *K5 No, not generally, apart from Unst. Asked in Stornoway (`Ask if you need to know'), didn't always work. Did dig out the Highland formulary. Conflicting information a on mental health referrals in one island practice and did the wrong thing so felt a bit daft with the patients when you do something like that. See C7, not aware of local intranets.* *C7 Not much at present, this area needs development through new clinical lead role.* *C11 VC not bad but challenging as trying to 1) Provide support to working GPs 2) provide some link to professional development and CPD and can't do both. Looking at new models.*
GP6	Joy GP Experience	How good was (were) your practice induction(s)?	Interview Test – Recruitment & Induction (B) B2 , Operation of the Joy (D) D5 D9 D11	K6	*K6 No not everywhere, a bit patchy, but some practices really good (South Uist, Glen Elg). Some locum packs not brilliant.* *K6 Variable. Wick - in at the deep end, didn't know Vision so a difficult first day. Better with others but, so long as you took your time, you could get there. Carbost - particularly good. Dr there did very well with a book. Overall, was sufficient.* *K6 Varied enormously, Scalloway Ok, Unst fantastic. All had some things in place but there are definitely ways to improve what is there. Key problem is the antiquated nature of Scottish EMIS, very difficult to work with when you first come from England. Good practice in Unst was EMIS screen shots to help. It gets easier each time and I have a standard list of questions I ask by email or on arrival now.* *K6 Had worked before in Shetland so not applicable.*
GP7	Joy GP Experience	Do you think your service was appreciated by the wider multidisciplinary primary health care	Interview Test – We didn't Know (E) E5 E6	K7	*K7 Some patients very grateful in small places and some appreciated having a different GP.* *K7 Very much so. With Wick, sensed fatigue with the number of locums.* *K7 Yes, but a bit of wariness on both sides. Patients because of having to explain themselves regularly to locums. Practices for having to deal with a lot of temporary*

		team or patients?			*doctors, possibly sometimes with issues. Seemed to be appreciated personally and several places asked me to go back. Think you make your own appreciation sometimes – you can't expect to just walk in and for everyone to think you're fantastic.* *K7 Appreciated yes, practices. Patients - difficult to say, they were very accommodating as perhaps they have some idea that it is hard to get regular GPs sometimes in remote areas.*
GP8	Joy GP Experience	Are there any lessons that can be learned from your experience?	Interview Test – General Question but related to Section J (Philosophy and original intentions)	K8	*J12 K8 Overriding thoughts; As a retired GP wanted to do the Joy, and didn't mind working hard but wanted some time to take in the great locations. Part of the Joy is living in a different community and it has been great for that. Good, relevant accommodation is necessary as well as a work car, important for us was that I brought my wife to some placements and you have to think about the couple, what will the partner do? Having said that great experience, a lot of colleagues jealous in England, not just GPs. Remoteness - A little scary to be honest, particularly with sick patients in remote places. Chances of a call out remote, but when you were it could be serious. BASICs training came into play but still worry a little bit before going out on placement at the start (& perhaps a doctor should?). Discussed 2 x cases. Experience wonderful, got the Joy, loved it, and helped me carry on being a GP.* *J12 K8 The joy is still evolving, paperwork will improve, HrHub will get more organised. One thing about the Hub is that they always try to do their best. We are inventing a new wheel.* *K8 J12 Anxieties over T&Cs - Will be much simpler and easy to get across the basic offer early on next recruitment. Inclusion - Just some concerns as GPs so far recruited are all quite similar, white , middle aged, middle class , perhaps 2/3 men. Not as this is a problem but it is not a diverse mix and it may mean The Joy is seen as not so inclusive or open. Noticeable coming from England.*
GP9	Joy GP Experience	Do you feel that you have had the benefit of the joy?	Interview Test – General Question but related to Section J (Philosophy and original intentions)	K8a	*K1 Absolutely, great fun, worked for the joy in different places, not too onerous and in some places workload a bit too quiet, uncomfortable being paid for on-call when this happens.* *K8a Yes I definitely did. Was a bit nervy on what to expect after BASICCs week. Even after first attachment felt good and it got better each time.* *K8a Absolutely loved it. Difficult start at first practice and I had some health problems of my own when I came so any negativity was mine. Am much more able to appreciate*

					things now. Love it more and more. Very important to bear in mind that I come with my partner and he has to enjoy it plus important to be able to have some time off and go and look at the area, not really in for a 10 session week in the busy town practices as you seem to lose some of the point of being here. Can't believe I get paid for it sometimes. Privilege to spend time with patient and families and have done things I haven't done for a long time in England (terminal care etc.) It gets better as you go on. *K1 Yes, definitely, atypical experience as had worked in Shetland before and was looking for a way to go back on a stable contract that allowed for work elsewhere.*

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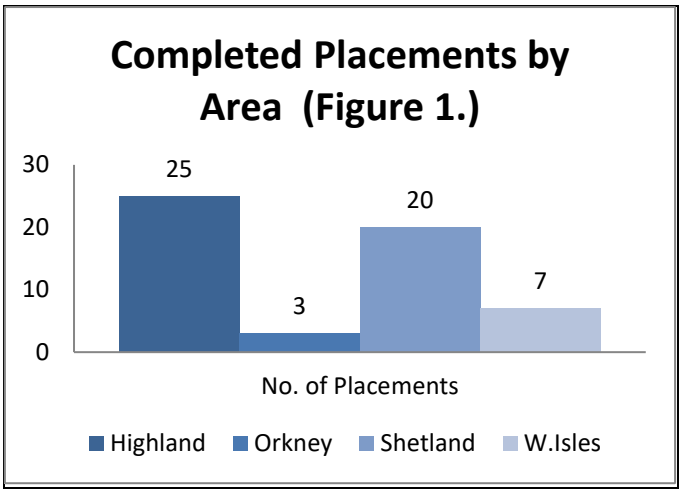
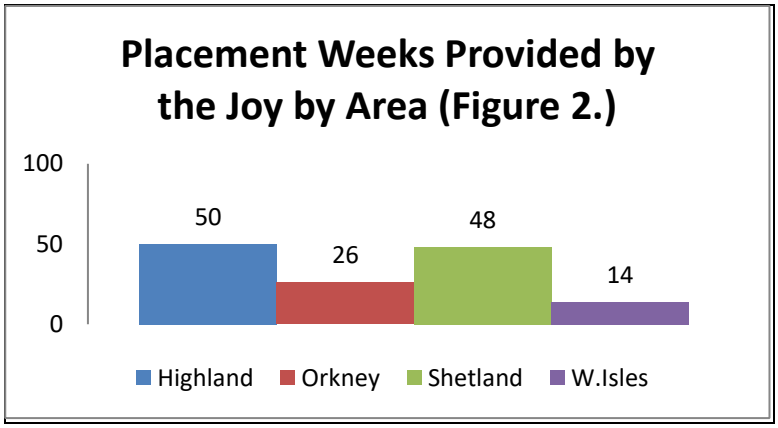
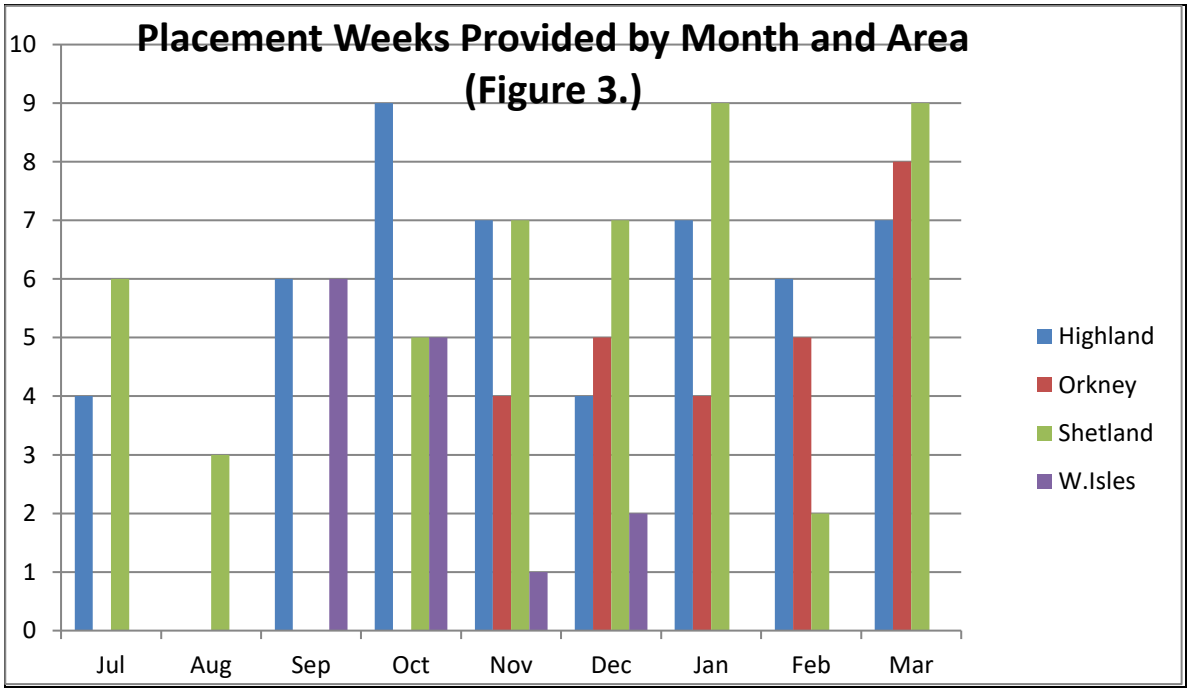




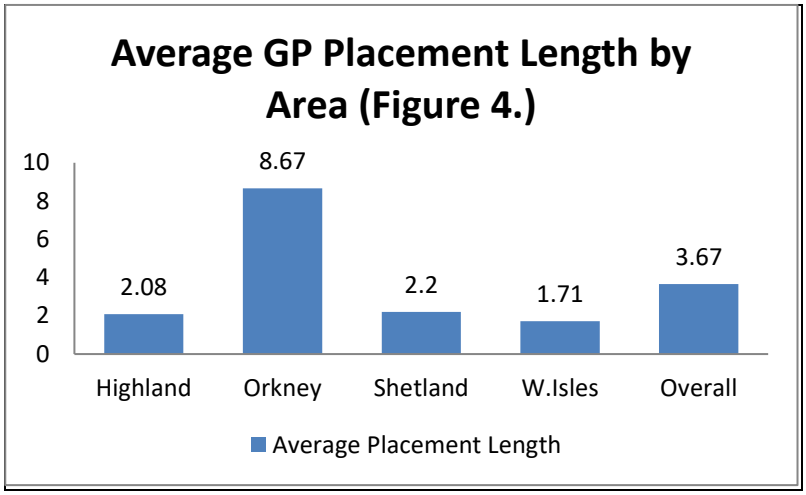


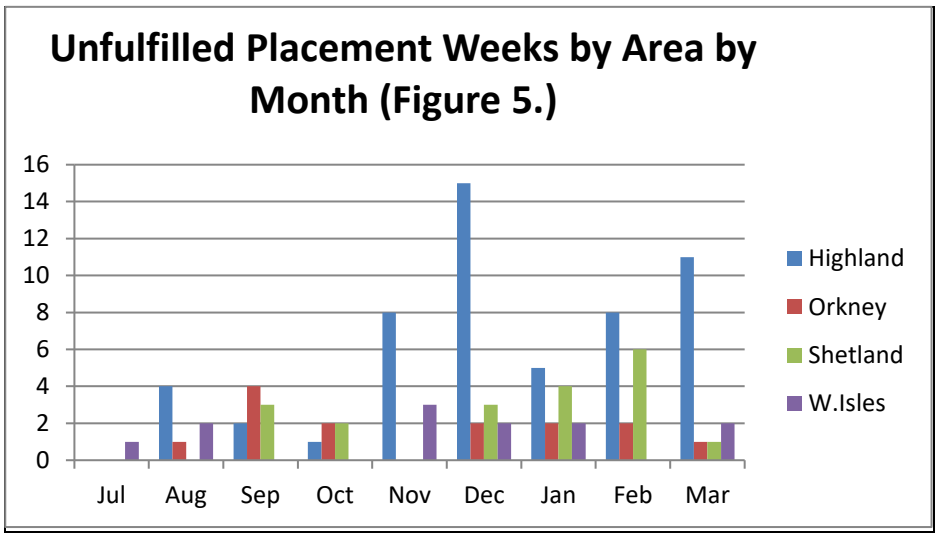
vdzl·yűűúl·ű̀ØŜ Analysis Period 1/7/2019 – 31/03/2020				
Ref.	Theme	Data Evidence	Evidence Comment	PIO Commentary
QA1	Placements Completed	Overall 55 Highland 25 Orkney 3 Shetland 20 W.Isles 7	From HrHub Return (see appendix F), vacancies advertised for the period were 65	*Evidence* *A placement can be multiple weeks or even less than a week but generally average out into a common currency.. A tighter picture of activity is by looking at the number of actual placement weeks worked (see QA2). Placements (as episodes) does give an idea of the transactions activity (& probably costs) of GPs getting to and from posts (eg travel, setting up accommodation, travel home etc.)* *There is not a tight correlation over the number of unfilled placements as several vacancies were withdrawn before becoming unfilled, often practices that could not get a Joy GP went back to sourcing a locum so we don't know the ultimate effect (also see unfulfilled placement analysis QA6 & 7) (see Figure 1.).*
QA2	Placement Weeks Completed	Overall 138 Highland 50 Orkney 26 Shetland 48 W.Isles 14	From HrHub Return (see appendix F), this is the weeks of service provided by Joy GPs. There is some averaging as some weeks were a number of days.	*Evidence* *138 GP weeks over a 9 month period suggests that the cover was equivalent to having an extra 3.53 GPs in post for that period.* *NHS Shetland are heavy users of the scheme, particularly outside of Lerwick. NHS Highland use Joy GPs much less than the island health boards in relation to population size or practice numbers. Though NHS Highland has used more placement weeks than any other board (50). Per head of population this is a lot less than the Island health boards (eg NHS Highland has 9 times the number of practices but similar number of weeks used compared to Shetland). Learning point (see also Qualitative analysis issue # 5 NHS Highland Practices not aware). Also see discussion on Recommendation (R19) at QA7 and Figure 2.)*
QA3	No. of GPs Deployed	16	From HrHub placement returns and Phase 1a analysis of Joy GP recruitment (see appendices A & F).	*Evidence* *33 Joy GPs had been recruited by July 2019 and another 6 added during the Autumn yet only 16 took part during the 9 month period. This may reflect that some GPs were thinking ahead and possibly looking at their own retirement plans and working later in 2020 (see comments from qualitative analysis Joy GP questions section, also see comments in Challenges to Methodology section).). Nearly all GPs worked in more than 2 regions, some in all four. (Learning point LP028 and suggestion for analysis in Further work section).*
QA4	No. of placement	July 2019 10 Aug 3	From HrHub placement returns (appendix F).	*Evidence* *Placement weeks by month look at seasonality.* *PIO*

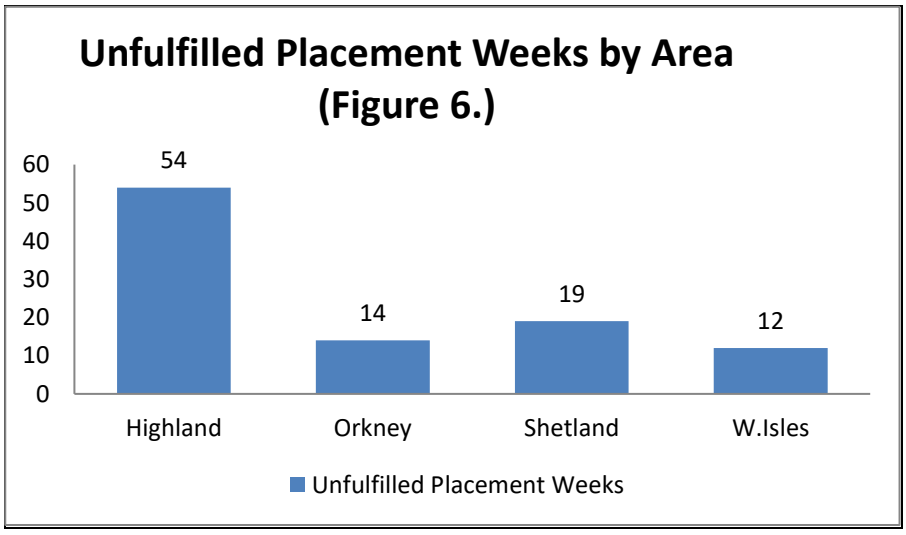
	weeks completed (by month)	Sept 12 Oct 19 Nov 19 Dec 18 Jan 2020 20 Feb 13 Mar 24		*Observation that in July and August, the scheme was only building up as recruited GPs were still waiting for a completion of recruitment processing to start work and also it was the summer holiday period. Most of rest of period has a consistent take up. Rise in March 2020 may have Covid19 lockdown influence (see graph at Figure 3.).* *Average – 15.33 weeks worked per month.pm.*
QA5	Av. Length of GP Placement	Overall 3.62 Weeks Overall Adjusted 2.08 Weeks[8] Highland 1.88 Orkney 8.67 Shetland 2.2 W.Isles 1.71	From HrHub placement returns (appendix F). The Orkney total is distorted by the fact that one Joy GP has been on a 22 week placement (Skerryvore) so an averaging figure has been used to provide the adjusted more realistic figure.	*PIO* *With the adjusted figures the average length of placement is consistent across the different health board areas apart from Orkney. The relationship between the Joy and Orkney is slightly different as the Orkney Isles Network of Care (OINOC) scheme is still in operation, essentially the demand for Joy GPs is less there and there is a tendency to longer placements (see graph at Figure 4.).*
QA6	No. of unfulfilled placement weeks	Overall 99 July 2019 1 Aug 7 Sept 9 Oct 5 Nov 11 Dec 22 Jan 2020 13 Feb 16 Mar 15	From HrHub placement returns (appendix F).	*Evidence* *Placement weeks unfilled by month look at seasonality. Average is 11 per month but over a third of thattotal were in Dec/Jan.* *PIO - Known at the time that the HrHub were trying to fill some challenging vacancies in remote locations over the Xmas/ New Year holidays (eg Acharacle, Applecross, Jura, North Harris, Unst and Orkney OOH). They were only partially successful in this (see graph at Figure 5.).*
QA7	Unfulfilled placement weeks by health board	Overall 99, Average per month - 11 Highland 54 (16.7pm) Orkney 14 (1.5pm) Shetland 19 (2.1pm) W.Isles 12 (1.3pm)	From HrHub placement returns (appendix F).	*PIO* *The significant observation here is that NHS Highland is having a lot more challenges filling practice vacancies than the island health board are.* *There has not been detailed investigation as to why this is but it is a learning point (LP029). See also discussion at GE30, Will some practices become difficult to recruit to? And issue #20 Problems for HR Hub filling short term vacancies. Also considered as a point for further work (see section). Why are there unfulfilled vacancies? Are there problem areas for recruitment?* *(See graph at Figure 7.)* *See Recommendation (R19): Will some practices become difficult to recruit Joy GPs to? – This issue needs more consideration.*

[8] Adjusted for Orkney as one placement 22 weeks.

QA8	Ratio of unfulfilled to filled placements	Overall 99/138 (71.7%) Highland 54/50 (108.0%) Orkney 14/26 (0.54%) Shetland 19/48 (0.39%) W.Isles 12/14 (0.86%)	From HrHub placement returns (Appendix F).	*PIO* *As with QA7, the significant observation here is that NHS Highland is having more challenges filling vacancies than the island health boards. See discussion at QA7, GE30 and R19 (see graph at Figure 7.).*


Average GP Placement Length by Area (Figure 4.)
10
8
6
4
2
0
8.67
2.08
2.2
1.71
3.67
Highland
Orkney
Shetland
W.Isles
Overall
Average Placement Length


Unfulfilled Placement Weeks by Area by Month (Figure 5.)
16
14
12
10
8
6
4
2
0
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Highland
Orkney
Shetland
W.Isles


Unfulfilled Placement Weeks by Area (Figure 6.)
60
50
40
30
20
10
0
54
14
19
12
Highland
Orkney
Shetland
W.Isles
Unfulfilled Placement Weeks

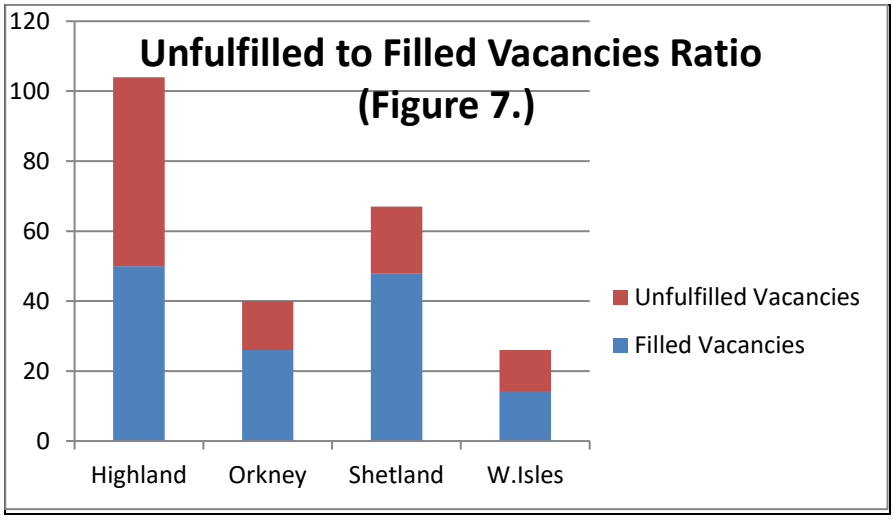
QA9	Practices – Highest users by weeks used	Skerryvore (Orkney) 22 Scalloway (Shetland) 22 Acharacle (Highland) 18 Broadbay (W.Isles) 12 Brae (Shetland) 12 Riverbank (Highland) 9 Wick (Highland) 9	From HrHub placement returns (Appendix F). Overall total for these practices represents 104/138 (75.3%) of the total.	*PIO* *The interesting point on this selection is that these 7 practices are heavy users of the scheme, by a long way, the next practices (eg Port Appin, Glenelg and Walls have only used 3 weeks each). The suggestion here is that these practices have greater need or, are particularly aware of the benefits of the scheme. It might be useful to understand their needs and why this is. Recommended for further evaluation (see Further work section and Figure 7.)*
QA10	Practices with highest unfulfilled vacancy weeks	(this selection of practices have 55.5% of all unfulfilled weeks) Brae (Shetland) 14 Wick (Highland) 13 Acharacle (Highland) 11 Broadbay (W.Isles) 9 Riverbank (Highland) 8	From HrHub placement returns (appendix F).	*PIO* *The suggestion here is that there is some issue as to why these 5 practices, from different health board areas, have a higher level of unfulfilled vacancies (55.5% of the total). There may be several reasons. Other practices do have unfulfilled placements (eg Stronsay 4, Jura 3, Lerwick, North Harris 2) but not at this level. It could be that the practices have challenges; Joy GPs may also have issues with the practices. More information is required. Key learning point (LP031) (also see discussion at GE30 Will some practices become difficult to recruit to?). Recommended for further work (see Further work section and Figure 9a.).*
QA11	Comparison of practice types between NHS Highland/ Orkney, Shetland and Western Isles[9]	Overall No. of Practices 114 Highland 88[10] (71GMS, 17 2c) Orkney 7 (5 GMS, 2 2c) Shetland 10 (2 GMS, 8 2c) W.Isles 9 (9 GMS only)	From NHS Scotland Information Services Division (ISD) 2019 Data https://www.isdscotland.org/Health-Topics/General-Practice/Data/	*Evidence* *This section for reference mainly , but note relative sizes and balance between GMS (Independent)/ 2c (Health Board managed) practices;* *NHS Highland has roughly 9 times the number of practices compare to the individual island boards.* *PIO* *There is relevance here for the VAT issue (see issue #6 NHS Highland practices and issue #52 VAT costs). Future demand for Joy GPs may be weaker from non-Shetland GMS practices due to VAT charges.* *A Breakdown of highlands and Islands population (by area) is given at Figure 10 along with GP practice type by area Table.1).*
QA12	Registered Patient Populations	Overall 656,112 Highland Region - 584,182[11] Islands - 71,930 of which;	From NHS Scotland Information Services Division (ISD) 2019 Data https://www.isdsco	*Evidence* *For reference only - showing the adjusted totals in Highland without the urban area of Inverness (also see Figure 10 and Table 1.).*

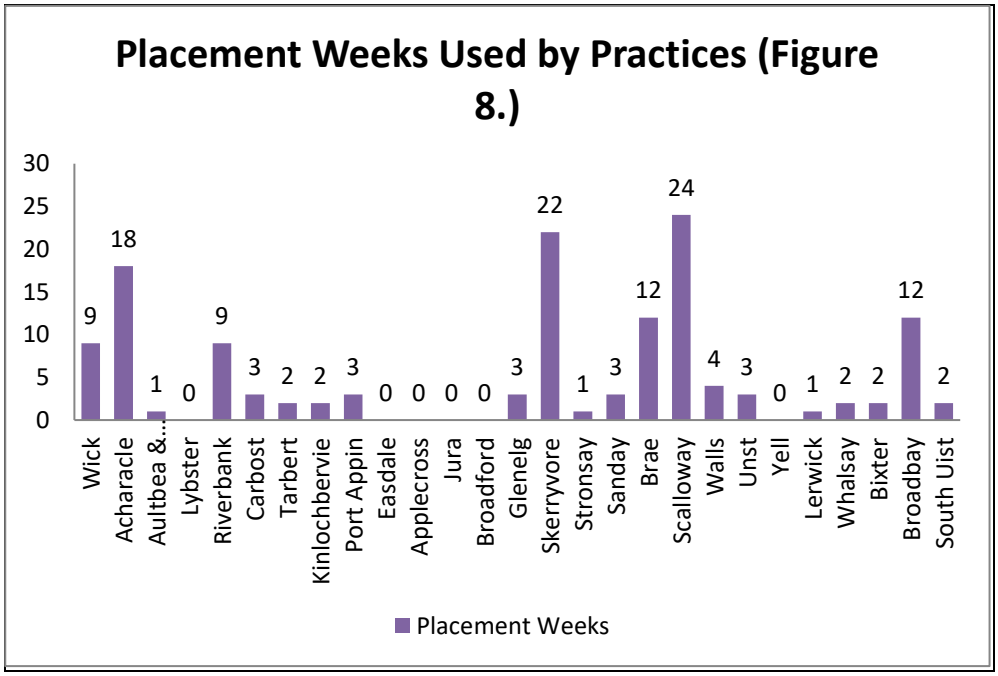
[9] Data by ISD as at 2019

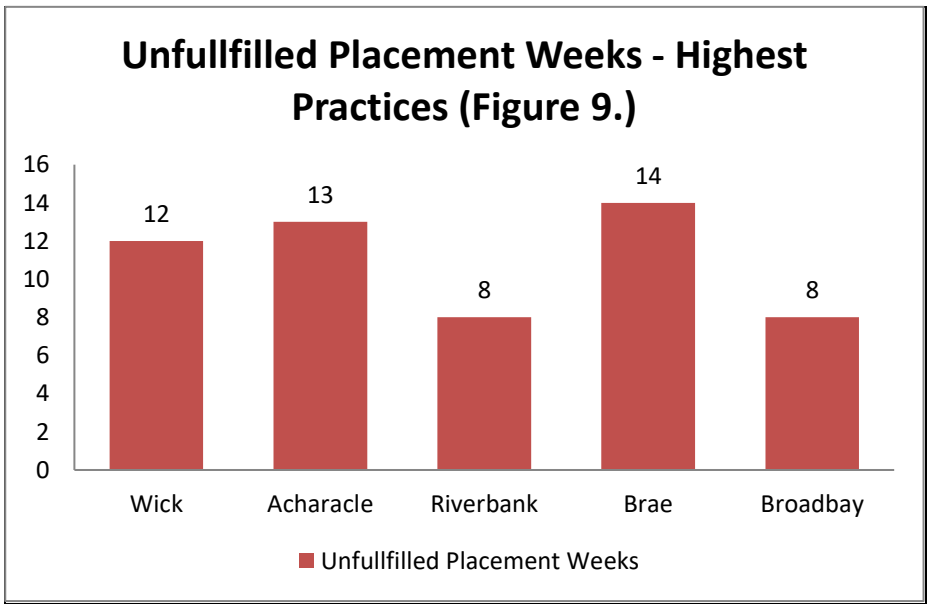
[10] NHS Highland practice numbers adjusted for 10 Inverness (GMS) practices that are not considered rural or remote and not part of the Joy scheme at the moment.

[11] NHS Highland population (656,181) adjusted for patient population of Inverness (71,999) therefore 584,182.

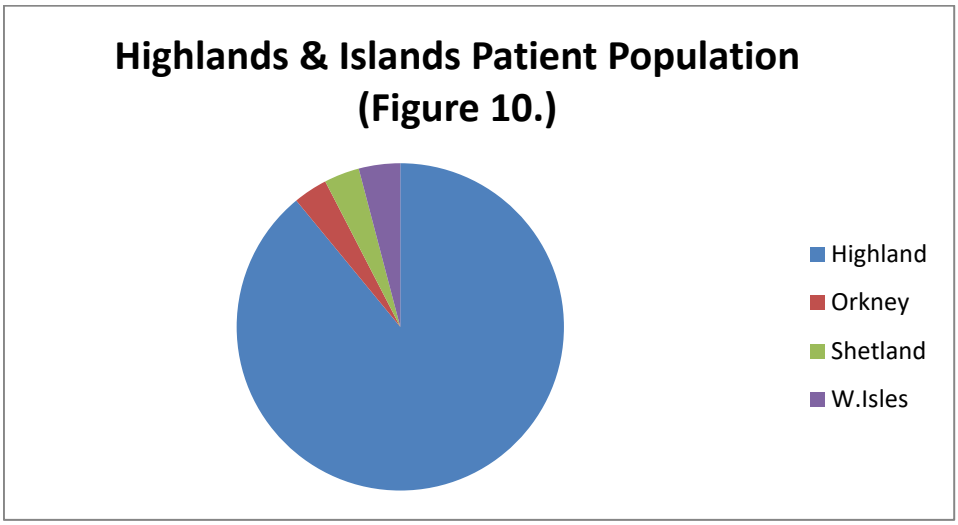
		Orkney 22,190 Shetland 22,910 W. Isles 26,830	tland.org/Health-Topics/General-Practice/Data/	


Unfulfilled to Filled Vacancies Ratio (Figure 7.)
120
100
80
60
40
20
0
Highland
Orkney
Shetland
W.Isles
Unfulfilled Vacancies
Filled Vacancies


Placement Weeks Used by Practices (Figure 8.)
30
25
20
15
10
5
0
9
18
1
0
9
3
2
2
3
0
0
0
0
3
22
1
3
12
24
4
3
0
1
2
2
12
2
Wick
Acharacle
Aultbea &...
Lybster
Riverbank
Carbost
Tarbert
Kinlochbervie
Port Appin
Easdale
Applecross
Jura
Broadford
Glenelg
Skerryvore
Stronsay
Sanday
Brae
Scalloway
Walls
Unst
Yell
Lerwick
Whalsay
Bixter
Broadbay
South Uist
Placement Weeks


Unfullfilled Placement Weeks - Highest Practices (Figure 9.)
16
14
12
10
8
6
4
2
0
12
13
8
14
8
Wick
Acharacle
Riverbank
Brae
Broadbay
Unfullfilled Placement Weeks

QA13	Joy GP week available to the different populations by No.	Overall 656,112/138 (4,754 pt) Highland Region 584,182[12]/50 (11,683pt) Islands 71,930/88 (817pt) of which; Orkney 22,190/26 (853pt) Shetland 22,910/48 (477pt) W. Isles 26,830/14 (1,916 pt.)	From HrHub placement returns. From NHS Scotland Information Services Division (ISD) 2019 Data https://www.isdscotland.org/Health-Topics/General-Practice/Data/	*PIO* *Slightly more convoluted analysis which shows how many patients shared a Joy GP week for each region. Re enforces the point that related to practice populations, NHS Highland using Joy GPs a lot less for their population than other board areas.*



Highlands & Islands population breakdown (Joy Area) and GP practice types (Table 1.)
(Inverness population and practices not included).

	Population (n)	GMS Practices	Non GMS	Total
Highland	584,182	71	17	88
Orkney	22,190	5	2	7
Shetland	22,910	2	8	10
W.Isles	26,830	9	0	9
Total Population(n)	656,112			

[12] NHS Highland population (656,181) adjusted for patient population of Inverness (71,999) therefore 584,182.

<table>
<tr><td>QA14</td><td>Vacancy Analysis</td><td>Vacancy analysis is possible using weekly vacancy lists issued by the HrHub to prospective Joy GPs. At any given point during the period it can be seen what vacancies were available, where, when and for how many days/weeks work. A sample check of 3 vacancy lists (from September, November 2019 and January 2020) was made to identify any themes. They record when and where the vacancies are and duration, a cross check has been done to see whether the vacancies were ultimately filled. The data cannot easily be checked with placement data as many vacancies were ultimately withdrawn usually because the vacancies could not be filled and often practices then got in locum GPs or made other arrangements. With the placement data there is a more optimistic view of recruitment whereby 58% of all placement requests were fulfilled. Individual practices are identified but it would not be representative to use with this simple analysis. These samples should be used with caution. Full data is available in appendix H.</td></tr>
<tr><td></td><td></td><td>
<u>Vacancy Sampling</u>
56 vacancies were taken from 3 samples covering all 4 health board areas with weeks available (n) in September / November 2019 and January 2020;

<u>Placement Vacancies Available</u> (Weeks Available)
Highland – 39 (with 46.5 weeks available)
Orkney – 5 (7.5)
Shetland – 7 (14)
W.Isles – 5 (8.5)
Overall – 56 (76.5)

Unfortunately it is not easily possible to see how many of those weeks were actually filled as the vacancies were often withdrawn or filled by locums (to understand that ratio further research would be necessary involving a survey of practices (see Further work section).
We can however analyse, more accurately, unfulfilled vacancies using the same sample. Of the 76.5 vacancy weeks available approximately 55 went unfilled, by far the highest in NHS Highland area (35). We can approximate weeks filled and unfilled for each health board by inference but caution should be used with this data as it is only a rough estimate based on a limited sample and not definitively researched;

Estimate of how many vacancy weeks were filled and unfilled for 3 sampled vacancy notices (Table 2.) (See Appendix G.)
<table>
<tr><th></th><th>Vacancy Weeks originally available</th><th>Unfulfilled Vacancy Weeks</th><th>Estimated filled or withdrawn vacancy weeks</th></tr>
<tr><td>Highland</td><td>46.5</td><td>35 (75%)</td><td>11.5 (25%)</td></tr>
<tr><td>Orkney</td><td>7.5</td><td>7.5 (100%)</td><td>0</td></tr>
<tr><td>Shetland</td><td>14</td><td>4 (29%)</td><td>10 (71%)</td></tr>
<tr><td>W.Isles</td><td>8.5</td><td>8.5 (100%)</td><td>0</td></tr>
<tr><td>Totals</td><td>76.5</td><td>55 (72%)</td><td>21.5 (28%)</td></tr>
</table>

See also Figure 11 and Appendix G.
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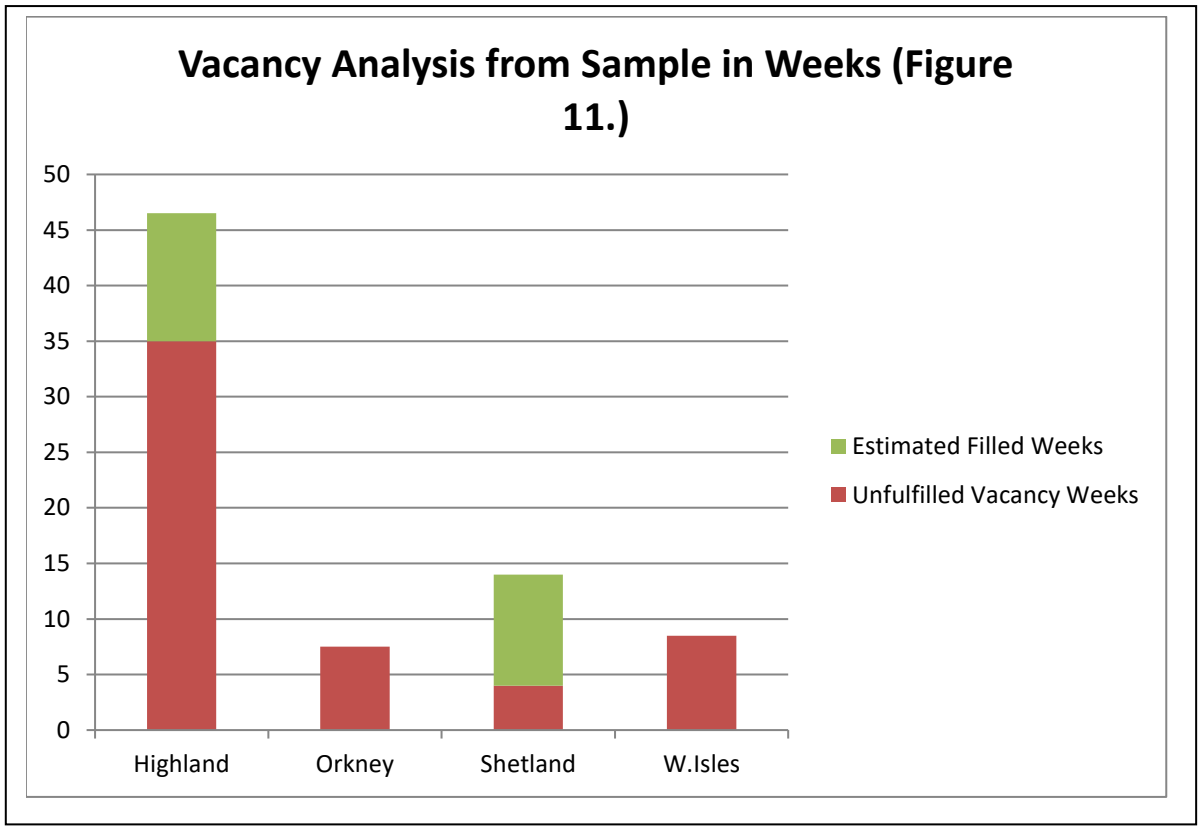

Vacancy Analysis from Sample in Weeks (Figure 11.)
50
45
40
35
30
25
20
15
10
5
0
Highland
Orkney
Shetland
W.Isles
Estimated Filled Weeks
Unfulfilled Vacancy Weeks

Summaries of findings

Success
Success factors
Learning points

Success

Was the project a success?

The RTJ programme has been an unequivocal success and met all of the original objectives.

In what areas has the Joy been successful? (see a more detailed discussion at GE34)		
Area	Evidence / discussion	Ref.
It has been most successful in testing the model at a regional Highlands and Islands scale.	Main discussions at GE34 and Issue #54, has the Joy been successful? General acceptance from management participants that the Joy has been successful and by inference, the model has been tested successfully at a regional scale.	GE34 Issue 054
Recruitment has been an area of particular success with 4 health boards working together on complex detail to establish an agreed contract that was attractive to potential Joy GPs. Over 46 GPs have been or are in the process of being recruited.	In general terms, marketing and the recruitment process have been successful in terms of output. See also comments at SF 002 & 004 (below)	GE1, GE7 Issue 054
By the end of March 2020, 138 weeks of quality GP cover has been provided to 21 H&I practices, the equivalent to providing 3.5 full time GPs.	Empirical evidence at QA2, QA3	QA2
Improving knowledge on specific challenges being faced by some practices and enabling solutions to be developed.	Discussion issue 009 and 0023.	GE34
Joy GPs do feel that they have `Rediscovered the Joy'. There have also been a few substantive post recruitments as a result and the scheme has helped retain many GPs who would have otherwise retired and been lost to the NHS.	See Joy GP responses section in evidence and issue 046.	Joy GP Evidence
The management team have worked in an innovative and agile way helping to create a positive `can do' team feel.	See discussions at 0049 and 0055.	Issues 0049 and 0055.
There has been a psychological uplift from being able to recruit GPs where many felt that this would not be possible.	See discussion at GE43 and S0012	GE43

Success Factors

Key Success Factors	
	Marketing and promotion of the scheme to prospective GPs
	The Joy programme is in a position to break the mould and operate outside normal NHS board cultures, new ideas can be developed quickly and tested.
	GP employment contracts are very flexible and allow GPs to work in many places and when the GP wants to work, fitting in with lifestyle, these are key attractants.
	The Joy is highlighting issues that were not particularly prominent at management level. The opportunity is that with greater visibility we can investigate and look at solutions to improve the service and patient outcomes.
	Willingness of NHS Shetland to take the risk and host the employment of Joy GPs
	Funding provided by the Scottish Government
	The ability to use the project budget flexibly and the Agile approach in helping the project develop. Essentially this means that the project had room to evolve and test new things as it evolved.

Success Factors

The factors that have contributed materially and enabled the success of the Joy. The wording for these responses has been taken generally, from interview participant responses.
Critical – `Must have' factors which, if they had not happened, the Joy would have not progressed or perhaps failed.
Key – Factors that have contributed materially to the success of the programme.
Key opportunity – Could be a future success factor.

Evidence Theme Reference	Theme	Type	Factor	Rec Ref.	SF Ref. No.
GE1	Effective Marketing	Critical	Marketing and promotion of the scheme to prospective GPs	R1	S001
GE7	Recruitment and Induction	Critical	Without interested Joy GPs being recruited to be available on time, in sufficient numbers, but not too many at one time, with an acceptable level of employment due diligence, then the Joy scheme could not operate properly.		S002
GE8	Operation and management of the Joy	Key opportunity	The Joy programme is in a position to break the mould and operate outside the normal NHS board cultures, new ideas can be developed quickly and tested.	R4	S003
GE9	Effective recruitment and induction	Critical	GP employment contracts are very flexible and allow GPs to work in many places and when the GP wants to work, fitting in with lifestyle, these are key attractants.		S004
GE10/ issue 008	Effective recruitment and induction	Critical	Creating the advantageous employment contract Ts and Cs (Terms and Conditions) for Joy GPs (see also issues 008 and 015 on accommodation).	R5	S005
GE11 GE12	Clinical Governance	Key opportunity	The recruitment of a clinical lead means that a role now exists that can drive through initiatives in clinical effectiveness; event analysis and feedback to individual and organisational improvement.	R6, R25	S006
GE19	Effective Management	Key	The Hrhub now have a lot of knowledge on the nuances of dealing with both Joy GPs and practice arrangements, this is a key success factor and the expertise needs to be retained (see also issue 053 on HrHub capacity).	R40, R41	S007
GE19	Effective Management	Key	Management arrangements have been basically effective.	R11, R12, R13	S008
GE23	Effective Management	Key Opportunity	The team is very active and willing to take responsible risks and the culture probably operates in a markedly different way to other NHS departments who tend to be more processors and reactive. The team is clearly dynamic and now the Joy concept has been proven, they are looking at wider ways the success can be brought to other areas.	R15	S009
GE25	Effective Management	Key	The first recruitment event (March 2019) was considered to be a success (see phase 1a evaluation report appendix A). Factors have certainly been considered important in influencing the 2020 event, a key learning factor.		S010
GE34/ Issue 009	Values, philosophy &	Critical Key	A critical success factor has been in improving knowledge of operational or clinical issues in primary	R22	S011

	Original intentions/ Recruitment and Induction/ We didn't know/ Limitations	Opportunity	care (see discussion at issue 009). The Joy is highlighting issues that were not particularly prominent at management level. The opportunity is that with greater visibility we can investigate and look at solutions.		
GE43	Values, philosophy & Original intentions	Critical	A psychological uplift from recruiting GPs where many felt that this would not be possible. Hope perhaps?		S012
GE43	Values, philosophy & Original intentions	Critical	The Joy has helped retain many Joy GPs who would have retired/ been lost to the system.		S013
GE43	Values, philosophy & Original intentions	Key	Have managed to recruit to some substantive GP posts – possibly a consequence of the Joy.		S014
GE43	Values, philosophy & Original intentions	Key	New blood, new ideas in from outside		S015
GE43	Values, philosophy & Original intentions	Key	Joy GP time has replaced locum GP time in quite a few of the 21 practices where the Joy has provided GPs and this would perhaps mean a qualitative improvement.		S016
Issue 008	Recruitment & Induction	Critical	Recruitment has been a real area of success with 4 health boards working together on complex detail to establish an agreed contract that was still attractive enough for potential Joy GPs (see GE10 discussion on employment contracts).	R5	S017
Issue 012	Operation and management of the Joy	Critical Key opportunity	The growth of knowledge and experience by the HrHub (see also issue #53).	R30 R41	S018
Issue 015	Recruitment and induction	Key	Provision of reasonable accommodation and practice transport is probably a key success factor as it increases the satisfaction and retention of Joy GPs (see also GE10).	R5	S019
Issue 017	Operation and management/ Limitations of the Joy	Critical	Willingness of NHS Shetland to take the risk and host employment of Joy GPs.		S020
Issue 027	Operation and management/ Limitations of the Joy	Critical	Hosting of the scheme by a health board under less constraint and with more freedom to act.	R31	S021
Issue 037	Clinical Governance	Key Opportunity	Role of the Joy Clinical Governance lead - providing action, direction and reassurance around clinical governance in future.	R6. R9	S022
Issue 046	Original Philosophy and Values	Critical	Support and attractants for Joy GPs, particularly rediscovering the Joy, landscape and experience for partners.		S023
Issue 049	Project Methodology/	Critical	The ability to use the project budget flexibly and the Agile approach in helping the project develop.	R38	S024

	Original values and intentions		Essentially this means that the project had room to evolve and test new things as it evolved (also see issue 055).		
Issue 050	Operation & Management	Critical	Critical reliance on knowledge and skills of 2 people to run the HrHub.	R29, R40	S025
Issue 050	Operation & Management	Critical	Funding provided by the Scottish Government which, so far, has been agreed annually	R41	S026
Issue 055	Operation & management/ Original Philosophy and Values	Key	The Joy has been successful because it has developed quickly and has not been bogged down (see also issue 049).		S027
Issue 061	Marketing	Key Opportunity	Using the Joy Web pages to express the benefits of the Joy to MDT professions in future.	R44	S028
Issue 062	Original Philosophy and Values	Key Opportunity	The Joy's agile approach may be well suited to testing new models of service and technology (eg NHS Near Me, MS Teams) in remote and rural areas in a world living with Covid 19.	R45	SO29

Learning Points

Summary – How do we improve the current model?

Effective Induction

- Greater consistency on induction support for GPs not familiar with Scotland and better more standardised induction guides to be available in all practices using the scheme (R26).
- Creation of a help video for professionals new to Scottish primary care IT systems (R28).

Effective Clinical Governance

- The Clinical Leads for The Joy, AMDs and the Joy GP Clinical Lead need to further discuss and review how The Joy is leading to continuous clinical improvement (R9)
- An expanded programme with MDT professions should consider a more formal governance structure to report and oversee Clinical Governance and initiatives.(R9a)
- The GP VC needs to be developed to provide wider Continuous Professional Development (CPD) opportunities for Joy GPs (R10).
- Future evaluation of the Joy programme should consider the social and clinical outcomes of the scheme for patients and the public health of communities (R17).

Effective Management

- More effective communication and dialogue is required between the Joy management team, the wider Joy group and GP Support Team. Creative ways need to be considered to keep team buy in and a sense of being in a special cohort. Regular cascades of information (eg a regular newsletter e-mail) should keep stakeholders up to date on where the project is, and where it is going (R11, R21).
- The Joy management team need to make sure they spend time listening and looking at issues and ideas raised by staff supporting the Joy and Joy GPs (R11a).
- The risk register needs to be regularly reviewed and business continuity risks considered (R16).

Development Work – Future Model

The evaluation was also asked to consider future expansions of the programme covering a wider geography and other primary care multidisciplinary team (MDT) professions. Recommendations include;

If the programme expands, clarity is necessary on what professions will be included and the geographical coverage.

(R15) Joy management team are unlikely to have the capacity for an expanded scheme, they will need to review;

- Management structure
- Management delegation arrangements
- Professional representation and support for each profession
- Management skill sets required for an expansion

(R12) A more formalised management structure needs to include;

- More formal and fixed management meeting and cascade communication arrangements.
- An organisational diagram indicating managerial and professional leadership arrangements.
- More formalised clinical governance forums and reporting.
- Adequate admin support for the Joy management team.

- A wider marketing approach needs to be considered in discussion with stakeholders, especially if the project is to be extended to Multi-Disciplinary Team (MDT) professions (R1).
- H&I primary care IT systems appear outdated compared to the rest of the UK. Joy management and local health boards need to consider raising the profile of this issue through the necessary NHS Scotland IT user forums and procurement channels (R4a)
- Longer term funding arrangements will help keep the programme stable and allow more confident development of strategy and planning of RTJ initiatives (R41).
- Practices are consulted on future Joy initiatives and their opinions, along with those of patients, are considered (R43).
- The Joy team consider what they can do to provide solutions for NHS Scotland in a world having to live with Covid19 (R45).

<u>Other key learning points from the evaluation</u>

- There has been improving knowledge of operational or clinical issues in primary care. There has been an evolution in thought about finding solutions for some of the problems faced in provision in primary care services in some rural areas (LP008).

- 4 health boards worked very well together successfully to create an effective contract offer for Joy GPs with standardised terms and conditions that was both affordable and attractive enough (LP003).

- Although Scottish Government funding was a critical success factor, annual funding arrangements are problematic (LP023).

- Recruiting GPs directly to health boards takes time; a key delay is getting GPs from outside Scotland onto the Scottish GP Performers list (LP001).

- Welcome, handover and induction were recognised as a challenge in some practices early on (LP010). Key issues were identified as;

    - GPs were not given time or support to adjust or orientate in some practices. There was sometimes an expectation problem whereby practices and GPs took time to adjust.
    - Induction packs were poor in some places or not up to date.

- Scottish primary care IT systems are different to England, older and less well integrated with other systems than other parts of the UK which meant that new Joy GPs took more time, initially, to see patients. However many GPs felt that they had more time available in rural practices to see and connect with the patients.

- Take up of Joy GPs is much higher in the Islands rather than the Highlands and some practices use it a lot more than others (LP027).

- Joy GP satisfaction is high, confirming that they do gain a valuable and refreshing experience; many have stayed out of retirement to undertake Joy work (LP025).

- Joy GPs did have concerns about raising quality issues with practices and sometimes lacked confidence in this area (LP018).

- The Joy management team has launched the programme, evaluated, evolved in response to challenges and improved practice. An energetic and agile approach was adopted from the very beginning enabling quicker responses and a willing ness to adapt (LP005).

- There are limits to the evaluation, patients and practices voices need to be heard and further work needs to consider how clinical outcomes for patients and public health for communities has changed (Recommendation R17).

Key Learning Points	
	The Joy is highlighting issues that were not particularly prominent. There has been an evolution in thought about some of the problems we now realise that we face.
	The Joy has helped retain many Joy GPs who would have retired/ been lost to the system
	The programme has been successful in the following terms; - 48 Joy GPs have been recruited[13]

[13] However, see Challenges to methodology section 10) E.

	- 138 Placement weeks have been provide to 21 practices in all 4 health board areas at rural and remote practices equivalent to 3.53 x GP WTE.
	Proven the test of change that the Joy model can work and there is validity in the concept, the model can be developed and extended to other areas and professions.

Learning Points

A key requirement of the evaluation, learning that has arisen from operation of the programme, understanding issues that we didn't really know before it started.

The wording for these responses has generally been taken from participant comments.

Theme Ref.	Theme	Type	Learning Point	Rec. Ref.	No.
GE7	Effective Marketing/ Recruitment and Induction	Key	Tt takes time to get recruited GPs into post because; a. Recruitment process for applicants needs to be undertaken involving interview and selection. b. Need often for a 3 month notice period, very often, Joy GPs are selective about when they want to start work c. PVGs[14] are required. d. Getting non Scottish GPs onto Scottish GP Performers list is a very slow process (managed nationally). e. Reference chasing takes time.	R3	LP001
GE8	Support Infrastructure	Key	Joy GPs, fresh in from other parts of the UK, have had difficulty getting to grips with Scottish IT systems because they are 'klunky' and out of date. This has highlighted an induction problem but also that there are possibly clinical risks stemming from the poor interaction between different systems.	R4a	LP002
GE10/ Issue 008	Effective Recruitment and Induction	Key	Key learning points on ; a) How to create employment contracts with Ts & Cs that are affordable, flexible and attractive. b) 4 health boards working together on complex detail to establish an agreed contract that was still attractive enough for potential Joy GPs	R5	LP003
GE18a/ Issue 007	Clinical Governance	Key Key opportunity	The Joy GP VC has supported those who attended and provided feedback for the management team, it has not covered all Joy GPs and though there is some learning we have not yet managed to use it for accredited CPD time. The format does need review in the way it delivers continuous improvement. It may not be the perfect solution, but does at least, provide some support and reflections on practice (see GE18a, issue 007). Despite the shortcomings, it is very often a popular meeting happening on average every fortnight. By early 2020	R10	LP004

[14] Protecting Vulnerable Groups Scheme – Pre employment check.

			there was a feeling that format does need to be refreshed.		
GE19	Effective Management	Key	We had to organically grow the team and had to learn quickly, but in the end nothing was left undone. Sometimes things were done on a fairly ad hoc basis in the end, what we did was good enough and nothing foreseen that we couldn't manage. In future, the management team will need to be bigger with more delegation.	R11, R12, R13	LP005
GE25	Effective Management	Key	The first recruitment event in 2019 was considered to be a success (see phase 1a evaluation report). Experience has certainly been important in influencing the 2020 event[15] this is considered to be a key learning point.		LP006
GE30	Marketing and Recruitment/ Limitations of the Joy	Key	Some practices may be difficult to recruit to without adjustments or incentives. The answer may hinge on what expectations Joy GPs have before they come and this will be relevant as to what they perceive as the benefits, it may be better to promote the scheme on holistic rejuvenating practice experience and being part of a team rather than the scenery.	R19	LP007
GE34/ Issue 009	Values, philosophy & Original intentions	Key	A critical success factor has been in improving knowledge of operational or clinical issues in primary care (see discussion at issue 009). The Joy is highlighting issues that were not particularly prominent at management level There has been an evolution in thought about some of the problems we now realise that we face,	R22	LP008
GE43	Recruitment and Induction	Key	The Joy has helped retain many Joy GPs who would have retired/ been lost to the system.		LP009
Issue 002	Recruitment and Induction	Key	Welcome, handover and induction were recognised as a challenge in some practices early on. Key issues were identified as; a) GPs given no time to adjust/orientate in some practices. Quite often practices did not know the difference with general locums who were already used to Scottish systems. b) Induction packs were poor in some places or not up to date. c) Scottish primary care IT systems different to England, more `klunky' which made GPs took more time to see patients initially (see GE 8, R4a)	R4a R26, R27	LP010
Issue 005	Marketing/ Operation and management of the Joy	Key	The empirical evidence is that take up of Joy locums by NHS Highland based practices (adjusted for population size or practices numbers) has been far less than the Islands. Further evaluation could examine why this difference persists and in what better way the Joy could serve NHS Highland? (see Further work section).		LP011
Issue 007	Clinical Governance		See text at GE18a above (Joy GP VC).	R10	LP012
Issue 008	Effective Recruitment and Induction		See text at GE10 above (creation of employment contracts).	R5	LP013

[15] Unfortunately 2020 had to be cancelled, a consequence of the Covid19 lockdown.

Issue 009	Recruitment and Induction/ We didn't know/ Limitations		See text at GE34 above (improving the knowledge of issues in primary care).		LP014
Issue 011	Marketing		(Assets) Such as the Joy recruitment videos - It could be that they have not been used, so far, as effectively as they might	R29	LP015
Issue 023	We didn't know/ Limitations of the Joy	Key	The way that the management team now works through development proposals as a team in a structured way.		LP016
Issue 023	We didn't know/ Limitations of the Joy	Key	A rough framework has now been established as an overarching strategy for Joy programme development.		LP017
Issue 026/ 019	Clinical Governance	Key	Joy GPs did have concerns about raising quality issues with practices and sometimes lacked confidence in this area.	R33	LP018
Issue 027	Operation and management/ Limitations of the Joy		Management of the scheme by a health board under less constraint is seen as a critical success factor, it may be important issue when the scheme expands (see also GE10).		LP019
Issue 032	Recruitment and Induction/ Clinical Governance		H&I formularies are less restrictive than NHS England; Joy GPs have more freedom to prescribe but does this work against evidence based prescribing and leading to higher costs?		LP020
Issue 045	We didn't know	Key	Although the Joy has enabled visibility of the challenges, and can suggest solutions, the responsibility for management is the relevant primary care team and health board (see also issue 009, issue 030)		LP021
Issue 050/053	Operation & Management	Key	Capacity of the Joy HrHub are adequate for at least double the number of Joy GPs at current level, but recruitment campaigns add significantly to the workload so extra resources are sometimes required to support them.	R40	LP022
Issue 050	Operation and management/ Limitations of the Joy	Key	Annual funding model of SG has the side effect of insecurity in terms of; a) Making employed Joy staff insecure and the model unstable, particularly towards the end of temporary contracts. b) Strategy is short term and harder to commit to future initiatives (see issue 023).	R41	LP023
Issue 053/ 012/ 050	Operation & Management	Key	The growth of knowledge and experience by the HrHub has been a key success factor. There is an operational risk to the operation of the project if their expertise and knowledge is lost.	R30 R40 R41	LP024
Issue 054	Values, philosophy & Original intentions/ Management and Operation	Key	<u>Success</u> The programme has been successful in the following terms; - 48 Joy GPs have been recruited 138 Placement weeks have been provide to 21 practices in all 4 health board areas at rural and remote practices equivalent to 3.53 x GP WTE.		LP025

			- It has provided hope to GPs in H&I "a) To prove we could recruit doctors when prevailing belief was that you couldn't. b) Changed attitudes so that there has been more hope that solutions can be found though, we have to be flexible with what we can offer. ..challenging the old mind set. If no Joy – We would have lost a lot more GPs in the H&I, some of Joy GPs would have left health and retired/ been lost to the NHS. - Proven the test of change that the Joy model can work and there is validity in the concept, the model can be developed and extended.. - Provides a platform on which to develop the model for other primary care professions and parts of Scotland. - Improved knowledge of issues and challenges within primary care. - Joy GP satisfaction is high; they are a motivated, experienced team who will spread confidence. - Learning points and success factors are now known.		
Issue 060	Values, philosophy & Original intentions		Coherent involvement needs to include respect and care for the patients. Perhaps, along with practices, this has been a neglected part of the Joy it has been a little bit (only) 2 sided at the moment.	R17 R43	LP026
QA 2/ issue 005	Marketing/ Operation of the Joy	Key	NHS Highland use of Joy GPs is much less than the island health boards in terms of population size or practice numbers. Though NHSH have used more placement weeks than any other board (50), per head of population this is a lot less than the Island health boards (see further work section).	R19	LP027
QA7/QA8/ QA10, issue 005	Marketing/ Operation of the Joy	Key	The significant observation here is that NHS Highland is having a lot more challenges filling vacancies than the island health boards. There has not been detailed analysis as to why this is. (see also GE30 and issue 020 discussions with ljdzl·yűúl·úÓŜ analysis of unfulfilled placements at QA7) (for further work section).	R19	LP028
QA9	Marketing/ Operation of the Joy	Key	A key group of 7 practices are heavy users of the scheme. It might be useful to understand their needs and why this is (for further work section).		LP029
QA10	Marketing/ Operation of the Joy	Key	5 practices from different health boards, have a higher level of unfulfilled vacancies (55.5% of the total) It might be useful to understand their needs and why this is (see GE30) (for further work section).		LP030

Challenges Identified;

Challenges Identified	
	Although Scottish Government funding was a critical success factor, **annual funding arrangements are problematic**.
	Recruiting GPs directly to health boards takes time; a critical delay is getting GPs from outside Scotland onto the Scottish GP Performers list.
	Take up of Joy GPs is much **higher in the Islands rather than the Highlands** and some practices use it a lot more than others.
	It takes time to get recruited GPs into post because; a. Recruitment process for applicants needs to be undertaken involving interview and selection. b. Need often for a 3 month notice period, very often, Joy GPs are selective about when they want to start work c. PVGs[1] are required. d. Getting non Scottish GPs onto Scottish GP Performers list is a very slow process (managed nationally). e. Reference chasing takes time.
	Welcome, handover and induction were recognised as a challenge in some practices early on. Key issues were identified as; ▪ GPs were given no time to adjust/orientate in some practices. ▪ Quite often practices did not know the difference with general locums who were already used to Scottish systems. ▪ Induction packs were poor in some places or not up to date. ▪ Scottish primary care IT systems different to England, more `klunky' which made GPs took more time to see patients initially.

Recommendations

- Report Recommendations

Joy Evaluation Report Recommendations				
Discussion Ref.	Theme	Relevant to an expanded Joy?	Recommendation	Rec. Ref.
GE1	Effective Marketing	Yes	***Recommendation (R1)**: A wider marketing approach needs to be considered in discussion with stakeholders, especially if the project is to be extended to Multi-Disciplinary Team (MDT) professions.*	R1
GE5	Effective Marketing	Yes	***Recommendation (R2):** New marketing and recruitment campaigns for an expanded Joy will possibly be Scotland wide and need to be co-ordinated nationally rather than only for 4 health boards. When recruiting for a wider range of MDT professions, SRMC should seek to influence national marketing & recruitment strategy and also look to use a wider number of marketing channels in a planned way.*	R2
GE7	Effective Marketing/ Effective Recruitment	Yes	***Recommendation (R3):** The first Joy recruitment campaign, following the date of the original BMJ advert in January 2019, to the first placement of Joy GPs in July 2019, took approximately 25 weeks. This time frame should be born in mind for a similar scheme or extension of the Joy to other geographical areas or MDT professions.*	R3
GE8	Effective Marketing/ Recruitment and Induction/ Operation & management of the Joy		***Recommendation (R4):** A system needs to be developed to discuss and review ideas that surface. The Joy programme is in a position to break the mould and operate outside the normal NHS board structures and cultures, new ideas can be developed quickly and tested. This is a key opportunity.*	R4
GE8	Recruitment and Induction/ Operation & management of the Joy		***Recommendation (R4a):*** *H&I primary care IT systems appear outdated compared to the rest of the UK. Joy management and local health boards need to consider raising the profile of this issue through the necessary NHS Scotland IT user forums and procurement channels (R4a)*	R4a
GE10	Effective Recruitment		***Recommendation (R5):** Review Joy GP contract terms and conditions annually between participating health boards (also see R36 on VAT issue).*	R5
GE11 GE12	Effective Clinical Governance		***Recommendation (R6)**: The activity and effectiveness of the Joy clinical lead role is assessed and reviewed over the*	R6

			course of the first year to establish the effectiveness of CG arrangements for the Joy as the programme changes and drives through some quality improvement initiatives (also see R9).	
GE13	Effective Clinical Governance		***Recommendation (R7):*** *Joy GPs are made aware who their line manager/ clinical lead are, when starting placements.*	R7
GE14	Effective Clinical Governance		***Recommendation (R8):*** *Support needs for Joy GP appraisals are considered in an active way for 2020/1 onwards. All Joy GPs should be able to get feedback on their own performance in the role.*	R8
GE18	Philosophy and original values/ Effective Clinical Governance	Yes	***Recommendation (R9):*** *The Clinical Leads for The Joy, AMDs and the Joy GP Clinical Lead need to further discuss and review how The Joy is leading to continuous clinical improvement (R9)* ***Recommendation (R9a):*** *An expanded programme with MDT professions should consider a more formal governance structure to report and oversee Clinical Governance and initiatives.(R9a)*	R9 R9a
GE18a	Philosophy and original values/ Effective Clinical Governance		***Recommendation (R10):*** *The GP VC needs to be developed to provide wider Continuous Professional Development (CPD) opportunities for Joy GPs (R10).*	R10
GE19	Effective Management	Yes	***Recommendation (R11):*** *More effective communication and dialogue is required between the Joy management team, the wider Joy group and GP Support Team. Creative ways need to be considered to keep team buy in and a sense of being in a special cohort. Regular cascades of information (eg a regular newsletter e-mail) should keep stakeholders up to date on where the project is, and where it is going (R11).* *The Joy management team need to make sure they spend time listening and looking at issues and ideas raised by staff supporting the Joy and Joy GPs (R11a).* *In order to help keep the Joy participants together as an effective team;* *(a) Joy management must continue seeking creative ways to keep regular discussions within the wider Joy team on going, there is no recommendation on what form, but effort must be put in to regularly do this.* *(b) Meetings must spend some of the time looking at what*	R11

			issues have been raised by Joy staff and what support needs to be provided. *(c) Management meetings need to continue to review risks (also see R16 on Risk management).* *(d) The management team need to regularly consider how they are disseminating information to the rest of the team and externally, and how that team are kept enthused and engaged.*	
GE19	Effective Management	Yes	***Recommendation (R12):*** *For an expanded Joy programme involving either/or;* *a) A wider geography* *b) Wider number of professions* *c) Using more Joy GPs or other professionals.* *A more formalised management structure needs to be agreed with;* *a) More formal and fixed management meeting and cascade communication arrangements.* *b) An organisational diagram indicating management and professional leadership arrangements.* *c) Adequate admin support for the Joy management team, possibly, consideration of the role of a joy operations manager if the workload is considered sufficient. Extra resources will probably be required for these roles.* *A more formalised management structure needs to include;* o *More formal and fixed management meeting and cascade communication arrangements.* o *An organisational diagram indicating managerial and professional leadership arrangements.* o *More formalised clinical governance forums and reporting.* o *Adequate admin support for the Joy management team.*	R12
GE20	Effective Management	Yes	***Recommendation (R13):*** *A monthly data set is developed to indicate basic activity, placement history, vacancies, staff availability forecasts, project spend. Comparisons could now be set and used based on monthly activity in 2019/20. Further work should be considered to look at how clinical data can be gathered and used to show what changes the Joy is having on patient care.*	R13

GE22	Effective Management		***Recommendation (R14):*** *A discussion needs to be held on the best way to use feedback within the Joy. Effective feedback systems on performance, challenges and success, both clinically and managerially, need to be worked out and described. There are of course confidentiality and data protection rules that – for good reason - prevent identification of individuals so this has to be borne in mind.* *Good feedback is essential to managing the team effort, anticipating problems and fostering team involvement. This should be described as part of any Joy governance documents and description of formal Joy structure. This should aid continuous improvement.*	R14
GE23	Effective Management	Yes	***Recommendation (R15):*** *Joy management team are unlikely to have the capacity for an expanded scheme, they will need to review;* • *Management structure* • *Management delegation arrangements* • *Professional representation and support for each profession* • *Management skill sets required for an expansion*	R15
GE24	Effective Management		***Recommendation (R16):*** *The risk register needs to be regularly reviewed and business continuity risks considered.*	R16
GE28 Issue # 60	Patient Aspects/ Philosophy and Original Values		***Recommendation (R17):*** *Future evaluation of the Joy programme should consider the social and clinical outcomes of the scheme for patients and the public health of communities.*	R17
GE29	Development of the Joy/ Innovation/ Effective Management		***Recommendation (R18):*** *A lessons learned log needs to be kept and reviewed by Joy management. The wider Joy team and Joy GPs need to be encouraged to keep bringing service delivery ideas, no matter how radical, forward. The management team should not discourage this and should consider making innovation a key part of the values and philosophy of the future Joy.*	R18
GE30	Marketing/ Recruitment and Induction/ Limitations of the Joy	Yes	***Recommendation (R19):*** *Will some practices become difficult to recruit Joy GPs to? – This issue needs more consideration if the Joy is to be expanded to a wider geography and more professions. Clear that this model is for remote and rural areas and was designed as a solution*	R19

			for remote and rural problems. The marketing message will need to be reviewed if the model is to include non H&I or urban areas.	
GE31	Joy Sustainability		***Recommendation (R20):*** *Even if the Joy does not continue in its current model, health boards should look into better collaborative arrangements and consider the benefits of the HrHub model in terms of much more flexible, creative recruitment and contract arrangements. The Joy management team and HrHub have a lot of experience now.*	R20
GE32	Effective Management		***Recommendation (R21):*** *To improve engagement and teamwork, the Joy management team need to cascade information regularly to the wider Joy team. The cascade could include, e-mail, regular newsletter or copy of minutes, but it should at least use one of the.*	R21
GE34	Values, philosophy & Original intentions	Yes	***Recommendation (R22):*** *Any change of model and operation of the Joy needs to continue to be evaluated, this time including some defined success indicators and potential benchmarks considered at the start. Future evaluations should consider how effective and efficient new models are in providing solutions for primary care service provision across in Scotland as a whole and clinical outcomes for patients (see also see section on future evaluation).*	R22
GE35	Values, philosophy & Original intentions		***Recommendation (R23):*** *Vision and values need to be re-visited when the programme changes or expands - to ensure they are still relevant.*	R23
GE37	Values, philosophy & Original intentions/ Effective Management		***Recommendation (R24):*** *Joy GP, or other MDT professional team building needs to be considered as an active, conscious and regular exercise. This should be reviewed by the joy management team for effectiveness and improvement and a useful means of feedback on the health of the teams. Team building needs to be considered for the Joy management team itself and other operational teams within the Joy (eg HrHub).*	R24
GE40	Values, philosophy & Original intentions/ Effective Clinical Governance		***Recommendation (R 25):*** *Effectiveness of the role of the Joy GP Clinical lead needs to be assessed and evaluated in a future Joy programme (see also R6).*	R25
Issue 001	Recruitment and Induction		***Recommendation (R26):*** *Better, more standardised induction guides to be available in all practices using the scheme. New Joy GPs must be*	R26

			given protected time and support to get to grips with IT systems, patient referral and logistics information - for their location - before commencing work fully.	
Issue 002	Recruitment and Induction		***Recommendation (R27):*** *As well as the help from a good, up to date induction manual, particularly on first Joy placement, Joy GPs will also need;* *a) Time to orientate,* *b) Support getting into accommodation and understanding local transport, secondary care, OOH , dispensary and other logistical arrangements* *c) A good handover, where possible.* *d) Support from an experienced user working with the primary care IT systems (see also R26 and R37).*	R27
Issue 003	Recruitment & Induction	Yes	***Recommendation (R28):*** *Creation of a help video for professionals new to Scottish primary care IT systems (see also R27).*	R28
Issue 011	Marketing		***Recommendation (R29):*** *Link for the current Joy GP promotional videos should be included in all adverts. Any future marketing campaign should have wider discussion amongst Joy team - to get in a wider range of ideas and buy in. The role and assessed effectiveness of the videos should be considered at Joy management meetings and whenever new marketing is planned.*	R29
Issue 012	Operation and Management		***Recommendation (R30):*** *1) Capacity of the HrHub needs to be understood in terms of its ability to support future developments of the scheme.* *2) Future planning of Hub models need to bear in mind the key assets of;* *(c) The expertise built up administering the scheme and working with practices/Joy GPs* *(d) The critical role of maintaining the network.* 3) *With only 2 staff, business continuity contingency needs to be considered should either (or both) of the staff leave. Knowledge and procedures should be written down as a critical risk management requirement.*	R30
Issue 015	Recruitment and Induction		***Recommendation (R31):*** *The impact of special financial measures in NHS Highland needs to be monitored and AMD Highland supported if there is pressure to dilute the offer to Joy GPs or cutbacks on using the Joy scheme.*	R31

Issue 018	We didn't know		***Recommendation (R32):*** *New models and the benefits of the Joy proposal needs to be shared more widely with NHS Highland senior teams to improve buy in, support and operational effectiveness.*	R32
Issue 019	We didn't know		***Recommendation (R33):*** *Training/ professional development needs need to be considered for GPs recruited under the Wanderers and Adventurers scheme for practice development roles.*	R33
Issue 022	Recruitment and Induction		***Recommendation (R34):*** *The use of CPD and online training for Joy GPs needs to be planned, tested and developed.*	R34
Issue 029	Operation & Management/ We didn't know		***Recommendation (R35):*** *VAT and invoice payment need to be considered as risk factors as part of cash flow modelling for future versions of the Joy scheme (see also R39).*	R35
Issue 032	Recruitment and Induction/ Clinical Governance		***Recommendation (R36):*** *Guidance on how to access H&I clinical guidelines and formularies needs to be made more explicit on GP induction.*	R36
Issue 041	Recruitment and Induction/ Clinical Governance		***Recommendation (R37):*** *Induction guides need to be clear show GPs where current clinical protocols, guidelines, formularies, treatments and medicines app and SOPs are held, on paper or online(also see R27 on Induction Packs).*	R37
Issue 049	Project Methodology/ Original Philosophy values and intention		***Recommendation (R38):*** *Future developments of the Joy programme need to be evaluated from the beginning to allow comparative analysis of future expectations and other models.*	R38
Issue 052	Operation and management/ Limitations of the Joy		***Recommendation (R39):*** *Future operation and iterations of the Joy programme need to consider having employment contracts issued by the relevant health board for the area of the practice being supported. This should be explored by NHS boards and relative HR and finance departments (see also R35).*	R39
Issue 053	Operation and management		***Recommendation (R40):*** *The current HrHub model can cope with administering and managing perhaps double the number of current Joy GPs (c40) however they may require additional help during recruitment campaigns (see also R30).The whole capacity of the hub will have to be reconsidered if the scheme expands to additional MDT professions.*	R40
Issue 053	Operation and management		***Recommendation (R41):*** *Longer term funding arrangements will help keep the programme stable and allow more confident development*	R41

			of strategy and planning of RTJ initiatives.	
Issue 059	Operation and management		***Recommendation (R42):*** *Expansion and restructuring of the Joy will have an effect on the stress levels and capacity of the management team particularly. This needs to be considered as a risk factor and appropriate mitigation considered (see also R15)*	R42
Issue 060	Philosophy and Original Values		***Recommendation (R43):*** *Practices are consulted on future Joy initiatives and their opinions, along with those of patients, are considered.*	R43
Issue 061	Philosophy and Original Values	Yes	***Recommendation (R44):*** *Future developments of the Joy scheme will need to be reflected in the Joy web pages. Additional pages and emphasis on other professions will require the input of the relevant professional lead in expressing the benefits to those professions.*	R44
Issue 062	Philosophy and Original Values/ We didn't know		***Recommendation (R45):*** *The Joy team consider what they can do to provide solutions for NHS Scotland in a world having to live with Covid19 .*	R45

- Further Work

Further Work			
This section, as an aid, suggests further work and evaluation topics for consideration that are could be useful to future development of the Joy programme.			
Ref.	Suggested Additional Outputs	Relevant evidence section in this report.	PIO Comment
Recruitment & Induction			
FW01	GP Induction guidance/ template	Issues # 1 & 2, Recommendations 26 & 27.	Will, Joy management need some assurance as to how these guides are being developed and the progress of implementation? As well as feedback on how useful the new guidance is.? Research Are there other models of GP induction for Scotland, eg running a course before deployment? What else works in Scotland?
FW02	Improvement of induction process and practice welcome	Issue 25, Recommendations 26 and 27.	Work is underway but should be followed by an audit to test.
FW03	Attractants for Joy GPs	46	Although information is available from a small sample of Joy GPs as to why they came and what attracted them to the scheme (see Joy GP evidence section and appendix A.). Perhaps a more comprehensive study could be undertaken covering all 46 GPs and asking those GPs who have not taken up placements, why not? These responses would be useful in looking at how other MDT professions might respond to Joy type schemes.
FW04	Looking at the longer term GP recruitment position for the scheme and how that has an impact.	See challenges to Methodology section.	Do we now have more Joy GPs on the scheme than we are likely to be able to use? Of the GPs we have actually recruited how many are cleared to work and have signed their employment contracts? How many are dormant and do not put in for work? Has the Joy had an effect on substantive post GP recruitment in the H&I ? Are we getting the right skill set with the GPs we are recruiting? Do we need to look at additional training or support?
Clinical Governance			
FW05	Patient clinical outcomes, community public health outcomes	GE27, GE28, GE33, issue 60 Recommendation 17.	Further Evaluation section & 60. The Joy cannot be fully evaluated until the clinical outcomes on patient care, community public health and impacts on other aspects of care (eg pre hospital emergency care, secondary health care, other

			services) are understood. This could be quite a significant study and would require resources.
FW06	CG Development	GE11 GE12, GE19 Recommendation 6 See section on Future Evaluation & issue 48	Would fall under the clinical directors and CG lead, a CG work plan needs to be agreed and developed that explains the link between planned activity and clinical improvement.
FW07	Joy VC	GE18a and Recommendation R10	Use of the Joy GP VC needs to be evaluated and tested as a tool to support team building and CPD provision.
FW08	Guidance on H&I formularies to be included in induction materials	Issue 32, Recommendation 26 and 36	For clinical lead roles to consider.
<u>Management</u>			
FW09	Choice of future Joy Key Performance Indicators (KPI's)	GE20 & R13	Discussion at GE20 looks at developing a regular data set for the Joy so that, internally, regular consistent data is available. It will also be appropriate for an expanded joy to consider KPI's for better control and performance management. The number and type of KPI's can vary depending on the size and scope of a larger programme. KPI's need to be tested in terms of ; a) Who the intended audience is and why? b) The availability of information and the effort required to keep getting the information. The following groups and suggested KPIs need to be considered; <u>Clinical Outcomes for patients</u> in practices supported by the Joy (clinical input required) <u>Clinical Governance Outcomes</u> - No of SEAs Joy staff engaged in - Number of clinical audits underway or completed. - Number of clinical meetings/ cases discussed - CPD hours completed by Joy health professionals - Health professional appraisals completed (by period). - Number of hours Joy staff engaged in clinical governance activity <u>Activity</u> Number of placements provided (by period/ practice/ region) Number of placement weeks provided (by period/ practice/ region) Number of placement/ weeks unfulfilled (by period/

			practice/ region). Number of Joy GPs on deployment (period) Number of Vacancies filled/ unfulfilled (at one month/ two months/ longer) <u>Recruitment</u> Number of website hits Number of expressions of interest from health professionals. Number of job applications received/ approved/ declined Number applications under processing Number offered employment contracts Number accepted / signed employment contracts. Number of new professional practice/ H&I inductions completed. Number of standardised induction guides in use. <u>Financial</u> Spend (Current Year) v target Forecast Out Turn <u>Staff Governance and support</u> Number of Joy staff time sick leave Staff training hours provided/ taken up Numbers of Joy staff in post/ by professional group. Date of last newsletter/ cascade for staff.
FW10	Accountability framework for the Joy	GE19, 38, 48 Recommendations R11 & R12	Creation of an organisational chart, involving professional accountability is underway but agreement over the remit of the new Joy needs to be agreed as well. A major project but critical if the Joy expands.
<u>Shared Learning</u>			
FW11	Good practice guides	Issues 3, 48 and Recommendation R28	Need to define what guides are required, suggested; (1) Induction of Joy GPs (2) Induction for other MDT staff (3) Something on guide to clinical governance in the H&I. (4) Using H&I Primary Care IT systems.
FW12	Charter	Issue 48	Scope and nature of the contract needs to be developed along with a (legal) risk assessment of what signing a charter would mean.
FW13	Quality Framework	See section on Future Evaluation & 48.	Work would need to be co-ordinated with health boards and assess the benefits, feasibility of a common (?) quality framework. Discussion at issue 48, this could be a lot of work though.
FW14	HrHub toolkit for other HrHubs	48, also see Recommendation 30	This would depend on what the model of the future Joy will be. The HrHub have a lot of experience that could help design this.
<u>Financial</u>			
FW15	Financial costs and efficiencies of the Joy	Issues 47, 48	Discussion at issue 48, can be estimated, but a more accurate assessment would be useful. Analysis provided could include;

			I. Total costs per Joy GP *II.* Total costs per weeks cover provided *III.* Analysis of unfulfilled placements by practice and health board area *IV.* Analysis of the cost of unfulfilled placements by health board area. *V.* The total costs of the scheme vs spending those costs in other ways (the opportunity cost of the Joy).
FW16	How much has Joy GP time replaced locum time in practices	GE43, 47, 48	Can be estimated but a more accurate *assessment would be useful. Analysis provided could include;* *I. Total costs per Joy GP* *II. Total costs per weeks cover provided* *III. Analysis of unfulfilled placements by practice and health board area* *IV. Analysis of the cost of unfulfilled placements by health board area.*
FW17	Outdated Scottish Primary care IT systems	GE8, R4a,	This is perhaps something that the Joy could take forward as a cause – to get rural areas onto a decent platform with good broadband capacity. Other organisations could help and may have taken the challenge forward themselves but is this a cause that the Joy management team feels it should champion? For the H&I, if the Joy doesn't do it, who will? Current evaluation hasn't investigated the challenge of national IT re provisioning, but we understand that any roll out is at least 2 years away.
<u>Practices</u>			
FW18	Practice and MDT opinions/ Voice of practices and communities	GE33, 60	Practices and patients voices have been missing from the Joy so far, an exercise to address patient, practice and community professional's views.
FW19	Establishing why there is demand for Joy scheme	52, R39	Further evaluation work to understand what practices would like to see and why they have used the Joy scheme in the way that they have. With decline in demand for Joy GPs during Covid lockdown (2020) will the scheme be needed afterwards? Could the money have benefited practices another way? Are many practices in Highland still not aware of the scheme? Or is it not attractive/too difficult for them?
<u>Activity Analysis</u>			
FW20	Why lesser take up in Highland practices	QA2, QA4, QA7, QA8, 5 Recommendation 19	A learning point LP028 useful work to understand why this is and inform Joy operation.
FW21	Why are some practices heavy users of the Joy?	QA9	A learning point LP029 useful work to understand why this is and inform Joy operation.

FW22	Why do some practices have so many unfilled placements?	QA10	A learning point LP030 useful work to understand why this is and inform Joy operation.
FW23	Evaluate if Joy GPs are taking up permanent roles in the H&I after the Joy?	33	For further Joy evaluation could use the audit process. The age of the Joy GPs is also relevant, if many are approaching retirement age, for how long will they really be able to contribute? If they are not willing to work for more than a year or two, the scheme will be constantly re-recruiting. One Joy GP (1045) expressed that younger doctors now could not cope so easily with what they would have to deal with in the H&I, would this suggest that recruits in future would need more training beyond basic Primary Health Emergency Care (PHEC) provision?
<u>New Developments</u>			
FW24	What have we learned from the Covid19 experience?	Future evaluation section, 62	Unfortunately the evaluation does not go as far as looking at the impact of the Covid lockdown. Clear that the new situation has impacted on the demand for Joy GPs, how that changes as lockdown is eased needs to be considered. Is there an effect on supply? What are the factors behind changes in behaviour? Does the role of the Joy need to be re evaluated.as a result? Possible, that we could now be recruiting GPs to consult remotely rather than in the home or at surgery this could have profound implications for future models.
FW25	Evaluation plan for new version of the Joy	Future evaluation section	A proposal for an extended Joy has been submitted to the Scottish government (July 2020). Scope for the future evaluation programme needs consideration, preferably before the new programme starts. Do SRMC have the resources for further evaluation?
FW26	Evaluation of Wanderers and Adventurers scheme.	23, 42	Related to FW25 but should Wanderers and Adventurers/ GP Support team programme be evaluated separately along with any other new Joy initiative?
FW27	What service could the Joy offer NHS Scotland in a world having to live with Covid 19?	62	Joy management team to look at the Joy's agile approach could help with testing new models of service and technology (eg NHS Near Me, MS Teams) in remote and rural areas in future.

- Future Evaluation

This section is intended as a resource for future evaluation of the Joy as it changes.
A future evaluation could use all or only some (or none!) of the suggested data or information that could be collected but the root decision will depend on what stakeholders of the Joy actually want to evaluate and why?.

This has to be tested first – What do you want to achieve from any future evaluation?
There would need to be some consensus to prevent any evaluation failing by trying to be all things to all people. To get the best results, clear outcomes need to be set down at the beginning and ideally before any new Joy initiative is taken forward. NHS Modernisation Test of Change methodology should be considered for assessment of any change to the programme before it is implemented. [1]
Broadly, an evaluation could consider the following areas;

a) Operation and management of the Joy
b) Patient and community outcomes
c) Governance and accountability (incl. clinical governance)
d) Innovation, learning and usefulness of the programme in a national context[16]
e) Effectiveness and efficiency of the model.

Questions and analysis using qualitative and ljdzl·yűλűl·űλØŜ methods could be assembled to look at any one or all of these areas. The evaluation also has to consider the time factor, how long a period will it assess? Is it a one off evaluation or a long running even, ongoing evaluation? When are the results needed?
For a one off evaluation, outcomes and a plan of research and analysis need to be agreed along with a timescale and support resources.
For a longer term process, all the above and regular data collection and testing process need to be put in place to collect required data. See evidence discussions at GE20 (Need for a regular data set) and issues #47 How much time and resources has the Joy used up? & #48 Toolkit for future evaluations.

Excellent evaluation resources are available through the NHS National Institute for Health Research , particularly the evaluation toolkit http://www.nhsevaluationtoolkit.net/ designed for commissioners and potential providers in the West of England, it provides a clear step guide for evaluations; Involve, understand, set clear aims & objectives, plan, share and act (see References section 17).

Suggested Evaluation Structure	
Setting up an Evaluation Any evaluation needs a structure and this will follow for the type of evaluation required, it should use the steps suggested in the West of England Model (see	PIO This (Joy) evaluation has followed the format (worked out in advance) ;

[16] Or wider.

reference above); **Involving** the participants Setting **clear aims, objectives and timescale** Be clear **who is doing the evaluation** and what their resources are **Activity to be planned** and agreed in advance The findings **shared** **Act** - The findings should influence future behaviour	Collect evidence (Qualitative and vdzl·yúlúl·ûlØŜ) Summarise findings Make Recommendations Suggestion future work and links to Resources
<u>Evaluation Structure</u> Can be assembled in many different ways, but probably the principle; Ask a question or put forward an idea – assemble evidence – suggest an answer and test against the evidence. Make a recommendation based on the different answers. Usually the questions or ideas can be grouped into themes. Healthcare Improvement Scotland Quality Framework[17] (which is based on the EFQM model) [18] uses following headings; 1. Key organisational outcomes 2. Impact on people experiencing care, service users, carers and families 3. Impact on staff 4. Impact on community 5. Safe, effective and person-centred care delivery 6. Policies, planning and governance 7. Workforce management and support 8. Partnerships and resources 9. Quality improvement-focused leadership	In the Joy evaluation the themes emerged as; Marketing Recruitment & Induction Clinical Governance and Management Management and Operation of the Joy We didn't know what we didn't know Limitations of the Joy Compared to values, philosophy and original intentions Issues raised Joy GP observations But it could have been categorised in other ways depending on what is in the agreed evaluation scope.

Things that could be included within a future Joy evaluation	
General Topic Requiring Evaluation	Suggested Evaluation Method
Regular Collated Information	
Placement History; - When (by week) - Practice - Region - Unfulfilled placements	Will demonstrate progress of placements over time/ by geography and where there may be problems from unfulfilled placements. (Monthly stats collected by HrHub).
Hours Dedicated to Joy Operation and management by other staff (monthly);	Will demonstrate total effort/resources involved in delivering the Hub model. Will

[17] http://www.healthcareimprovementscotland.org/our_work/governance_and_assurance/quality_of_care_approach/quality_framework.aspx

[18] The EFQM model https://www.efqm.org/ , a globally recognised framework that supports organisations in managing change and improving performance.

- HrHub Hours worked - AMD time - HR Director - PC Leads - SRMC Programme Manager & other SRMC staff time - Other NHS staff time	demonstrate changes overtime, can be converted to cash £ costs and used for ratio analysis with other data sets (eg placement provided). May be more challenging to obtain accurate numbers. (Monthly stats collected – Joy management).
Financial Spend (Monthly breakdown); From the Joy budget, by line.	Control measure, can provide of analysis of cash spend and efficiency of cash used (eg cost per professional recruited/ deployed, costs of marketing etc.) Monthly stats provided by Hr Director(s)/ budget holder(s)..
Joy advertising and promotional activity; - No of contacts/enquiries received - Estimated audience - No. of job applications received.	Can provide analysis of interested generated for Joy advertised posts. Some analysis as to how effective channel efforts are. How effective he spend on advertising is. (Monthly stats collected by HrHub).
CG Activity (monthly); - No of SEAs Joy staff/professionals involved in. - Joy VCs held/ no.s participating - Clinical audits completed - Feedback forms received - CPD events held. - Joy staff satisfaction surveys completed - Patient satisfaction survey completed.	Can provide analysis of CG activity underway and highlight problems in specific areas. (Monthly stats collected by Joy GP clinical lead).
Recruitment – No. of Joy professionals by profession ; - recruited - waiting interview - awaiting selection - selected awaiting processing - offer made - accepted offer - rejected - why rejected?	Can provide analysis of where recruitment is at any given time/ profession and highlight any issues. (Monthly stats collected by HrHub).
Qualitative Information	
<u>Marketing and Recruitment</u> - Could marketing and promotion of the scheme for recruitment purposes been better? (GE1) - Have adequate numbers of Joy GPs been recruited in a timely fashion GE7)? - Were the salaries, terms and conditions of employment a barrier to recruitment of Joy GPs/ MDT professions? Have contracts been reviewed annually (GE9)? - Why are there unfulfilled vacancies? Are there problem areas for recruitment? (see GE30, QA6, QA7, QA10) Need	Can be answered by simple questionnaire with tick boxes/free text spaces where necessary. Ideally needs to be supported by interview of key staff.

to know why. - How long do Joy GPs/ MDT professionals stay? What is the turnover rate? - What is the age profile for the professionals coming in?	
<u>Clinical Governance</u> GE11, GE12, GE40 Do you feel that clinical management / governance arrangements are robust enough regarding the Joy project? - Have all Joy GPs been given an adequate induction (issue #1, #2, #3)? - What has been done with practices to look at the quality of local induction and improve it (issue # 25)? - Are all Joy professionals using the correct clinical guidance and can they access it (issue # 32)? - Have all Joy GPs been in contact with Joy clinical lead/ AMD? (GE40) - Have all GPs been offered feedback? (GE22) - Have feedback returns been reviewed? Are there adequate returns? - Have Joy GPs taken part in the Joy GP VCs, or similar meeting? (GE18a, issue #7). - What training/ CPD has been required and delivered to Joy professionals (issue# 19)? - Have clinical guidelines been reviewed/ updated, considered by senior clinicians? - Has a monthly report of CG activity been made to the Joy management team and local health boards CG reporting framework? - Has the Clinical Governance action plan been created? Is it used, when was it last updated? (GE18) - Is there a record of clinical governance meetings, actions and discussions? (GE18) Have outcomes been disseminated?	Can be answered by simple questionnaire with tick boxes/free text spaces where necessary. Needs to be supported by interview of key staff/ CG Leads. Control records would be useful lists of those appraised, CPD attendance, VC attendance, control list of clinical guidelines & updating. Collation of monthly reports to see changes over time.
Have the management arrangements been successful? - Has the joy management structure been clearly defined (ie organisational chart)? (GE19) - For each role, has a broad list of skills been defined and do the current members have those skills? (GE23) - For each member has contribution to the Joy been defined (eg hpw)? - Have host organisations supported the Joy correctly (issue #15) ? - Are communications with the wider Joy team and practices effective (issue # 28)? - Has the effectiveness of the clinical management and support arrangements been reviewed? (GE19) - <u>Management Meetings</u> - Are regular meetings involving the whole management	Needs to be supported by interview of key staff/ all senior management leads. Control records useful, minutes of meetings and action lists, monthly data sets.

team effectively held? - Are decisions recorded, working actions allocated and reviewed at subsequent meetings? - Are monthly data sets and activity summaries available to Joy management (GE20)? - Are there regular cascades of information to the wider Joy team (GE32)? Or Health Boards? On what the management team are doing. - Is there oversight of clinical governance activity and issues? (GE19) - Is there oversight of financial governance and issues? - Is a risk register used and considered (GE24, issue # 11)? - Is there time to discuss ideas and issues brought up by Joy staff/ GPs and any lessons learned (GE29)? - Is there time to consider other compliance issues (eg health and safety, confidentiality, issues with HR procedures, discrimination, diversity (GE42) etc.)? - As a duty of care have stress levels/ burn out in any part of the Joy been considered? (issue #57) - Is there a positive team feel/ a healthy culture?	
<u>Feedback</u> GE27, GE28, GE33 What do practices and other primary care MDTs (who have used the Joy) think of the Joy? What do local communities think of the Joy? What do Joy GPs/ other professionals engaged as part of the Joy, think of the Joy experience?	Specific questionnaire needs to be designed, but can be fairly simple with free text boxes.
Success?	
<u>Has the Joy/project been successful?</u> <u>Operationally</u> - Has success now been defined and has the Joy met those defined standards? - For Scotland as a whole? - For each profession included? - Is learning being widely shared (within and outside the Joy)? To health boards and primary care managers? Scottish Government? - Are critical success factors, opportunities and risks understood by the management team? - Are Joy GPs and other professionals making longer term relationships with practices? <u>Clinical and Community Outcomes</u> - Is there a programme to look at outcomes for patients and public health for communities? (GE28, issue#60) Clinical audits, practice surveys, research, patient	Can only be done if success is defined by original objectives and the scope of the evaluation is clear. It is really a test of change. Did the Joy do what it was planned to do?

opinions?	
<u>What has been learnt since the last evaluation?</u> GE35, GE36 - Has that learning been shared? - Changes since recommendation of 2020 evaluation? - Has the scheme changed in vision, values or objectives (GE43)? - Do any specific Joy projects require separate evaluation?	Needs to be supported by interview of key staff/ all senior management leads.
<u>The Joy in Context</u> What other options exist now that the Joy has been running for 12 months? (Further Work) Has the joy had an effect on overall GP substantive recruitment in the H&I? (Value for Money) Could the Joy funding have been used more effectively another way? What do practices in the different health board areas think of the Joy? Is there a difference between GMS/ Health board practices? What do other bodies think of the Joy (BMA, LMC, RCGP..), are they aware of it? What do MDT professional leads think of the applicability of the Joy solution to their respective professions? Is there a need and where?	Research Practice survey, more challenging to survey those practices who haven't used the scheme and find out why they didn't.

<u>Resources</u>

- Glossary

Glossary	
The Joy	The Rediscover the Joy of holistic General Practice Programme
AMD	Associate Medical Director
H&I	Highlands and Islands
PIO	Principal Investigation Officer of the evaluation
UHI	University of the Highlands & Islands based in Inverness
Ts & Cs	Terms and Conditions
OINOC	Orkney Isles Network of Care
MDT	Multi-Disciplinary Team – generally refers to other health professions (non GP) working in primary care in Scotland (eg Nurses, Pharmacists, Practice Managers etc.)

- References

As part of the evaluation a literature search was undertaken with the help of Highland Health Sciences Library (UHI) at the Centre for Health Science in Inverness. The following resources have been considered and suggested as further reading including links to other initiatives.

References	
1	**A systematic review of strategies to recruit and retain primary care doctors.** **Verma, Puja. Ford, John. Stuart, Arabella** BMC Health Services 2016; 16 (126): (12 April 2016) AN: 121243 BACKGROUND: There is a workforce crisis in primary care. Previous research has looked at the reasons underlying recruitment and retention problems, but little research has looked at what works to improve recruitment and retention. The aim of this systematic review is to evaluate interventions and strategies used to recruit and retain primary care doctors internationally. METHODS: A systematic review was undertaken. MEDLINE, EMBASE, CENTRAL and grey literature were searched from inception to January 2015. Articles assessing interventions aimed at recruiting or retaining doctors in high income countries, applicable to primary care doctors were included. No restrictions on language or year of publication. The first author screened all titles and abstracts and a second author screened 20 per cent. Data extraction was carried out by one author and checked by a second. Meta-analysis was not possible due to heterogeneity. RESULTS: Fifty-one studies assessing 42 interventions were retrieved. Interventions were categorised into thirteen groups: financial incentives (n=11), recruiting rural students (n=6), international recruitment (n=4), rural or primary care focused undergraduate placements (n=3), rural or underserved postgraduate training (n=3), well-being or peer support initiatives (n=3), marketing (n=2), mixed interventions (n=5), support for professional development or research (n=5), retainer schemes (n=4), re-entry schemes (n=1), specialised recruiters or case managers (n=2) and delayed partnerships (n=2). Studies were of low methodological quality with no RCTs and only 15 studies with a comparison group. Weak evidence supported the use of postgraduate placements in underserved areas, undergraduate rural placements and recruiting students to medical school from rural areas. There was mixed evidence about financial incentives. A marketing campaign was associated with lower recruitment. CONCLUSIONS: This is the first systematic review of interventions to improve recruitment and retention of primary care doctors. Although the evidence base for recruiting and care doctors is weak and more high quality research is needed, this review found evidence to support undergraduate and postgraduate placements in underserved areas, and selective recruitment of medical students. Other initiatives covered may have potential to improve recruitment and retention of primary care practitioners, but their effectiveness has not been established. [Abstract] Publisher Information 2016 ISSN 1472-6963 **Link** to the Ovid Full Text or citation: https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-016-1370-1

	Click here for full text options
2	**Factors in recruiting and retaining health professionals for rural practice** **Daniels, Zina M.** Journal of Rural Health, vol 23, no 1, win 2007, p 62-71 AN: DH337606 Record in progress Rural communities, often with complex health care issues, have difficulty creating and sustaining an adequate health professional workforce. The purpose of the study was to identify factors associated with rural recruitment and retention of graduates from a variety of health professional programs in the southwestern United States. The methods were a survey collecting longitudinal data was mailed to graduates from 12 health professional programs in new Mexico. First rural and any rural employments since graduation were outcomes for univariate analyses. Multivariate analysis that controlled for extraneous variables explored factors important to those who took a first rural position, stayed rural, or changed practice locations. The findings were, of 1,396 surveys delivered, response rate was 59%. Size of childhood town, rural practicum completion, discipline, and age at graduation were associated with rural practice choice (P<.05). Those who first practiced in rural versus urban areas were more likely to view the following factors as important to their practice decision: community need, financial aid, community size, return to hometown, and rural training program participation (P<.05). Those remaining rural versus moving away were more likely to consider community size and return to hometown as important (P<.05). Having enough work available, income potential, professional opportunity, and serving community health needs were important to all groups. The conclusion was rural background and preference for smaller sized communities are associated with both recruitment and retention. Loan forgiveness and rural training programs appear to support recruitment. Retention efforts must focus on financial incentives, professional opportunity, and desirability of rural locations. Cites 24 references. [Journal abstract] ISSN 1748-0361 **Link** to the Ovid Full Text or citation: Click here for full text options
3	**Retaining the general practitioner workforce in England: what matters to GPs? A cross-sectional study. Dale J; Potter R; Owen K; Parsons N; Realpe A; Leach J**. BMC Family Practice. 16:140, 2015 Oct 16. UI: 26475707 BACKGROUND: The general practice (GP) workforce in England is in crisis, reflected in increasing rates of early retirement and intentions to reduce hours of working. This study aimed to investigate underlying factors and how these might be mitigated. METHODS: GPs in central England were invited to participate in an on-line survey exploring career plans and views and experiences of work-related pressures. Quantitative data were analysed using logistic regression analysis and principal components analysis. Qualitative data were analysed using a thematic framework approach.

	RESULTS: Of 1,192 GPs who participated, 978 (82.0 %) stated that they intend to leave general practice, take a career break and/or reduce clinical hours of work within the next five years. This included 488 (41.9 %) who intend to leave practice, and almost a quarter (279; 23.2 %) intending to take a career break. Only 67 (5.6 %) planned to increase their hours of clinical work. For participants planning to leave practice, the issues that most influenced intentions were volume and intensity of workload, time spent on "unimportant tasks", introduction of seven-day working and lack of job satisfaction. Four hundred fifty five participants responded to open questions (39128 words in total). The main themes were the cumulative impact of work-related pressures, the changing and growing nature of the workload, and the consequent stress. Reducing workload intensity, workload volume, administrative activities, with increased time for patient care, no out-of-hour commitments, more flexible working conditions and greater clinical autonomy were identified as the most important requirements to address the workforce crisis. In addition, incentive payments, increased pay and protected time for education and training were also rated as important. CONCLUSIONS: New models of professionalism and organisational arrangements may be needed to address the issues described here. Without urgent action, the GP workforce crisis in England seems set to worsen. Institution: Warwick Medical School, Coventry, CV4 7AL, UK. Year of Publication 2015 **Link** to the Ovid Full Text or citation: Click here for full text options https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4608111/
4	**General practitioner non-principals benefit from flexible working.** **French F; Andrew J; Awramenko M; Coutts H; Leighton-Beck L; Mollison J; Needham G; Scott A; Walker K.** Journal of Health Organization & Management. 19(1):5-15, 2005. UI: 15938599 PURPOSE: The purpose of this study is to explore non-principals' working patterns and attitudes to work. DESIGN/METHODOLOGY/APPROACH: The article is based on data provided by a questionnaire survey. Findings - Gender division was apparent among the non-principals. Males were more likely to work full-time, because their spouses modified their working hours. RESEARCH LIMITATIONS/IMPLICATIONS: It was impossible to identify all non-principals in Scotland or to compare responders and non-responders, due to the lack of official data. Hence, the results might not be representative. PRACTICAL IMPLICATIONS: More flexible posts would enable GPs to more easily combine paid work with family commitments. It is anticipated that the new GP contract should deliver this. ORIGINALITY/VALUE: This was the first time a study of all non-principals in Scotland had been attempted. The findings provide a more comprehensive picture of GPs in

	Scotland and provide valuable information for policymakers. Authors Full Name : French, Fiona; Andrew, Jane; Awramenko, Morag; Coutts, Helen; Leighton-Beck, Linda; Mollison, Jill; Needham, Gillian; Scott, Anthony; Walker, Kim. Institution: French, Fiona. NHS Education for Scotland, North Scotland Region, Aberdeen, UK. Year of Publication 2005 **Link** to the Ovid Full Text or citation: Print only. Click here for full text options
5	**What would attract general practice trainees into rural practice in New Zealand?** **Hill D; Martin I; Farry P.** New Zealand Medical Journal. 115(1161):U161, 2002 Sep 13. [Journal Article. Research Support, Non-U.S. Gov't] UI: 12386668 AIM: The shortage of rural doctors is acknowledged worldwide. This study aimed to identify incentives that would attract doctors into rural practice in New Zealand. **Link** to the Ovid Full Text or citation: Click here for full text options https://pubmed.ncbi.nlm.nih.gov/12386668/
6	**Job satisfaction, work-related stress and intentions to quit of Scottish GPS.** **Simoens S; Scott A; Sibbald B.** Scottish Medical Journal. 47(4):80-6, 2002 Aug. UI: 12235914 Job satisfaction and work-related stress influence physician retention, turnover, and patient satisfaction. This study purports to elicit the views of Scottish GPs on job satisfaction, stress, intentions to quit, and to examine any patterns by demographic, job, and practice characteristics. A descriptive, cross-sectional study was undertaken by postal questionnaire on a random sample of 1,000 GP principals, 359 GP non-principals, and 62 PMS GPs. The response rate was 56%. GPs were most satisfied with their colleagues, variety in the job, and amount of responsibility given. The most frequently mentioned sources of job stress were increasing workloads, paperwork, insufficient time to do justice to the job, increased and inappropriate demands from patients. White, female, young (under 40 years) and old (55 years and over) GP non-principals and PMS GPs who work less than 50 hours per week as a GP were more likely to be satisfied with their job and reported lower levels of stress. CONCLUSIONS: GP participation in the workforce could be promoted by introducing more flexible working patterns (e.g. part-time work), by expanding the scope of contractual arrangements, and by making patient expectations more realistic by clearly communicating what the role of a GP actually encompasses. Authors Full Name: Simoens, S; Scott, A; Sibbald, B. Institution: Health Economics Research Unit, University of Aberdeen, Foresterhill, Aberdeen AB25 2ZD. s.simoens@abdn.ac.uk

	Year of Publication 2002 **Link** to the Ovid Full Text or citation: Print only. Click here for full text options
7	**Closing the gap Key areas for action on the health and care workforce Overview** March 2019 The Kings Fund, Nuffield Trust, The Health Foundation Authors: Jake Beech, Simon Bottery, Anita Charlesworth, Harry Evans, Ben Gershlick, Nina Hemmings, Candace Imison, Pinchas Kahtan, Helen McKenna, Richard Murray and Billy Palmer Staffing is the make-or-break issue for the NHS in England. Workforce shortages are already having a direct impact on patient care and staff experience. Urgent action is now required to avoid a vicious cycle of growing shortages and declining quality. The workforce implementation plan to be published later this year presents a pivotal opportunity to do this. In this joint report with the Nuffield Trust and the Health Foundation, we set out a series of policy actions that, evidence suggests, should be at the heart of the workforce implementation plan. We focus on nursing and general practice, where the workforce problems are particularly severe. There are no silver bullets, but these are high-impact policy actions which, if properly funded and well implemented across the NHS, would over time create a sustainable model for general practice and help to eliminate nursing shortages. They will require investment of an extra £900 million per year by 2023/24 into the budget of Health Education England. Reference: https://www.kingsfund.org.uk/publications/closing-gap-health-care-workforce
8	**Doctors on oil rig style rotas as isles fight for NHS recruits** The Sunday Post, 9 Sept 2018 DOCTORS are being offered oil industry-style working patterns in a bid to fill frontline vacancies. NHS Orkney are hiring medical staff on a fortnight on/fortnight off rotas to help attract people unwilling or unable to permanently relocate to the islands. The shift pattern is similar to those who work offshore in the oil and gas industry but the health board says it has made a difference. The vacancy rate for nurses and midwives has now reached its highest level ever in Scotland, while long-term gaps remain for hundreds of consultancy posts. Doctors' unions last night urged other health boards to follow NHS Orkney's lead and think about fixing the recruitment problem. Dr Lewis Morrison, chairman of BMA Scotland, said: "Data published last week shows that the number of consultant positions remaining vacant for more than six months continues to rise. "This is unsustainable and is having a significant impact on the services that the NHS in Scotland provides to patients. "This working pattern is a good example of a health board offering flexibility to ensure that posts are attractive to

	potential applicants. “Doctors want to feel valued and this arrangement allows for a manageable work-life balance, alongside an interesting and fulfilling position. I would urge other boards to take note and consider ways in which they can recruit and retain staff by valuing and supporting doctors in their careers.” Latest figures show an increase in long-term consultant vacancies in the past year across Scotland, with 266 unfilled for six months or more. One in 20 nursing and midwifery posts are vacant and the Royal College of Nursing in Scotland has launched a public campaign to ask for more for nurses so that patients “receive safe, high-quality care”. Orkney Lib Dem MSP Liam McArthur said: “I know the health board has been in the situation where they have advertised vacancies and either nobody has applied or they have not been properly qualified so they do need to think creatively in this situation. I think most people will accept this as sensible.” **Link:**https://www.sundaypost.com/fp/doctors-on-riggers-rotas-as-isles-fight-for-nhs-recruits/
9	**Why do GPs leave direct patient care and what might help to retain them? A qualitative study of GPs in South West England** BMJ Open : Sansom A, Terry R, Fletcher E, et al. BMJ Open 2018;8:e019849. doi:10.1136/ bmjopen-2017-019849 Abstract Objective : To identify factors influencing general practitioners' (GPs’) decisions about whether or not to remain in direct patient care in general practice and what might help to retain them in that role. Design: Qualitative, in-depth, individual interviews exploring factors related to GPs leaving, remaining in and returning to direct patient care. Setting: South West England, UK. Participants 41 GPs: 7 retired; 8 intending to take early retirement; 11 who were on or intending to take a career break; 9 aged under 50 years who had left or were intending to leave direct patient care and 6 who were not intending to leave or to take a career break. Plus 19 stakeholders from a range of primary care-related professional organisations and roles. Results: Reasons for leaving direct patient care were complex and based on a range of job-related and individual factors. Three key themes underpinned the interviewed GPs’ thinking and rationale: issues relating to their personal and professional identity and the perceived value of general practice-based care within the healthcare system; concerns regarding fear and risk, for example, in respect of medical litigation and managing administrative challenges within the context of increasingly complex care pathways and environments; and issues around choice and volition in respect of personal social, financial, domestic and professional considerations. These themes provide increased understanding of the lived experiences of working in today’s National Health Service for this group of GPs. Conclusion: Future policies and strategies aimed at retaining GPs in direct patient care should clarify the role and expectations of general practice and align with GPs’ perception of their own roles and identity; demonstrate to GPs that they are valued and listened to in planning delivery of the UK healthcare; target GPs’ concerns regarding fear and risk, seeking to reduce these to manageable levels and give GPs

	viable options to support them to remain in direct patient care. Link: https://bmjopen.bmj.com/content/bmjopen/8/1/e019849.full.pdf
10	**Final Evaluation Report of the Being Here Programme: Stakeholder experiences of changes to remote and rural healthcare services** Dr. Sarah-Anne Munoz, Dr. Sara Bradley, Frances Hines Rural Health and Wellbeing, University of the Highlands and Islands (UHI) December 2018 The Being Here project was an initiative to build the sustainability of health and care services in remote and rural areas by developing and testing new delivery models for service provision in Scotland. The project was managed by NHS Highland and funded by the Scottish Government. The University of the Highlands and Islands was subcontracted to carry out some of the research and evaluation component. EXECUTIVE SUMMARY: The Being Here Project was an initiative to build the sustainability of health and care services in remote and rural areas by developing and testing new delivery models for service provision in Scotland. Completed in May 2015, the baseline evaluation established pre-Programme status in the pilot areas in West Lochaber and Argyll & Bute operational areas (Small Isles, Acharacle practice area, Mid Argyll and Kintyre) via stakeholder telephone interviews and reviewed activities to be covered by the Programme. The Being Here Programme was an initiative to build the sustainability of health and care services in remote and rural areas. In order to build that sustainability, the Programme aimed to develop and test new models for remote and rural health and care services in Scotland. The Research and Evaluation work comprised five work-packages: 1. Programme Management 2. Baseline Stakeholder Review 3. Programme Review and Community Engagement 4. Reports, Evaluations and Recommendations 5. Health Economics. The report evaluates the introduction of the initiatives, changing the way remote and rural health services were provided at the pilot sites. Key themes were discussed - Service quality , sustainability, breadth of service, practice model, GP recruitment , training for professionals, communication and consultation, technology, out of hours/ emergency care, community resilience, Individual responsibility and reciprocity, first aid and emergency responders, service innovation. The Being Here Programme aimed to develop new models of primary care for remote and rural areas that would be considered by healthcare professionals and community members as contributing positively to local community resilience. **Link:** https://www.uhi.ac.uk/en/research-enterprise/res-themes/institute-of-health-research-and-innovation/srhp/news/news-archive-2019/
11	**FLEXIBLE WORKING IN THE NHS: THE CASE FOR ACTION How designing roles flexibly will help the NHS find and keep talented staff**

	The NHS London Leadership Academy set up the London Women's Leadership Network (LWLN) in March 2017. London Leadership Academy is a pan-London leadership development organisation, working across all NHS organisations to design, deliver and commission outstanding leadership development that makes a real difference to staff delivering care to patients and service users. Executive Summary The staffing crisis in the NHS has the organisation close to breaking point. Large numbers of staff are leaving, with many citing work-life balance as the primary reason. Recruitment is proving challenging, vacancies remain unfilled, and agency costs are spiralling as a result. Yet, while flexible working is central to tackling these issues, there is no clear definition of what flexible working means within the NHS. Furthermore, the organisation tends to operate on a request-response model, in which flexibility is seen as a problem to be accommodated, rather than a way to meet the non-work needs of all staff. The variety of roles and ways of working adds further complexity, with different solutions needed for shift-based working. The solution is to redesign jobs and working practices for all, taking into account the specific clinical and operational constraints in each profession, job role and specialty. This innovative approach to flexible job design will create role-specific flexible options, for staff at all levels, and will help the NHS: • Reduce the number of people leaving • Reduce the amount spent on agency staff • Attract new staff • Improve the gender pay gap and help women progress • Promote local workforce inclusion and become an anchor institution. We therefore recommend that the NHS implements a three-part Action Plan for Flexibility, to drive sustainable change: • Define what flexibility means Develop a clear definition and vision for flexibility in the NHS. • Design flexible roles Create flexible job design options for each profession, job role and specialty. • Develop a flexible culture Build organisational cultures across the NHS which drive and promote flexible working at team level. By doing so, the NHS will be able to deliver a 24/7 environment which works for everyone, whatever their other responsibilities. The result will be a dramatic increase in the organisation's ability to attract, nurture, develop and keep its hard working, talented staff. **Link:** https://timewise.co.uk/wp-content/uploads/2018/07/Flexible-working-in-the-NHS-the-case-for-action.pdf
12	**Shaping the Future Together - Report of the Remote and Rural General Practice Working Group** Scottish Government Jan 2020 Professor Lewis Ritchie (Chair) **Key Messages** • The original remit of the Remote and Rural Group (the Group) was to support Implementation of the GP Contract in remote and rural areas. This was the basis for our initial extensive programme of engagement visits speaking to, hearing and learning from colleagues. This learning has helped to inform this report.

	• The Group was formed at a time of considerable change in the national primary care landscape. Delivering primary care transformation was recognised as needing shared vision, novel relationships, effective collaboration, good communications, trust and flexibility. This should be driven by local priorities, within the context of nationally agreed principles, delivered by strong clinical and managerial leadership. • Over time, the work of the Group has sought to assist implementation of the Contract, but also to inform future policy and contractual developments. We have sought to act as a sounding board via workshops and to directly gather views from those planning, providing and redesigning services locally in remote, rural and island communities. • For these reasons, the Group, with the agreement of Scottish Government and the BMA, will continue to work as a forum with direct engagement of GPs, clinicians, service planners and public representatives. • As part of its revised terms of reference (included as Annex B), the Group will, as appropriate, provide advice to the Scottish Government and BMA on remote and rural aspects of the current and future iterations of the GMS Contract, including Phase 2. **Link: https://www.gov.scot/publications/shaping-future-together-report-remote-rural-general-practice-working-group/**
13	**Making It Work** **Scottish MIW Group Jan 2019** **A Scottish Case study as part of the EU ERDF Northern Periphery and Arctic Programme 2014 -2020** From 2011-2018, an international collaboration including academics, human resources professionals, health services administrators, health professionals, and social and cultural development professionals, studied factors related to workforce recruitment and stability in rural and remote environments. Executive Summary The Scottish MIW Group consists of NHS Highland (NHSH), NHS Shetland (NHSS), NHS Orkney (NHSO), North of Scotland Planning Group (NoSPG) and NHS Education for Scotland (NES). It is aligned with ongoing work at the Remote and Rural Healthcare Alliance (RRHeal), the Scottish Rural Medicine Collaborative (SRMC), the Scottish Rural Health Partnership (SRHP) and the Scottish Government (SG). The Scottish case study aimed at improving the recruitment and retention of remote and rural multi-disciplinary teams. Our first objective was to gather information to help understand more fully what the current issues were around recruitment and retention in Scotland. This information provided us with grass root evidence to direct and validate project activities. Our second objective was to explore the role communities can play in the recruitment process with the intention of working with a rural community to develop useful community information for candidates. Our third objective was to develop and pilot innovative and authentic ways of

	advertising vacancies, by working in partnership with one rural and remote health and social care team. Our fourth objective focused on professional development and team cohesion: our aim was to find ways to improve access to learning, professional support and team building. There was a deliberate strategy of focussing on multi-disciplinary teams in the Scottish case study to complement the Scottish Government funded Scottish Rural Medicine Collaborative, which was running alongside Making It Work. **Link: https://rrmakingitwork.eu/wp-content/uploads/2019/03/Making-it-Work-The-Scottish-Case-Study-Report.pdf**
14	**Revitalising Recruitment and Retention to Orkney's Island Practices** **The Orkney Isles Network of Care** Case study document describing the vision, background, barriers, principles, solutions and outcomes to the Orkney Isles Network of Care model. **Link: https://www.srmc.scot.nhs.uk/wp-content/uploads/2020/04/SRMC-improvement-template-Annex-2.pdf**
15	**Addressing the crisis of GP recruitment and retention: a systematic review** **Catherine Marchand and Stephen Peckham** British Journal of General Practice April 2017; 67 (657): e227-e237. DOI: https://doi.org/10.3399/bjgp17X689929 **Background** The numbers of GPs and training places in general practice are declining, and retaining GPs in their practices is an increasing problem. **Aim** To identify evidence on different approaches to retention and recruitment of GPs, such as intrinsic versus extrinsic motivational determinants. **Design and setting** Synthesis of qualitative and quantitative research using seven electronic databases from 1990 onwards (Medline, Embase, Cochrane Library, Health Management Information Consortium [HMIC], Cumulative Index to Nursing and Allied Health Literature (Cinahl), PsycINFO, and the Turning Research Into Practice [TRIP] database). **Method** A qualitative approach to reviewing the literature on recruitment and retention of GPs was used. The studies included were English-language studies from Organisation for Economic Cooperation and Development countries. The titles and abstracts of 138 articles were reviewed and analysed by the research team. **Results** Some of the most important determinants to increase recruitment in primary care were early exposure to primary care practice, the fit between skills and attributes, and a significant experience in a primary care setting. Factors that seemed to influence retention were subspecialisation and portfolio careers, and job satisfaction. The most important determinants of recruitment and retention were intrinsic and idiosyncratic factors, such as recognition, rather than extrinsic factors, such as income.

	Conclusion Although the published evidence relating to GP recruitment and retention is limited, and most focused on attracting GPs to rural areas, the authors found that there are clear overlaps between strategies to increase recruitment and retention. Indeed, the most influential factors are idiosyncratic and intrinsic to the individuals. Link: https://bjgp.org/content/67/657/e227
16	**Evaluation: what to consider Commonly asked questions about how to approach evaluation of quality improvement in health care – Quick Guide** The Health Foundation March 2015 **Link:** https://www.health.org.uk/sites/default/files/EvaluationWhatToConsider.pdf
17	**Evaluation Works : A Toolkit to support commissioning of health and care services NHS Bristol, North Somerset and South Gloucestershire, West of England Academic Science Network, NHS National Institute for Health Research - Website** **Link:** http://www.nhsevaluationtoolkit.net/
18	**NHS workforce planning – part 2. The clinical workforce in general practice Audit Scotland August 2019** Expanding the primary care workforce is central to the government's 2020 vision of delivering more care at home and in the community. Primary care services face growing demand from an ageing population and an increase in the number of people with multiple chronic conditions. There are also pressures on workforce supply, including an ageing workforce and problems with recruitment and retention. The Scottish Government acknowledges these workforce pressures but has not estimated the impact they will have on primary care services. Link: https://www.audit-scotland.gov.uk/report/nhs-workforce-planning-part-2

Research compliance

The evaluation has been approved as NHS research sponsored by NHS Highland R&D department. It is registered on the Integrated Research Application System (IRAS) single system for applying for the permissions and approvals for health and social care / community care research in the UK (ref 270115). Research was approved on 16/3/2020.

Thank You

We are very grateful to all participants who were very helpful in providing their honest opinions and time. Very grateful to HrHub staff in Shetland for providing a reservoir of information to work with and the UHI Centre for Health Science Library staff who helped with references.

Appendices

A. Phase 1a Joy Evaluation Report (June 2019)
B. Evaluation Interview Questions V3.0
C. Evaluation Sample consent form v2.0
D. Evaluation Sample project information v2.0
E. Principal Investigation Officer (PIO) CV
F. The Joy GP Placement History (July 2019 – Mar 2020)
G. Sampling analysis of vacancy returns
H. Recruitment and Retention Collaboration and Cohesion Presentation (Sept 2018)

NHS Shetland HrHub Team 2019

Scottish Rural Medicine Collaborative (SRMC) Programme Team 2019

Appendix A.

Phase 1a Joy Evaluation Report (June 2019)

PELIMINARY PROJECT EVALUATION

1. Short Evaluation of Phase 1a - June 2019

To assist strategic decision making and facilitate nimble and agile project activity, this interim evaluation has been prepared from ljdzl·yűλűl·űλØŜ and qualitative information collected so far. This is an early attempt to capture the likely learning points from Phase 1a and is aimed to inform activity in Phase 1b and early consideration of the longer term future of the project. Comment and responses to this on this short evaluation will feed back into a more reflective analysis once the more formal evaluation, for phase 1a & b, has been considered and endorsed.

2. Project Background

Rediscover The Joy..(The Joy) is a project developed by key medical directors, primary care managers and HR staff at 4 Scottish health boards (Shetland, Orkney, Western Isles and Highland) from late 2018. It had arisen as a response to, chronic problems recruiting to regular GP vacancies in these rural Highlands & Islands areas. This has been an increasing problem for 3 of the health boards involved and is also a problem in other parts of rural Scotland not currently part of the project. The project team itself is a collaboration between health board HR, primary care managers and medical directors and has sought, since early 2019, to recruit GPs for fixed term placements of 12, 16 or more weeks to primary care medical practices in remote and rural areas. The aim is to ease problems from covering long term general practice vacancies as well as covering short notice leave and absence as well, as providing fresh opportunities for participating GPs to reconnect with a more rewarding, hands on and holistic experience of rural medicine and communities.

Discussions at a sustainability workshop, in Sept 2018, confirmed the then scale of the problem and further dialog between medical directors, lead GPs and HR staff discussed possible, more radical solutions, during that autumn. Experience from other professions and particularly, the successful multi-disciplinary Orkney `Isles Network of Care' service redesign, dating back to 2010, and other rural cover models, indicated that there may be opportunities for recruiting GPs on shorter fixed term placements of 12 or more weeks. This was thought to be attractive to later career GPs who wanted a refreshing change and could bring significant skills and a positive attitude with them. There was also interest in finding ways to help retain current trainee and younger GPs who might be looking to get a different, interesting experience as part of their own professional development.

There was the also the incentive of financial support from the Scottish Government, through the General Practice Rural Fund, who approved financial support (Dec 2018, £180,956) towards the

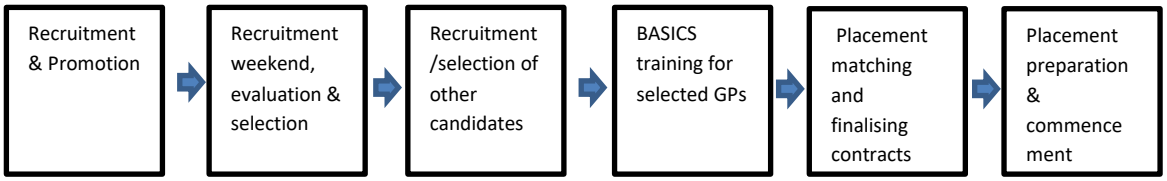
expenses of a rural GP recruitment pilot scheme. Preparation activity had already started and the first recruitment adverts went out, principally in the BMJ, at the end of January 2019 with a closing date of 3rd March. The period from December was busy for the project HR department at NHS Shetland and primary care managers, as arrangements had to be made between the 4 health boards over; job descriptions, contracts of employment terms, GP salaries as well as recruitment of a HR support team (1.7 wte) based in Shetland (to be known as `The Hub'). During February and March 2019 the recruitment process for GPs was in full swing. There were differing expectations between different individuals involved at this stage on how many GP candidates could be recruited (estimates 5 – 30).

Advertising and other promotional activities, in January and February 2019, resulted in (eventually) 56 applications (by CV) for posts, way above expectations.

The applications were sifted down to 31 candidates who were invited to a recruitment weekend held at the Ben Wyvis Hotel, Strathpeffer, on 16/17 March 2019. 14 candidates were able to attend but a high number (17) were not - for differing reasons. The Joy team took a deliberate approach using the weekend to evaluate the candidates, but also to bring out the candidates own qualities, ideas and buy in to the process. It was a deliberate aim that, with what was realised were some high quality candidates and a cohort approach, there was an opportunity to build up a mutual self-supporting network and perhaps an opportunity to freshen up the quality of local services as a result. Following the workshop, assessment and due diligence checks were undertaken and by mid-May, candidates were being sent confirmed offer letters for placements starting in July 2019. A matching exercise is currently underway (Jun 2019) to place GPs at primary care practices in the 4 health board areas taking account of their individual preferences and the notified vacancies/roles available. Recruited GPs have also been given BASICS emergency medicine training – necessary for isolated rural areas (May 2019).

Though the initial, selected, applicant GPs were invited and assessed through the recruitment weekend in March, there were also good applicants who either could not make the weekend or were referred through other routes (eg other health board recruitment campaigns) and word of mouth referrals (21). It was clear that there could be some useful extra recruitment and so an extra interview programme was arranged through April/May using a standardised format and more applicants were recruited (12). At the current stage (Jun 2019) the matching process is underway with the first placements expected to commence in July 2019. Appendix A gives an overview of the current state of recruitment as at June 2019.

3. <u>Activities and Inputs</u>



A simplified process map indicated the process undertaken since approval of Scottish Government funding there were more complex sub activities around;

a) The advertising and promotion process dictated by the BMJ placement timelines and agreement of the group over advert contents.

b) Agreement between the 4 health boards over GP pay rates, job descriptions and employment contract terms.
c) Recruitment of the HR Hub staff and necessity for recruitment approval through NHS Shetland internal process.
d) The mechanics of the recruitment weekend including establishment of evaluation processes, case studies etc., selection of venue and travel, accommodation and expenses claim arrangements.
e) Negotiation and arrangement of the BASICs course before accurate numbers were available.
f) The process of matching successful candidates to practices with vacancies

Staff in the HR Hub have kept in touch with recruited GPs through the whole process and continued to answer queries.

4. Time & resources made available – to June 2019

From established NHS Staff (estimates);
3 x medical directors (Orkney, Shetland, Western Isles) – % of wte spent on project CS (10%) KB (10%) DM 20%)
1 x HR director (Shetland) – LH (20%)
3 x primary care managers (Orkney, Shetland, Western Isles) – av. 2 x 12.5%
Other staff – HR Hub Staff 1.7wte (from 1/2/2019) – Salaries etc.
Other costs -

Advertising & promotion -	£15,327 (incl., a BMJ advert c £12,000)
Salaries Costs	£15,067 (HR Hub project staff)
Selection weekend -	£ 8,668
BASICS	£17,287
Total	£ 56,349

Estimated cost per candidate £6,500 (per HR director)
Effectiveness of advertising costs 26 offered places/ advertising costs - £ 589 per offered GP place.

5. Outcomes and impacts assessed

GPs recruited ready for deployment on placements – June 2019 – 26

GPs not selected throughout process – 20

GPs withdrew throughout process - 9

GP Vacancies by health board area/ total GP posts at beginning of project and before 2019 placements;

Shetland –4.9 wte/ 18.75 posts (figs from Oct 2018) – vacancy rate of 26.1%
Orkney – 0 vacancies/ Isles Network of Care Model in Operation
Western Isles – 6.5 wte/ 22 wte posts (figs from Sept 2018) – vacancy rate of 29.5%
Highland – Figures not available

GP Recruitment model – Process progress as at Jun 2019 (See Appendix A)

Assessed learning points and potential implications

The following evidence was collected through interviews with project team members during May/June 2019 to capture specific and general issues. It is not a complete exercise and has not, to date, included the opinion of staff rom NHS Highland. Members of staff were interviewed separately and not given the opinion of other individuals. The themes collected are often an amalgam of opinions from different individuals.

Issues/comments raised through interviews carried out with members of The Joy project team	Explanation or Consequence	Comment
The project is very much about creating a sustainable model rather than just filling GP slots – network creation and team building aspect very important	Team building activities, having a tight supportive relationship with candidates and high standards are critical to the project. The recruitment weekend, the robustness of the selection interview process and ongoing support for candidates are critical factors in creating bonding and building a network.	This experience cannot be tested fully until the recruited GPs are in place, but it is clear that a regular recruitment process has been supplemented by additional team building and aiming to create a connected self-supporting cohort. The effectiveness should be evaluated taking evidence from the candidates throughout their placement.
`Can do' attitude won the bid but time lines were then very tight. Deadlines to bid and spend through SG GP Rural Fund were tight. Great opportunity but generated real pressure on bottleneck areas.	There has been pressure on the HR and primary care manager team in forming the HR hub, agreeing contracts of employment, GP salary rates, developing the practice booking form mechanics, quickly. Success may depend on how agile the Joy project team can be to get GPs into post quickly. Administrative Bottlenecks have arisen at the following points; a) BMJ timelines for placement of first advertisement (Jan 19) b) Recruitment of Hub support staff took time and not able to get them in post until late Feb/early March 2019. Bulk of candidate processing work could only start then. c) Short timescale and changes to date of Recruitment Weekend (Mar 2019) d) Making practices across 4 health board areas aware of the service and enabling completion of placement booking form process (May/June 2019) e) Ensuring understanding of the process and arranging support in the practices across the areas.	There is a trade-off involved here between getting a robust administrational framework into place versus, an overall project aim of being nimble and getting quick results. The `breaking new ground' nature of the project means that bottlenecks cannot always be anticipated. For example, the practice booking process is well understood in Shetland but not so familiar across the wide Highland region where many practices seem to be unaware of the project, consequently there has been a lack of applications for placements from those areas. It is hard to judge how much the bottlenecks have delayed placement but certainly one or two candidates could have been in place in May 2019. Another key point is that the administration won't have to be developed again now that the model is established. Future recruitment campaigns should be far more efficient and consistent.
Agreed that the primary job recruitment advert would go out in BMJ, but wording and artwork needed	There appears to have been an impasse early on in the project where an executive decision needed to be taken over the exact nature of the wording and picture for the BMJ advert. The point being that, with no clear authority there was an impasse when a prompt decision needed	An observation on several issues is that though there has been senior direction to the project, it tends to come from individuals (medical director/head of HR) but is not always co-ordinated. Sometimes there is conflicting advice and sometimes no

careful consideration.	to be made. The decision was eventually made by the HR Director NHS Shetland and the advert turned out to be very successful. The advert went out at the same time as a similar NHS Wales advert but The Joy advert apparently was more successful (from discussions with NHS Wales staff), this point may be relevant at the discussion on the future of the project Part Three below.	advice to staff. Many of these issues have been worked through but, there is a need for the operational leads to provide consistent advice promptly. To do this a small group of operational leads needs to have regular contact to agree short sharp decisions on operational issues and keep the project to an agreed plan, scope, spend and timescale. A slimmer more agile management team/ group that can make decisions in a timeous way. The group also needs to consider what culture it wishes to promote and how this can be managed with the culture of other staff already working on the project. Would recommend head of HR, lead medical director and (possibly) SRMC lead but other configurations will be possible.
BMJ advert very expensive (c£12,500) but probably worth it. There were worries from many individuals (though not all) that interest would be minimal and possibly low quality.	The BMJ was very effective in attracting the large majority of the initial 51 applicants. But it was high cost. Other channels were used (eg Health Boards own websites and the NHS NSS SHOW website) but the BMJ was by far the most effective. Many of the candidates attracted were also are also high quality. Medical director (Shetland) (DM) felt that the type of candidate was probably anticipated correctly (ie GPs over 50 looking for an interesting way to finish their career but with the odd application from much younger GPs).	The opinion of GP candidates, on `what attracted them to the role?', was captured in an evaluation carried out during and after the recruitment weekend in March 2019 (see Appendix B). The adverts were seen by the majority of candidates and considered effective in attracting them to the roles. There were a number of suggestions as to what else could be considered in future adverts, some more practical than others.
Tight deadlines, a change of date made organising the recruitment weekend very challenging.	The need to have a venue in the Highland area and a short deadline to secure a hotel with accommodation for c 30 people and working room,s was challenging. The complexity of organising travel to Inverness and transporting participants to the Hotel as well as managing families and dogs etc. was also difficult and would have been far worse in the busy tourist season (May – Sept). There was some luck involved in getting a fit for purpose venue that was available. Some candidates had difficulty in getting themselves out of their regular practice commitments at such short notice. The short notice change in weekend date has also been cited by several people as generating a lot of stress and should have been agreed and fixed much earlier by the management group (see comment on decision making above).	With future rounds of recruitment, a more considered recruitment process plan can be established. The management group need to be mindful of the capacity of the HR Hub team at any given time. Events require a reasonable lead time to organise properly and longer if the venue has not been checked out. Any venue needs to be checked in person before the event for practicalities and, given that the team are also marketing the highlands and islands as a place to live and work, any venue needs to give a good impression and considered objective views need to be taken. Some of the area destination management organisations (DMO's) such as Orkney.com https://www.orkney.com/ Visit the Outer Hebrides https://www.visitouterhebrides.co.uk/ ,

		Promote Shetland https://www.shetland.org/ or Visit Scotland https://www.visitscotland.com/destinations-maps/highlands/ may be able to help.
Involvement of other health boards; NHS Highland came in later to the process and was not able to provide managers to support the recruitment activity. There have been problems making practices in the large Highland area aware of the project and buy in has been haphazard. There was also a debate about the late inclusion of Dumfries and Galloway who have similar problems.	There were a number of issues that may have ramifications for expansion of the project ; The 3 `core' island health board staff have experience working together and have similar perspectives and an understanding. NHS Highland is a much larger, less cohesive health board in terms of wide linkages between practices and with more limitations on how much manager/medical director support time has been available. The ability to raise awareness of the Joy project across the much larger number of highland rural practices has been a problem. NHS Dumfries & Galloway have a severe GP shortage as well, but an able management team. It was a judgement call not to include them as part of the Joy - due to fear of destabilising the existing project, but that may have been a mistake	NHS Highland has 64 rural practices in diverse geographical clusters (compared to Western Isles, Shetland and Orkney's combined total of 27). Communication with a centre based in Inverness and tight control and support is possibly not available in the way that it is in the islands board areas. The implied actions in this case are for managers in primary care in the larger health board areas, but also for how the hub and Joy management teams communicate with them. A programme designed to engage more closely with Highland practices needs to be orchestrated perhaps including VCs and visits between managers and the hub to increase awareness and buy in. Many practices will need to be prepared to be able to receive GP placements and the issue of BASICs training and sourcing of standardised emergency equipment needs to be resolved. A similar approach may be necessary with the inclusion of Dumfries & Galloway and the Borders. This should be assessed early. SRMC should be able to provide support in helping make the links.
Issue of trust between medical directors / HR staff.	There is occasionally, tension involving medical directors and HR staff. This reflects the differing drivers, pressure and risk awareness. From a medical director point of view ; 1) They have visibility of the effect of GP vacancies on practices in their areas, in terms of stress on teams and GPs, all trying to keep services going and clinical standards high. There is anxiety about `meltdown' in key high vacancy areas and there are challenges in maintaining cover for small isolated practices. Though action and responsibilities on The Joy were agreed in November/December 2018 directors feel that there has sometimes been an impasse where nothing seems to be happening and, to date, there has not been significant placement of GPs. They also feel that information on	This issue has been raised by several people, but not everybody. There has not been a breakdown in relationships and the recruitment campaign is progressing well although more slowly than some team members initially expected. There are some frustrations however, that; a) There has been the absence of wider reporting on where the recruitment process is at any given stage. b) That clinical staff are not mindful of the considerable effort that had to be made to put in place a robust HR and control framework. Clinicians may not always have the best judgement about what is possible and how quickly in these areas. c) Bottlenecks in administration have occurred (see above) but the unknown nature of the exercise means that it is sometimes, with the best will, difficult to

	progress is not often forthcoming and are anxious that the GP cohort currently being recruited are being left waiting and that some may lose interest and withdraw. 2) HR staff were given a difficult job to do, under time pressure. Firstly, in having to agree terms between health boards and the detail of the job description, practice booking arrangements and employment contracting. The necessity to put both the GP and HR Hub staff job descriptions through NHS Shetland recruitment panel caused delays. The necessity to recruit the 2 dedicated HR Hub staff caused a delay and it was not until early March that they were effective in post. There were also anxieties around the preparation for the recruitment weekend and general problems where medical directors were not available. The hub has also been busy fielding enquiries from interested GPs and candidates, and has been under pressure to pay expenses claims in a timely fashion. The NHS Shetland anxiety is that they take the risk if there are disputes over employment contracts and that they are accountable for the Scottish Government funding. There are financial and legal risks if they get it wrong. Another frustrating issue is that many GPs generally do not reply to e-mails meaning that in a lot of cases, discussions have to be held by phone or in and around clinics. These points of view also suggest that there are tensions rooted in conflicting expectations. This has not stopped the project proceeding but sometimes causes anxiety and an occasional short term breakdown of trust. There is a risk that, in desperation, medical directors undertake unilateral action in competition with the project. The part solution to these problems needs to be considered in terms of; a) Having the channels to communicate 2 way effectively to exchange views and update. b) Having a more tightly organised smaller management team to make timeous decisions and keep the project	anticipate them. This is a pilot project. d) Some candidates could have been in place much earlier. e) The complexities of dealing with practices in NHS Highland and making them aware of the project and opportunities is challenging. f) There is an anxiety that candidates have not been kept in touch with and some could be lost before placement. HR staff would dispute this as they have deliberately employed a pro-active programme of staying in touch. They assert that there has been contact with every candidate in a personal way since the recruitment weekend. Again the role of the management group and the way it communicates needs to be considered but see recommendation in previous section. Creation of an informative project dashboard – showing where candidates are in the recruitment pipeline at any given point – along with a short written monthly report is recommended. This will need to be mindful of Data Protection best practice but could help open transparency (see Appendix A for a suggested model). Just occasionally, there should be a whole team workshop meetings (probably by VC) to reset expectations and reduce tension. HR Hub capacity needs to be considered for any expansion of the programme. Although the current model has the capacity now to process many more applicants quickly, working with a wider range of health boards will require a much higher level of communications and development of communication and remote meeting channels.

	on track and mindful of the need to keep team members in the loop,	
Recruitment weekend turned out to be a great experience with a relevant venue. It was a great success in terms of being able to evaluate candidates but also empower them to help build their own network and be self-supporting when in post. Organising the recruitment weekend was challenging with change of dates, agreement over case study and very short notice for booking, GP candidates to attend and travel arrangements.	There has been unanimous feedback that the weekend was a success, particularly as a planned catalyst to empower the candidates and make their role more active increasing the buy in. There was some real passion generated and good bonding once participants got on the same wavelength. In terms of administration, organising the weekend proved challenging given the tight deadlines. The venue was probably a good one though a trade-off between health boards and it was sufficiently near Inverness airport to be practical.	A recruitment weekend evaluation was carried out in April 2019 taking back 10 returns from candidates involved (see Appendix B). This evaluation is reasonably detailed and provides useful feedback for designing future events. Overall the candidates were impressed by the weekend and found it useful though one or two points need to be considered. From a practical organisational aspect, the workshop needs a longer lead in time, perhaps six weeks enabling preparation for a tighter/ slicker event. Hotel capacity in rural Scotland is often limited during the summer (April – September) so this is not the time to organise events at short notice. Bear in mind that many candidates – for one reason or another, could not make the weekend (17) but it is anecdotally known that for one or two it was difficult for them to make cover arrangements with their home practices at the short notice. (See other comments above on the late changes to the date of the recruitment weekend)
Decision to allow applicants into the process after the recruitment weekend may be a problem. Exercise to test an interview before the full process was a good one	There are some anxieties that the decision to keep recruiting candidates after the weekend may cause a two tier problem whereby GPs have been recruited to different standards, this may be a problem if a dispute later breaks out with a disaffected GP. One test interview was carried out with a known GP, this has helped provide more confidence that the interview methodology is fair to all candidates.	Although this issue creates anxieties for the HR team – that there is not continuity of process - and it creates a risk if there is ever a legal or employment tribunal challenge, this may not be a problem if the interview and employment contracts process are of a consistent, HR professionally assessed format. Future campaigns need to bear this in mind.
Clinical governance, clinical management and support workload need to be thought out.	Incoming GPs to the scheme will be employed by NHS Shetland, they may work on placement in another part of the Highlands and Islands, their home – bulk of work –post may be in another part of the UK or even abroad. Various scenarios could be possible here. An important link is to the GPs own appraiser - reporting officer (RO) who will be based where the bulk of their work is done. Any clinical professional appraisal, certainly where there are issues of concern will need to bring in the RO. In theory these arrangements could put pressure on the capacity of the Medical Director (Shetland) who would be theoretically clinically	The medical directors will need to establish a workable solution, primarily to provide support to placement GPs. This may have to diverge from the strict employment contract linkage and medical directors from other health boards (eg Western Isles, Orkney, and Highland) may have to be given permission or rules relaxed to allow them to contribute to NHS Shetland employed GP appraisal correspondence or systems.. The question of how to support necessary CPD arrangements for placement GPs may have to be facilitated.

	responsible for GPs he/they have little contact with. A technical consideration is the need to provide VC or other conferencing facilities for the cohort of GPs at work on placement.	The Joy medical directors should be able to work out a practical solution and are currently doing so (June 2019) but this should be followed up by creation of written guidance or procedures. The employment of GPs normally based abroad or outside the NHS orbit will need to be given particular consideration in terms of appraisal and clinical governance risks. The same group will also have to consider the adoption of clinical procedures and adoption throughout participating practices (eg Emergency Care). VC infrastructure support is currently being looked at by the SRMC team. This is a challenge as different health board areas are issues different equipment and software with different ranges of permissions. Broadband connectivity is patchy in many rural practices and it may be that telephone conferences may be the only realistic alternative.
Hr Hub views – Basic HR admin process is now in place and is being tested. They are very proud of what they have done to date but appreciate that it took time to get in place. They are now looking at control systems to oversee and make more visible where the recruitment process is at any given time.	HR Systems – at arm's length from NHS Shetland's own HR department - have been put in place, tested and the first cycle of recruitment is nearly complete. Consideration is now being given as to ways to oversee the process and provide wider visibility.	The need for greater transparency and accountability has been recognised but during early 2019 had to come behind putting basic HR compliance in place. Recent work is focussed on creating a robust management information system to indicate where each GP application is and what the vacancy request situation is (ie supply and demand for GPs for different practices and different time slots). The first part of this is the draft flow chart at Appendix A, now open for consultation. The flowchart itself is built from other lists and spreadsheets set for each part of the recruitment journey.
Basics training & bonding very successful but future capacity limited.	BASICs is considered to be good quality training and critical for the GP remote and rural role. More recruitment weekend bonding could have been undertaken around the time of the first BASICs workshop (May 19) possibly. BASICs organisation may not have the capacity to deliver the high volumes of training required by an expended scheme. 18 places paid for as part of the first cohort preparation but not all candidates actually require the training (some have it, or similar skills already)	The BASICs team capacity needs to be addressed and it may not be simply a case of finding additional funding. Although a second BASICs course is planned for August 2019 the BASICs team may not be able to do much more for the project until 2020. This would need to be addressed as part of any scheme expansion.
Levelling standards for emergency equipment and drugs held at	There is a model of standardised emergency kit being held at rural practices (based on the Sandpiper bag). These are often supplemented	Complete levelling of provision to participating practices is challenging;

participating practices.	by `the dream bag' a complementary quick grab set of drugs for emergencies. Arrangements have been made for respective health boards to contribute to the purchase of the bags and standardised emergency protocols (based on the Orkney model) are being put into place.	a) There are differences of opinion with GPs over, particularly drugs, what is necessary in different locations. No one size fits all. b) Though general compatibility across the island practices is achievable. Admitting quite a lot of Highland practices may raise a significant financial cost to GMS practices or health boards. c) In practice similar drugs and equipment are available at most sites but universal acceptance may take time and cash resources.
Longer term anxiety about being able to capitalise quickly on the success of the project – needs to be agile. The opportunity may be time limited, competition from other areas etc.	There are differing views from the team on how the project should/could be expanded. Certainly a wider regional expansion in Scotland is one step, International recruitment is also considered though, the need for external (to the UK) candidates to undertake the GP `Return to Practice' type course is something that needs to be considered and possibly funded. There is the aspect of widening the scheme out to other MDT professions.	There is wide comprehension, in the team, that this is a pilot project and that they are doing something not knowingly done on this scale before. This is an exciting and good motivator however, at least some success needs to have been indicated and some evaluation undertaken before expansion or wider activity is considered. See part three for discussion on the issues behind the potential future of the project.
Has the project been successful so far?	The actual definition of success was not strictly defined at commencement.	26 GPs have been recruited for placement across 3 health board areas and should be in post from July 2019; this can be broadly termed a success. The project team have developed the capability to operate the programme and can manage further recruitment and placing with current resources. The effect on patient care in the communities concern has not yet been able to be established. As a pilot, the project is providing lessons learned for future initiatives to address GP vacancies.

6. <u>Recommendations</u>

1) Completion of evaluation of Phase 1 needs to be undertaken (2019/20).
Preparation of evaluation forms for GP candidates coming into placement in July 2019 is required to enable evaluation of phase 1b and capturing the GPs initial expectations.
Changes in patient or community satisfaction or expectations needs to be captured.

2) Establish a reporting template/dashboard for where the recruitment process currently is at, at any given point – a suggested model is included as Appendix A below for comment and consideration.

3) Strategic Options for an expansion to the programme need to be considered – this will mean exploring different business models for undertaking a larger recruitment, matching and quality control process over a wider geographical area and/or involving other professions. The capacity of the HR Hub model arrangements, management arrangements and BASICs support capacity need to be considered.

4) The management arrangements for the project need to be reviewed to enable more agile informed decision making and dissemination of information.

5) The future arrangements with NHS Highland practices need to be reviewed and may need communication channels and dedicated time put in place. The level of dialog and awareness of the Joy needs to be raised.

6) Any initiative towards international recruitment of GPs needs preliminary research to highlight the likely issues.

7. Suggested Template Dashboard – For Monthly or quarterly reporting

The model has been developed by the HR Hub team based on candidate flows since February 2019 and has been designed to consider ease of updating;

(See Appendix A)

CONSIDERATIONS/IMPLICATIONS FOR AN EXPANDED PROGRAMME

The following factors will be relevant in any aspirations to expand the scheme;

Issue	Nature of the Problem	Comment and any lessons from The Joy Phase 1?
Market forecast	How many short term placement GPs can actually be recruited?	Market demand is difficult to assess and though The Joy was very successful against, generally, low expectations it is difficult to see what the demand would be for say, a pan Scotland programme. The Highlands and Islands have some great attractant lifestyle, tourist attraction and outdoors features, this may not work as well for other rural areas in Scotland, particularly those not so remote without tourist or lifestyle attractions and with higher levels of depravation.
Capacity of the Hub	How much activity can the current Hub model cope with?	The hub has more capacity for an expanded programme now the initial process setting workload has been settled. Future work will be more around practice booking, matching and covering the system one off issues of GP administrational support. The current 2 dedicated Hub staff are engaged on an 18 month contract and so this will also need to be considered for the period after August 2020. Estimates are that now the legal and procedural administration is fully in place, the hub could take on a lot more work (certainly double) but there are further considerations if the present approach is rolled out to other MDT professions (see below)
Other Hub models	What models could be created to fulfil demand across Scotland?	The options for GP placement systems are generally; 1) An expanded single hub to cover the whole of Scotland or ; 2) Diverse, perhaps regional hubs. Primary care arrangements across Scotland are diverse and rooted in traditional community arrangements and geography. Expansion of the current Shetland based hub may be possible in simple terms of recruitment processing – accommodating the needs of a pan Scotland project but, it would be necessary for the team to gain a good comprehension of arrangements in other rural areas in Scotland and this will be a challenge. Also NHS Shetland would be taking on a larger number of employment contracts of GPs not necessarily employed or connected with Shetland itself. This may be problematic in terms of HR management, the clinical governance risk and medical director workload. Regional hubs covering geographical boards (suggested Dumfries& Galloway/ Borders, Ayrshire & Arran/ Lanarkshire, Grampian/Tayside) may be a solution but makes the whole arrangement considerably more complex and requiring additional management input to control. In this instance the Shetland Hub could be provide professional support and experience rather than management time. Health boards would have to collaborate over sharing risk and workloads in more complex arrangements. There are also possibly existing schemes that could be amalgamated with the Joy model this needs to be established. Another risk could also be that hubs get set up at cost but the GP take up remains poor with the hubs under employed. There cannot

		be an assumption that success under the current 4 health board pilot project can be replicated.
Capacity for Cohort Building	What is the capacity for Cohort building? How much medical director time and effort will be required, what resources and support will be required?	Cohort building has been a key aim of the current Joy project and will hopefully become a prominent feature and success. What medical director and other GP support resources need to be put in place for an expanded scheme? This will depend on the volume of recruitment of placement GPs. Again, is there a risk if recruitment to other rural areas is not successful?
Capacity for management and good clinical governance	Can a good, pan Scotland model be developed and what resources will it require?	What overarching clinical governance controls need to be put in place and resourced for an expanded scheme? This may require the input of national clinical leads. The current project is certainly manageable by the 3 island health boards but the capacity to manage a Scotland wide programme is unknown and would need to be researched as part of any business case.
Technical support	Supporting infrastructure will be required	Principally; a) An expanded hub would be able to make use of a more software efficient rostering system for GP placement management, piloting software is being currently considered at NHS Shetland. b) Team expansion will possibly require more office space particularly if more hubs are developed. This will also have implications for other HR departments. c) Clinical support for the hub will be greatly enhanced by adoption of Video Conference software. This may be problematic given the poor broadband connectivity of rural areas, but the issue requires investigation.
BASICS Capacity	Capacity is constrained. How can it be expanded in the short term (12 months)? Or Longer term? Can it be substituted in another way?	The BASICS team cannot easily expand capacity. Some extras funding can perhaps pay for another course in 2019/20 but the permanently expand BASICs they will need resources and time to `train the trainer' and some guarantee of financial commitment that an expanded Joy project can continue to make that worthwhile managing their risks. The BASICs organisation is unlikely to enter into initiatives to expand their capacity until they can see a sustainable future model is possible. The cost of providing standardised emergency equipment for participating practices may also be an issue. This will require extra funding and may make GMS practices less willing to join the project.
Dilution	Expansion of the Joy may mean dilution, long term, of the demand to work in the initial The Joy project areas (The Islands), it could also mean transferring the problem of GP shortages to urban areas.	There are consequences that can be inferred if the project is successful, some unintended. Suggested issues are ; a) Expansion of the scheme runs into the law of diminishing returns and the marginal ability to recruit placement GPs declines the wider the scheme goes. b) Practices in urban areas may suffer if they lose GPs or regular locums to the Joy. c) GMS practices set up their own competing project. d) Better GP cover highlights shortages in other MDT professions. e) There are tensions between areas that can recruit and those that can't.
Control and governance	For more dispersed recruitment models and hub	For dispersed models greater emphasis and resource needs to put into the management aspects. This may mean the creation of co-

	arrangements, what would be the most effective and efficient management and governance arrangement?	ordinating posts to achieve this and a balance struck between adequate control, agility and remaining efficient. The clinical management and risk needs be shared equitably between medical directors as well as having a robust and accountable framework in place that will work across multiple health board areas.
Funding	The initial project has had the benefit of funding from the Scottish Government, how much would be required to facilitate expanded model options?	Any further project expansion would require funding support in the short term to enable recruitment of key staff and support medical directors. The actual funding sought will be related to the business model options and these will require more robust options analysis than is possible here. Though Scottish Government funding can be sought for a one off pilot development, the longer term funding arrangements need to be presented as a business case to make clear how the final model can be made sustainable.
Ability of Health Boards to collaborate	Health boards have different culture, management, personalities and geography. How can working together effectively be facilitated on an expanded model?	This point is challenging, but Health Boards are driven by the serious service provision risks of GP and other key professions shortages as well as more strategic SG pledge to recruit 800 GPs over the next decade. A devolved hub model may be easier for the health boards to manage more straightforward bi-lateral relationship models with other health boards. Their disposition towards the project needs to be sounded out and an understanding of what other, similar, schemes are in place elsewhere (including the rest of the UK?)
Ability and appetite of Health Boards to re design remote and rural services	Primary Care Rural Service re design may be necessary in some areas, how can this be achieved and what initiatives are happening currently?	The argument here is that the, probably ,sustainable solution is longer term redesign of rural healthcare services and may have gone beyond simply finding a way to plug GP gaps even if the Joy has found a way to create some measure of success. The GP short placement solution may only be a stop gap while a more vigorous redesigns need to be considered.
Multi-Disciplinary Teams (MDT) - Integration	A whole system approach would mean that the Joy model may not be the most optimal solution and solving the GP issue alone may not solve the problem of how to integrate other professions and their shortages.	The Joy, so far, has been focused on recruitment and placement of GPs and it is hoped that the evaluation of Phase 1b considers more the integration of the GPs into the respective MDT's. This can consider how well the GPs fit and how well they can energise teams around them as well as assessing what support and issues are involved.
International Recruitment	There are issues on how to bring GPs quickly into the Scottish system and issues to consider of; a) Immigration arrangements for GP and family. Brexit problems? b) Professional Return to Practice requirements and suitability of existing training, qualifications and	The international opportunity will need a separate paper and further research to discuss the benefits, costs and risks. This is a complex issue.

	clinical skills c) Language and other cultural issues.	
Multi-Disciplinary Teams (MDT) – Recruitment of Other Professionals	If the Hub expands to a regional Scottish scale ,are there other professions with serious post vacancies that can be considered?	Some team members are cognisant of the fact that the pilot has potential for recruitment in other critical areas (eg Pharmacists, mental health professions, Advance Nurse Practitioners etc). This could also be considered but the resources required may be very significant in terms of engaging the support of the relevant clinical professional leads. The current model is only set up for GPs and Hub staff have good knowledge of GP administration, but to develop other professions, relevant professional leads would have to dedicate time. This would require an enlarged and different project team to include the relevant clinical leads and specific service managers. The increased complexity of involving other professions should not be under estimated and perhaps, neither should the possible benefits, but the exercise would require dedicated management resource to plan the options, risks and requirements. This is currently well beyond the scope of the current team (& SRMC).
Reputational Risks	Reputational risk can destabilise a project.	Expansion of the project in whatever model or profession will require support of the Scottish Government Primary Care Unit. There will be opinions from health boards and politicians that will influence future decision making but clear that the Joy Phase 1 could draw adverse publicity if some aspects are not successful. A programme that fills GP gaps in rural areas will gain national and pan UK profile and the project team will need to manage expectations by consciously controlling external communication and perhaps considering a media plan.. Robust evaluation should help.
Relationship with SRMC	The role of the SRMC has not so far been considered. Does the Joy need to be brought under the SRMC `Bureau' aspiration?	The Bureau could be a more natural umbrella under which the future project arrangements could work, relieving health boards or the Joy project team, of some of the burden and levelling standards across Scotland enabling full use of marketing expertise. SRMC have number of connections with other agencies, support, knowledge and a more holistic view of the situation across Scotland.
What is it that the Joy of GP Project has not revealed?	What is it that we don't know?	The Joy has so far concentrated on recruiting GPs for placements and putting into place all the administration necessary to support that process. Placements have not commenced yet and evaluation needs to capture lessons as part of Phase 1b. Also bear in mind that the scope of The Joy is limited to rural GP recruitment, it may work a lot differently with other professions and in different geographical areas.

8. <u>Methodology employed for Phase 1a evaluation</u>

This brief evaluation primarily used the following methods;

Analysis of;

The lists of candidates recruited by the scheme and those for interview and placement
Evaluation materials from the recruitment weekend and the evaluation report (Appendix B)
Application for a bid for Scottish Government Funding and summary of spend to date

NHS Shetland contract of employment and examples of offer of employment.
Copies of presentations by Medical Director (NHS Western Isles) and Scottish Government GP Advisor on the current state of GP vacancies in the island health boards and on the Orkney Isles model of care (from 2018)
BMJ advert

Structured interviews;

With 7 key professionals involved in the management of the Joy team including 3 medical directors, director of HR at NHS Shetland and the 3 HR Hub staff. The interviews were around 1 hour long and followed in time sequence the development of the project. Interviewees were given general questions and questions related to their role. They were not given detailed feedback on what other interviewees had said. So far there has been no discussion with staff at NHS Highland.

Thanks

I would like to thank all those that gave their time for a frank discussion of the project and the issues. All staff have been positive about the project and are proud of its success so far and this should be recognised. A lot of people have put a lot of hard work in to make the project work so far.

Any errors or omissions are all mine.

David Priest

SRMC June 2019

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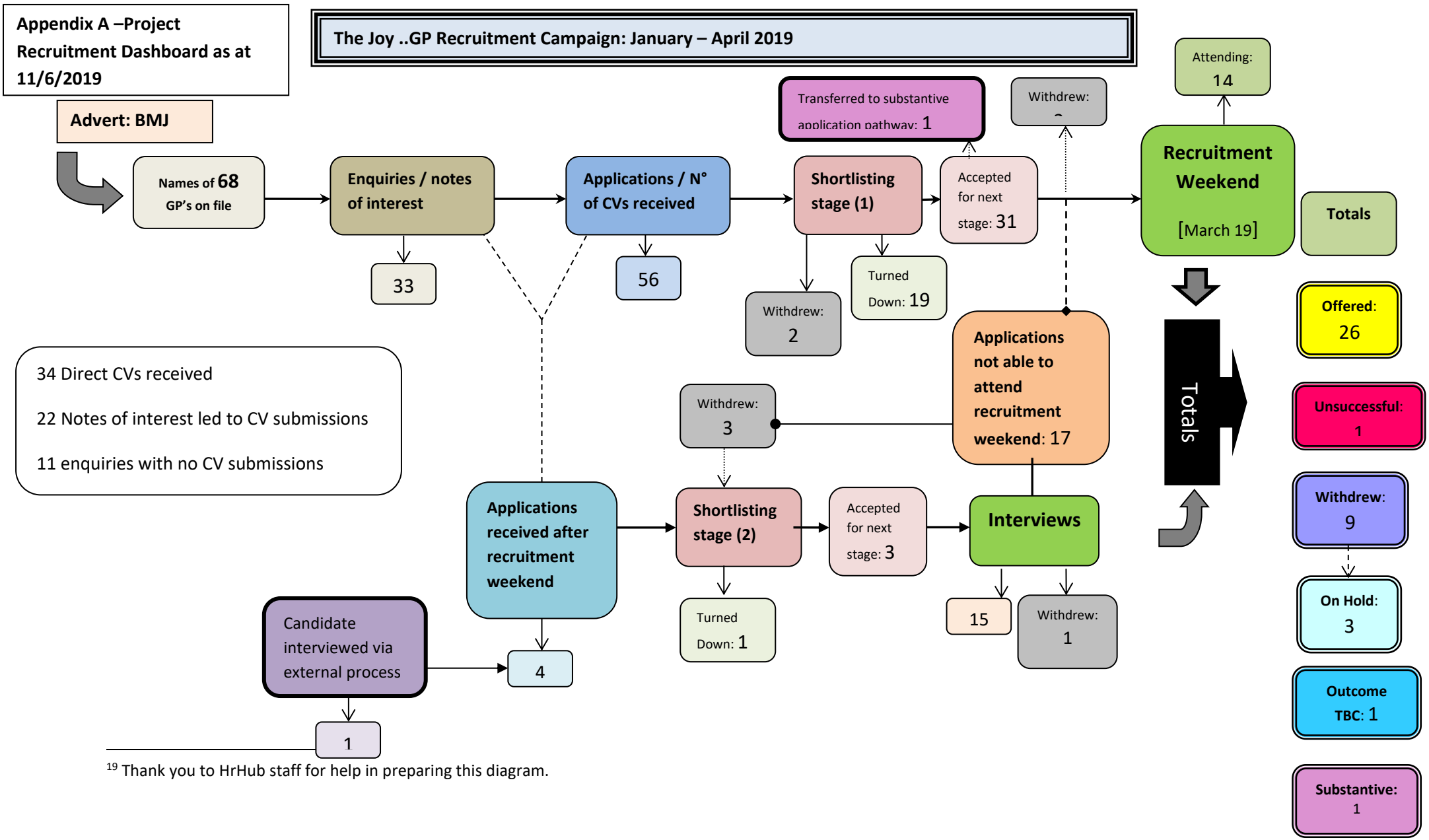
Appendix A –Project Recruitment Dashboard as at 11/6/2019



[19] Thank you to HrHub staff for help in preparing this diagram.

Appendix B: Evaluation Feedback from Recruitment Weekend (March 2019)

March 2019

GP Hub Recruitment Process - Evaluation Form COLLATED ANSWERS

14 forms sent out (10 returned & collated up to 26/04/2019)

How candidates heard about the job:					
BMJ advert	9	Friend/colleague	2	Social Media	

Themes about the job advert:
Flexibility of working times Working environment / Location Positive nature/willingness to invest Opportunity to try working in remote and rural Scotland Professional looking advert / the picture / romantic H&I Recruitment weekend to get to know each other / promise of a 'team' Something different Suitable for peri-retirement zone individuals / consideration of older GPs Provision of accommodation

What prompted candidates to find out more:
• Later career options. • Exploring living and working in Scotland. • The Scottish GP contract. • Possibility of the job and the possibilities of the roles. • Re-practice increasingly superfluous skills. • Conversations with current Shetland GP and administration staff. • Weekend in Inverness. • The ad was very informative. • Being able to travel to Scotland. • Find out more in person - get a feel for the culture of the organisation. • Essentially it was the right timing for me. • RCPG conference: One of my partners had visited your stand – he knew that I might be interested. • Looked like a post that I would enjoy. • I have always found rural medicine appealing. • Ideal opportunity as now salaried and children away at University. • February (always the worst month) in General Practice in Plymouth and a feeling that I will burn out if I have to do this much longer. • The advert had my dream on a plate. • I thought that even if I couldn't start immediately, I could start the ball rolling for the future. • The timing is right (for personal and family reasons) and the place is right. • That feeling of "Push that door and see if it opens."
What additional things would be useful in the advert?
• Some links to videos/bios of current GPs working there? • A link to a job description to help us shape our CVs and letters? • Be good to have a website which provides more information about the Hrhub and the various boards and opportunities. • Details of practices with vacancies to allow me to research practice profiles. • Might need to bullet point or title the paragraphs in a future advert, to emphasise the strong team building from the start and the 'organised' BASICS course for the group. The recruitment weekend also needs to be emphasised as 'residential'.
If you spoke to someone before submitting an application, what did you find helpful about it?
• Lisa and Sue: Both very welcoming and encouraging, making it clear it was fine to come back with questions as we thought of them.

• Understanding how the job(s) would be designed; the flexibility, etc. • I find the Hub team incredibly helpful when I corresponded by email about the logistics of attending for the assessment weekend.

For future reference, please indicate whether you would you like to receive: (please tick one)	
A) More contact/support from the Hub Team	2
B) Less contact/support from the Hub Team	
C) The same amount of contact/support from the Hub Team	8

How accessible was the location of our event for you to attend? (please tick all that apply)					
Relatively central within the Highlands & Islands area	9	Close to one of the main Scottish cities	4	Other	
Close to transport links (airport, train etc.)	6	If other, please comment: • It was a great location-no point in having it further south as candidates need to have realistic idea of what sorts of distances are involved. I'm glad you didn't choose Inverness itself as this is not representative of the region as a whole. It's easy enough for everyone to get to in a long weekend but also far enough to make candidates think about the practicalities of just getting to the Gateway to the rest of the region. • You were so kind in organising and funding personalised airport pickup and transport back. This made me feel very valued and that you really want this initiative to work. I had fully expected to have to make my own way to Strathpeffer and had looked up buses etc.			

How suitable did you feel the hotel was as a venue for our event? (please tick)					
Excellent	5	Good	3	Other	
Acceptable	2	If other, please comment: • I am sure you can find slightly more inspiring locations, which capture what it is like to be in Scotland. Does not have to be a hotel necessarily. • I liked the fact that there was so much space. The event could have felt quite claustrophobic otherwise. • Not sure! – I imagine there were certain budgetary constraints! • It was a slightly creaky old hotel but not stupidly opulent or tediously functional and had the necessary meeting rooms so I think you chose well!			

Would you recommend using this hotel again? (please tick)	Yes	6	No	1

There were 4 presentations at the event about health board areas. Did you feel that these provided you with adequate information about these areas? **(please tick)**

Western Isles	Yes	10	No	
Highland	Yes	10	No	
Orkney	Yes	10	No	
Shetland	Yes	10	No	

Comments & Suggestions:

- Would be helpful to have the slides circulated as reference to read again and capture the information in full.
- All speakers did well in conveying this information in their own way.
- The presentations were very different but were all stimulating. I got the impression that Orkney did not have a particular staffing problem just now, other than unexpected cover which led me to placing it last in my choices.

- All presentations were very useful, good opportunity to get a flavour for each area and to ask questions.
- I thought we got a good and realistic picture of each of the 4 areas.
- All presentations valuable and demonstrated relative similarities and differences
- But perhaps I won't know until I get there!

Did you enjoy the group discussion format? (please tick)	**Yes**	10	**No**	1

If not, why not?

- Yes and No. I think it was a necessary 'evil'. My hearing makes this challenging and I'm not normally one for big groups, but I thought it probably achieved an aim and it was good to get to know the other candidates through these sessions.
- The initial individual's presentations were very powerful and helpful, the group discussion after the case scenario was good. It was strange to have someone watching us during the group discussions at times.
- Once I got used to this model I found it stimulating but as ever the competition element was there, and some people dominated whilst others maybe did not get to say as much.
- It was much more fun than formal interviews. I can imagine it was a nightmare to evaluate insofar as you need to have robust documentation to show you have treated us all evenly and in the event of someone complaining that they were not recruited etc, but it helped us get to know one another and I'm sure you got a better sense of us than in a more stilted face to face interview.

If you were going through this recruitment process another time, would you prefer the continuous assessment model that we used or a traditional interview format?

- This was innovative way of assessing and provided you with feedback and information, and was enjoyable. Would not mind an element of slightly more formative assessment e.g. online module.

- In some ways the fact that it was a 24 hour session made it less pressurised as I felt you were looking at the people in general rather than looking for stock answers to stock questions in the very anxiety provoking situation of a face to face interview. Furthermore this allowed us to really reflect and ask questions in a comfortable way as

they arose rather than having standard questions to add to the end of the interview simply to show you care, as is often the case.
I have not had an interview for many many years and this was MUCH better than expected. (I don't know what you thought about me though and would be interested to know the results of your assessments). Finally this format gave us an opportunity to bond as a group which I think will prove really useful in the months, and hopefully years, to come.

- I think the continuous assessment model is probably better, I think that in trying to attract older GPs, many of whom may not have had an interview for decades, they could be more uncomfortable with a traditional interview. Neither will necessarily tell you if we are all suited to the work, but it could pick out people clearly unsuited.

- Maybe a bit of both? Continuous assessment good method, but maybe would have been nice to have some one-to-one time as well, as would be nice to have a discussion relevant to your own circumstances.

- I think continuous assessment is good for quiet philosophical types such as myself who like to listen first before contributing. Everybody looked good after a while together.

- I would be happy with either model; however the strength of the format you used was important in terms of giving us information, allowing us to ask questions and allowing us to meet each other and make new connections.

- I thought that this was an excellent recruitment process and I was very impressed by the concept. It was a very practical way of getting a group of colleagues to bond together in a relatively low stress environment. It also simultaneously allowed mutual assessment, 2-way information gathering, project design, good quality education and enjoyment in a lovely setting. It would be hard to see how fitting individual interviews into this setting would work – I think it would be more threatening and disrupt the whole flow of the weekend. My only criticism would be that the 'joy' of the process might be dampened if some of the candidates were not successful and this needs to be factored in. The key is in the short listing, I think.

- Continuous model: more relaxed and good to meet others.

- I think this model provided all parties with insight into each other's personality, it was very useful for applicants as we were able to see who we would be likely to be working with, not usually a feature of traditional interviews.

- Continuous assessment model – more fun and probably allows you a better understanding of the candidates.

Comments or suggestions to improve the programme:

- A lot of the presentations were information giving – this could have been provided beforehand as slides to read and understand and then we could have had bit more Q&A. Maybe have a few more GPs from each area to be available for questions?

- When we had the round table discussions it would have been helpful to have had something with the question written on as we kept having to ask the question again to make sure we were answering it properly.
  Some people were quite dominant in the discussion and that squeezed others out. Maybe that's just life? It would be good to know whether we actually will get a position for sure or whether it is dependent on other factors (e.g. passing the BASICS course, passing occupational health etc, etc.) and also would be good to have some kind of time scale of when we should be able to expect to hear more. I know other people will be interested if other roles come up. My peer support group were round last week and found I had a large map of the Western Isles on my wall. Cue a detailed series of questions. They had almost all seen the ads and were to a man interested. The flexibility yet certainty of employment is very attractive to a lot of people coming towards the stage of leaving practice.

- I felt the written case was somewhat patronising; it was bread and butter general practice in many respects. The discussion after was very good. I understand that there had to be some method of measurement and assessment which was probably the reason it was chosen. As I said at an earlier time, I think that highlighting the success of this process and the outcomes will be important particularly to try to attract GPs in the later parts of their careers, before they switch off completely. It is likely that the UK will be short of GPs for the next decade, so all areas will need to try to keep older GPs working by removing some of the stresses, or making opportunities such as this more attractive.

- Excellent weekend, thoroughly enjoyed it!! Everyone very friendly and welcoming. The only suggestion is maybe a bit more information on pay – e.g., some examples of how pay will work depending on the different jobs/working patterns, as still not completely clear on that.

- Can't imagine that it could have been better. We all knew where we stood before the close of the event.
- I have been really impressed so far with the level of organisation, the level of flexibility and the way in which you have made me feel like I would be a very valued member of the workforce. It has definitely added to my desire to come and work with you.

- It would be very helpful if candidates got a certificate of attendance outlining the programme so that they could use this as evidence for their appraisals. I don't think it needs any formal educational approval as candidates will just use the certificate as a starting point for reflection.

- ? extend to ANP recruitment.

- I know that I was surprised at the emphasis on growing our own team and almost on looking for leadership for this on Day 1. I was not prepared for that and wonder if you might have given stronger hints in the information after shortlisting (or maybe I just completely failed to pick up on the signals...). It felt like this was an exploratory weekend for me and I was not yet ready to stick a head above the parapet towards leadership while still very much feeling my way into a new venture.

Suggestions for the Hub to Action:

Facebook Page / Website:

- Short videos/bios of current GPs
- A link to a job description
- Information about the Hrhub and the various boards and opportunities
- Details of practices with vacancies
- Circulate the presentation slides as reference for candidates to read again

Certificate of Attendance at Recruitment Event:

- Certificate of attendance outlining the programme that can be used as evidence for appraisals

Feedback Comments

...thank you for a wonderful few days. It was a well organised and, yes, joyful experience. HW (March 2019, Strathpeffer, Scotland)

We thoroughly enjoyed the weekend and it has given me something new to look forward to! JR (March 2019, Strathpeffer, Scotland)

Thank you for such a brilliant weekend...definitely got the thought processes going ....hope it's a gorgeous morning on Shetland ... look forward to hearing from you x HW (March 2019, Strathpeffer, Scotland)

I had a great weekend...was really good to meet you all and hear about all the amazing opportunities. Thank you all for going to so much trouble. LD (March 2019, Strathpeffer, Scotland)

*It was an excellent, productive and fun weekend...Once again thanks for all your hospitality and making us all feel part of a team. Look forward to hearing more soon. PG (*March 2019, Strathpeffer, Scotland)

*Thank you for the weekend. It was definitely interesting. I was seriously impressed by the energy and enthusiasm of the weekend, by the other candidates and by the model you seem to be proposing. AG (*March 2019, Strathpeffer, Scotland).

Appendix C: Original Rediscover the Joy Project Plan, December 2018

Rediscover the Joy of Holistic Rural General Practice Project Plan

Project Overview

This is a collaborative pilot project between NHS Shetland, Western Isles, Orkney and Highland, with support from the Scottish Rural Medicine Collaborative (SRMC), to recruit to vacant substantive posts (employing a tried and tested model of GP staffing) and to develop a Rural GP Support Team to provide high quality GP locums to rural practices. This 18-month project is a test of change, which if successful, will be expanded to support all Scottish Rural Practices. The Scottish Government has provided £180,000 of funding to support the project.

Situation

GP recruitment to substantive posts in remote and rural areas is challenging.

- Remote and Rural practices struggle to engage both substantive GPs and short term locums to cover planned leave.
- The ability to cover unplanned leave, especially in single handed practices, is especially difficult.
- Models of working where practitioners provide 2-4 week blocks of single-handed 24/7 cover in remote practice, in rotation with consistent colleagues, has proved popular.

Background

- The provision of rural General Medical Services requires experienced GPs with a broad skill set and the ability to manage the full spectrum of medical presentations, usually working with only a small support team and sometimes in isolation. Rural GPs need to provide emergency care to acutely sick and injured patients, often for a number of hours before retrieval services arrive. They also need to manage a higher degree of uncertainty in the community.
- Rural practice typically allows more time for practitioners to spend with their patients, but due to a smaller MDT and lack of easy access to secondary care, the role of rural practitioners is significantly broader than urban counterparts and often requires the provision of more complex and time consuming care in the community.
- The provision of emergency care is a significant anxiety to most practitioners when considering working in remote and rural areas.
- Rural practitioners derive significant job satisfaction from providing holistic care to their patients within their community.
- Many GPs describe symptoms of burnout as the intensity and complexity of their daily workload continues to increase. Time pressures and complexity of care make it increasingly difficult for practitioners to address all the needs of their patients.
- Some GPs feel unable to continue working at their current intensity and are taking early retirement. These GPs are then lost to the NHS.
- At the RCGP Annual Conference October 2018, SRMC asked GPs in their 50's about their views on a scheme where:
    - GPs considering retirement were supported to work in rural areas for 12-18 weeks/year
    - They would receive training from BASICS Scotland in emergency care
    - All practices would have emergency equipment set out in a standardised manner and GPs would have access to ScotSTAR Consultant support for emergency care

    - They would be supported to gain necessary evidence for appraisal and assigned a Responsible Officer, if required, to allow continued revalidation
    - There was universal enthusiasm for the scheme
- In October 2018, NHS Orkney advertised 3 Island GP posts for 12 and 16 weeks/year. There was a lot of interest in the posts, resulting in 12 applications. 10 were from GPs in the 50's and early 60's. High quality GPs were successfully recruited to all three posts. Since 2015 NHS Orkney has successfully recruited to all GP and ANP outer island posts using this model. (See Appendix 1: ***Orkney Isles Network of Care Case Study*** for a brief description.)

Components of the Project

Human Resources Management

The HR Hub's remit is to support the attraction, recruitment and relationship management of GPs interested in working in remote, rural and island settings and to set up the necessary systems and processes that can then be stepped up and potentially utilised in the future within a 'Recruitment Bureau' concept . The pilot will therefore test the success of attracting and retaining GPs. The HR Hub will consist of the Director of HR and Support Services from NHS Shetland (Lorraine Hall) to ensure that the agreed objectives are being met and to manage the overall pilot; including reporting and feedback to all parties and the sharing of learning. This will enable agile changes to be made to ensure success. Lorraine will link in with Martine Scott the SRMC Programme Manager to ensure that appropriate synergies are being made with the work of the SRMC. A Recruitment/Relationship Manager, along with a Recruitment Co-Ordinator will be recruited on a fixed term basis for the 18month duration of the pilot. There will be opportunity to extend, should the pilot be successful and rolled out further. (Please note that should this happen, a matrix approach can be taken). NHS Shetland, as part of their commitment to the pilot will provide office accommodation and equipment for the Hub.

Effective management and delivery of recruitment and resourcing activity will be key to success. The HR Hub's mission will be to simplify the recruitment process for Health Boards (HBs), GP practices and candidates alike, to make the process of attracting and recruiting staff as seamless as possible and to act as a conduit to all parties.

Along with attracting staff, the recruitment process will include (in partnership with the relevant HB/GP Practice) the offer of employment, a confidential occupational health questionnaire and Disclosure Scotland. Payment for Disclosure will come from the employing HB/GP Practice. The HR Hub will organise and collate references, before sharing them with the employing HB/GP Practice. The HR Hub will also ensure appointees are entered onto the relevant Performers List and ensure that they are engaged into the appraisal system.

When recruiting to the Rural GP Support Team (see below) short listing, interviewing and appointment will be undertaken by one representative from each HB. Close working and timely decision making will be key to success.

The HR Hub will look to recruit via Recruitment campaigns to:

Recruitment for Substantive positions

The recruitment campaign will offer the opportunity for GPs to take up vacant substantive posts within the participating HBs. Should a GP be interested in working in another H B area then the HR

Hub will work to match them to a post within that HB. Once appointed to a substantive post the relevant HB/GP Practice would then take over the HR functions of the appointment. The HR Hub will continue to support the individual GP into post and beyond to ensure that the placement is considered a success by all parties.

Creating a Rural Practice Support Team

The objective is to provide a highly motivated, mutually supportive team of experienced GP to provide locum services to rural practices. The service will expect individual team members to be fully involved in the day to day running of the practices they serve; engaging in administrative functions, quality improvement activity, staff and student training; in addition to undertaking the full range of clinical work required.

In return, appointed GPs will:

- Receive a contract for 12-18 weeks of clinical commitment each year. This contract will attract annual and study leave. Longer contracts could be provided, if required.
    - The contract will ask for a minimum of 2 weeks/year of cover to any practice at very short notice. This is designed to provide a pool of potential availability to cover sick leave etc.
- Be provided with placements to rural practices, typically lasting 1-3 weeks. This could be to a series of different practices across the 4 HBs or to one of a more limited range of practices, depending on GP preference. If the scheme recruits a large number of GPs, placements within other HBs will be offered.
- Be enrolled on the Performers List and assigned a Responsible Officer, if required.
- Be provided with BASICS Scotland training at the outset and enrolled on the BASICS Scotland Portfolio Project.
    - Practices wishing to utilise the Rural Practice Support Team will be required to provide standardised emergency equipment and drugs, set out in a proscribed manner and to utilise an agreed set of emergency care protocols.
- Have the support of practices to help them collect necessary data (audits, patient feedback etc.) required for their annual appraisal.
- Receive standardised feedback from each practice, which will also be sent to the HR Hub and utilised to support quality control. Unsatisfactory feedback will be passed on to a senior manager or clinician within the practice's HB and actively managed. Following resolution, a report will be returned to the HR Hub.
- Be asked to provide structured feedback to the practice, via the HR Hub.
- Be offered mentoring, provided through the Scottish Government funded mentoring scheme. By definition these GPs are experiencing a change in their circumstances and career. A BMA study has shown that mentoring can increase retention within the profession.
- Be part of geographically isolated, but digitally connected team. Team building will be created and maintained through:
    - A residential recruitment weekend near Inverness.
    - Undertaking BASICS training together at a specifically commissioned course.
    - Day to day communication opportunity through a WhatsApp group.
    - Weekly videoconference meeting to provide a forum for clinical governance, development, mutual education and support

Project Funding

Pump priming funding support has been provided by the Scottish Government as outlined in Appendix 2: *Rural Fund Bid. Rediscover the Joy of General Practice*.

Health Board Commitment

Participating HBs are asked to estimate their likely usage of the Rural GP Support Team and provide funding to support recruitment to that level. Funding might come from both HBs and independent GMS practices. HBs and practices will therefore contract with the HR Hub to utilise a certain amount of Rural GP Support Team time. However, if they under utilise the time contracted they will be reimbursed for the amount that is unused. As the HR Hub will be able to support any HB in Scotland, it is anticipated that any surplus capacity will always be utilised.

It is planned to have further discussions with Scottish Government around the possibility of "guarantor funding" to allow the recruitment of Rural GP Support Team members, over and above the number contracted by participating HBs. This will mean that if there is a good response to the recruitment campaign, good candidates will not be lost to NHS Scotland.

Standardised Emergency Care Provision

The provision of emergency care is an issue of great concern to both remote communities and the practitioners that serve them. Experienced urban GPs often have had little exposure to emergency care and concerns around the delivery often act as a significant deterrent to taking up a rural post.

To address this impediment, this project looks to establish a system of standardised emergency care (See Appendix 2: *Standardised Scottish System for Emergency Care*) built on:

- BASICS Scotland training through an initial 2½ day course and maintained through the BASICS Portfolio Project
- Standardised:
    - Emergency care protocols
    - Equipment (Sandpiper Bag)
    - Emergency drugs
- Real time remote consultant support from the ScotSTAR retrieval service

Successful applicants will therefore be enrolled on a commissioned BASICS course and the Portfolio Project.

Participating practices will need to provide standardised equipment, set out in the proscribed manner. This will allow members of the Rural GP Support Team to move between practices with confidence.

Appraisal and Revalidation

Successful applicants (who are not undertaking GP work in another HB) will be given the opportunity to be appraised and revalidated through one of the participating HBs. Allocation and support of the process will be provided by the HR Hub. Responsible Officers within participating HBs need to agree to taking on an appropriate share of GPs into their appraisal system.

Monitoring, Evaluation and Sharing the Learning

This project is closely linked with the SRMC bureau proposal dated August 2018 and is an ideal opportunity to carry out a test of change. It will provide an extended pool of candidates to develop a qualitative evaluation based on the IRAS methodology

https://www.myresearchproject.org.uk/ELearning/whatisIRAS.html

"*The Integrated Research Application System (IRAS)* is a single system for applying for the permissions and approvals for health and social care / community care research in the UK*

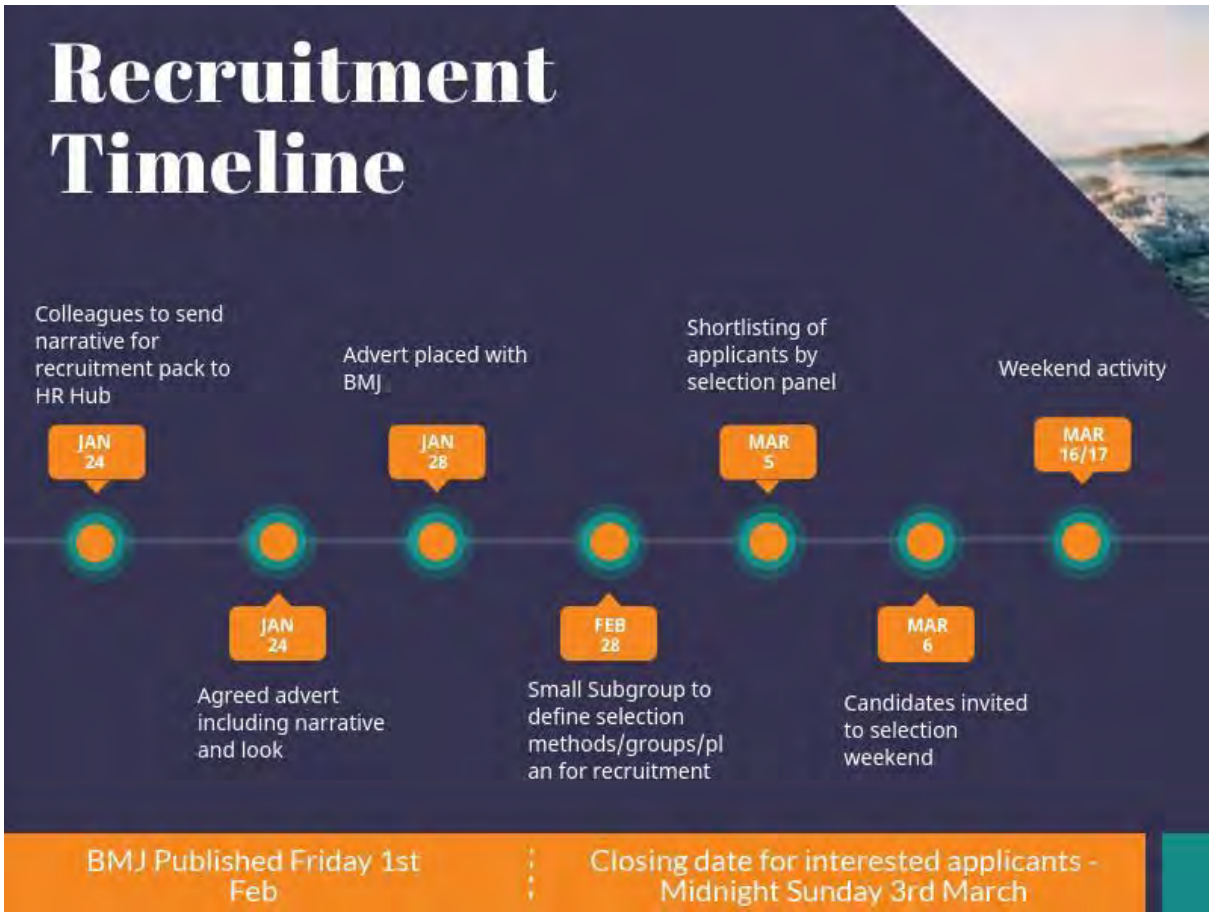
- *Enables you to enter the information about your project once instead of duplicating information in separate application forms*
- *Uses filters to ensure that the data collected and collated is appropriate to the type of study, and consequently the permissions and approvals required*
- *Helps you to meet regulatory and governance requirements*

Using an IRAS methodology has several advantages.

- It is an established portal /toolkit that will ensure that a UK nationally agreed systematic approach is followed.
- The output will obtain research approval for regulatory and governance purposes and will yield a credible body of evidence that can be used to publish academic articles in the future.
- This will involve SRMC obtaining qualitative and quantitative data directly from all involved.

In addition, SRMC and key project staff will co-produce a set of key performance indicators to monitor progress and direction of travel. Reviews will take place annually and reporting frequencies will need to align with SRMC programme quarterly reports.

Recruitment Timeline



Actions Required from Participating Health Boards

- Agreement to the principles set out in this project proposal by mid-January 2019.
- Agreement reached around standardised rate of pay by 31/12/18
- A commitment to financially support the recruitment of a specific WTE number of GPs by end January 2019.
- A commitment to provide appraisal to an appropriate proportion of Rural GP Support Team. Agreement about what constitutes a fair distribution of appraisal support by mid-January.

Charlie Siderfin
NHS Orkney

Lorraine Hall
NHS Shetland

Martine Scott
Scottish Rural Medicine Collaborative

17th December 2018

Appendix B.

Rediscover The Joy Evaluation - Interview Question Control

Version 3.0_Mar 2020				
IRAS ID :	*270115*			
Question Set	**Related Evaluation Area/ Issue**	**Primary Mandatory Questions**	**Supplementary Questions**	**Why this question?**
Amendments to Version 3.0				
20/03/2020				
Additions				
D1	*23*	*If the Joy gets bigger, will a different management structure be required?, what will need to change?*	*Broadly, what are the factors that need to be considered?*	*Points from several interviews, management of the Joy needs to be rationalised because it needs to provide better support and direction.*
	17	*Future critical factor - Does the Joy have to move on to longer term funding? What if this can't be agreed?*		*Brought up in other interviews, Joy cannot continue on current arrangement.*
	17	*If pitching for longer term funding, what benefits would a bigger Joy (by profession/ geography) be able to bring?*	*What would the sales pitch be?*	*Benefits for patients are long term, should provide stability for struggling practices, stability and make lives easier for MDTs, creates a platform for future developments*
	57	*You were included in the Joy management team later, has this addressed the skills balance and lack of capacity adequately?*		*Joy management team skills*
		Will the Joy will need a better online presence if it gets bigger? If so how can this be resourced?	*How effective is the SRMC website in supporting the Joy?*	*Profile and remote support will become bigger challenges.*
	59	*Is management burn out potentially still a problem?*		*Concern that management team getting overloaded.*
D1	*38*	*Management of the Joy not meeting regularly, how can this be addressed?*		*Problem late 2019, will it recur if clinicians/ directors too busy?*
	57	*How well has SRMC supported the Joy?*		*SRMC role sometimes low profile, how effective has the support been?*
	48	*Evaluation Requirement Requested*		*Clarify what participant thinks the scope is.*

	48	*a) Toolkit/ format for future evaluations*	*What would the toolkit be composed of?*	*Separate piece of work but can suggest a standard set of questions to be asked regularly at pre-determined intervals. Linked to ISO, NHS Scotland frameworks? How the Joy is seen by outside?*
	52	*b) Toolkit / format for other hubs*	*VAT problem*	*Contract framework/ placement framework by health board.*
	48	*c) Good practice guide*	*Good practice of what? To who? Could be a full time job?*	*Areas; Management of a project, placement system, how to look after Joy professionals, T&Cs points to consider, links to support, CG, clinical management, clinical guidelines and formularies, FAQs, Scottish Primary Care IT, referral guidelines*
	48	*d) Creating a charter*		*Separate piece of work*
	48	*e) Accountability, a roles and responsibilities model and governance framework in future.*	*Bit more than an evaluation, more development of a governance framework, needs definition of what is in and out of scope.*	*Separate piece of work, would need to understand the scope of the future Joy by profession/ by geography*
		Critical success factors of the Joy?	*Flexibility of GP contracts?*	*General feel for what is the key success factors behind the Joy.*
C11		*How could the Joy VC been better used?*		*C11 Question on how effective Joy VC was but is there a better way to use it?*
	9	*Is W&A the solution for practices with management, workload or other challenges?*		*Does this not lead back to the local health board plan?*
	18	*The Joy has not made connections with other local primary health care initiatives?*		*Point from a health board director, Joy doesn't seem to connect to local initiatives to improve primary care.*
	23	*Lessons from the way in which W&A was brought forward?*		*W&A project idea was a bit rushed in?*
	27	*One health board managing contracts and the hub - Critical success factor?*	*But is there too much strain or risk?*	*Risk to NHS Shetland*
	29/52	*VAT Issue - serious risk factor in dampening demand for Joy GPs from other health board GMS practices?*	*Does future Joy employment contract management need to be decentralised?*	*Is VAT a future risk factor?*
	55	*Is a success factor the fact that the Joy has been an Agile project?*		*Is Agile a success factor?*

C10	*37*	*How have arrangements for the clinical lead been developed?*		*Need for support of a Joy clinical need identified Aug 2019 and a job description agreed by Oct 2019 but funding might be a problem. How and why was this need assessed?*
Deletions				
Nil (0)				
Marketing Theme (A)				
A1	*Effective Marketing*	*Could marketing and promotion of the scheme for recruitment purposes been better?*	*Would it have been possible to improve marketing communication and how?*	*To see how effective the marketing efforts have been to recruit GPs and raise scheme profile. Efforts have been a BMJ advert, SRMC Website, v word of mouth, stands at key GP conferences*
A2	*Effective Marketing*	*Could marketing and promotion of the scheme generally been better to raise awareness within the health sector in Scotland?*		*Emphasis on promoting the scheme rather than attracting GPs. Any bright ideas? Could we have changed emphasis, more of something/ less of others?*
A3	*5*	*Are practices in the Highland Area aware of the Joy Scheme ?*	*Would it have been possible to improve marketing communication and how?*	*Test the issue that there is a slow take up or an acceptance problem in highland region*
A4	*5, 28*	*How effectively has it been promoted by the Joy Team within Highland?*		*Test the issue that the programme could have been promoted differently or more effectively in Highland. Concern from issues (5) that highland practices not taking up the scheme and Highland PC team considering better ways to communicate (28)*
A5	*11*	*How effective have the marketing promotional Videos been in attracting interest to the Joy scheme?*	*No. of views? Who has made reference to it?*	*Though the Videos should be a good idea, not sure that their effectiveness is being monitored/ considered. Not sure if there was good process behind agreement to make the Video (11).*
A6	*11*	*Has feedback on the Video been sought?*	*Were references to the video positive?*	*If there was any feedback, what did it say?*
A7	*24*	*Did the Joy GPs realise that some practices had workload and other challenges?*	*Were there problems?*	*Marketing problem as GPs are being attracted by word of mouth, they might not be getting the Joy?*
A8	*Effective Marketing*	*Where did you first hear about the Joy Scheme?*	*Could we have marketed/ promoted it more effectively? How?*	*How are potential GPs finding out? What is our best channel for recruitment?*

A9	*Effective Marketing*	*Why were you attracted to apply?*	*Is the Joy an effective Brand?*	*What are particular attractants, the location, outdoors, connecting with patients, being part of a supportive team, doing something different? - Useful to think about marketing mix.*
A10	*Effective Marketing*	*Marketing Budget - Has it been adequate?*	*Why?*	*Have we been spending enough on marketing? Should we have accelerated it?*
A11	*Effective Marketing*	*Has there ever been a review of how the marketing has been done or the marketing budget?*	*If yes, what was agreed?*	*Test that the marketing mix and spend is getting reviewed and improved?*
A12	*Effective Marketing*	*Has a key success factor with the Joy the ability to provide flexible contracts to suit both GPs and Practices? Is it as simple as that?*		*Clear that what is attracting Joy GPs is*
Induction and Recruitment Theme (B)				
B1	*Effective Marketing & Recruitment*	*Have adequate numbers of Joy GPs been recruited in a timely fashion?*	*How does this compare to your original expectations?*	*Tests original, current and possibly future expectations on what the scheme is capable of providing.*
B2	*2, 3, 22, 25*	*Have recruited Joy GPs been given a good induction?*	*What is the evidence?*	*Issues raised that induction patchy depending on the practice, this has been known about since July 2019 so aim is to find out what has been done and how well the Joy team are looking at quality issues.*
	2, 3, 22, 25	*Induction issues were reported by Joy GPs in several practices, were you aware?*	*What has been done to improve the situation in future?*	
	2, 3, 22, 25	*If so, what were the nature of the problems? Where they minor or more significant?*	*Is it better now?*	
	2, 3, 22, 25		*What work has been done to improve induction packs?*	*A core induction pack was worked on in Shetland early 2019) and there may have been other work, what happened?*
B3	*Effective Marketing & Recruitment*	*The idea of a Video made to help induct GPs with H&I IT - GP VC # 6 (26/9/2019) - Has anything been considered?*		*Was reported to Joy Management after VC, but are they acting or considering actions and improvements? Also issue (22)*
B4	*4, 43*	*There are references to potential Joy GPs becoming frustrated with the recruitment process, were you aware that there has been an issue?*	*If there was a problem, what steps have been taken to solve them?*	*2 reports (4) (43) but also anecdotal evidence May - July 2019 that pre job offer GPs were feeling left out of loop and not hearing anything, discussed also under Phase 1a evaluation*

	4, 43	*What have the problems been?*	*Was there an expectations problem from the GPs point of view?*	
B5	*Effective Recruitment*	*Were the salaries, terms and conditions of employment a barrier to recruitment of Joy GPs?*	*If so, how could they have been improved?*	*Test out assumption that agreed salaries T&C were attractive enough, does this issue require further scrutiny?*
	Effective Recruitment		*Were any other factors a barrier?*	
B6	*Effective Recruitment*	*What were the challenges in setting pay, terms & conditions for Joy GPs?*	*Cars, travel & accommodation?*	*Are we sure that pay, employment T&C are adequate to attract and retain Joy GPs? Issues around this mid 2019 (8)*
B7	*Effective Recruitment*		*Introduction of GP time sheets - is it a problem on retention or recruitment?*	*Issue raised Dec 2019 , not sure if it is a serious problem*
B8	*1,2, 9*	*Is there a problem with Joy GPs having high expectations for working in the H&I but being disappointed and unsupported when they start work?*		*Issues raised early on that practices don't understand that the Joy GP's are different to locums, poor inductions and less support in terms of IT and quality systems around them.*
Approach to Clinical Governance (C)				
C1	*Effective Clinical Governance*	*Do you feel that clinical governance/ management arrangements are robust enough regarding the Joy project?*	*If not, what are the risks and how could they be improved?*	*Clear view of the perception of effectiveness of CG arrangements. Also a test of professional opinion and that accountability understood CS, DM, KB, PD.*
C2	*Effective Clinical Governance*	*Could they be improved and how?*		*Confirm commitment and motivation to continually improve the Joy.*
C3	*Effective Clinical Governance*	*Is there effective line management and support in place for Joy GPs when working?*		*Test what AMDs think is in place v the opinion of Joy GPs, might be early to assess this one. Consider for later evaluations.*
C4	*Effective Clinical Governance*	*Is Joy GP performance linked to appraisal and feedback mechanisms?*	*How?*	*It should be, but probably early in the cycle to assess this, most Joy GPs have been revalidated elsewhere and we haven't got too far into appraisal cycle on the Joy.*
C5	*Effective Clinical Governance*	*Does appraisal and reflection inform CPD for Joy GPs?*	*How? Are there examples of good practice?*	*Test if there is much process at all at the moment.*
C6	*Effective Clinical*	*What clinical or management problems have been*		*General question to see how AMDs see CG related problems*

	Governance	*highlighted?*		
C7	*41*	*How are Joy GPs kept up to date with H&I adopted clinical protocols, procedures, guidelines and best practice?*	*Is this system effective?*	*Joy GPs have raised issue that they fall outside of H&I communications often for latest clinical developments and guidance (41). To test the awareness of AMDs that this may be an issue and are any steps being taken to improve the situation?*
C8	*Effective Clinical Governance*	*Are Significant Event audits discussed and considered with Joy GPs?*	*Give examples?*	*Clear from Joy VCs that SEA have been discussed with practices, is this consistent across H&I? Have Joy VC discussions been picked up as an SEA issues (19)(26)(32)*
C9	*Philosophy and values*	*How could you demonstrate continuous improvement?*		*General question to tease out how much AMDs have a feel for what improvements are going on as a result the Joy.*
C10	*37*	*How have arrangements for the clinical lead been developed?*	*What if funding for this post cannot be found?*	*Need for support of a Joy clinical need identified Aug 2019 and a job description agreed by Oct 2019 but funding might be a problem. How and why was this need assessed?*
C11	*7,44*	*How effective has the Joy GP VCs been in supporting Joy GPs/ Reflective practice and/or development of the programme?*	*Are there limitations with the VCs? What alternatives could there be?*	*The Joy GP VC has been a useful forum for feedback and support and also referred to in the Joy Philosophy and Values. The forum is not used by all GPs and has changed in nature over the 5 months since it started in July 2019*
Management & Operation of The Joy (D)				
D1	*Effective Management*	*Effectiveness of the Management of The Joy - Have the management arrangements been successful?*	*Give examples of where it has been successful.*	*There is evidence from several people that management arrangements were realised to be an issue as the project expanded, the question is to tease out what those issues and remedies could be.*
D2	*Evaluation Phase 1A*	*Do you have an updated picture of where the Joy programme is at any given time - eg Placements completed, who is in post, forecasts, budget spend for the project, an overview of risks?*	*Are you satisfied in this regard? If not, how could it be improved?*	*Question designed to indicate what management information is being circulated, but what is also really needed.*

D3	*38*	*Have any of the following been a problem;*	*Irregular Meetings, Delays in getting responses from Joy Management, have thigs happened without warning, poor communication examples*	*Designed to suggest likely problems and the impact.*
D4	*28*	*Has there been effective communications?*	*Between practices/ Joy GPs/ HrHub, Joy Management*	*Designed to suggest likely problems and the impact. Use scoring?*
D5	*21, 34*	*Has there been effective feedback on how the project is working?*	*Is feedback being communicated, acted upon and evaluated? Between GPs/ Practices/ HrHub and Joy Management*	*Designed to suggest likely problems and the impact, referred to (21) (34).*
D6			*Are actions followed up? If not, has this caused problems?*	*Designed to suggest likely problems and the impact.*
D7	*38*	*How effective are Hub/ Joy Management Meetings?*	*Do they happen, is there a good attendance, are decisions made and actions considered?*	*Evidence from several people that Joy management meetings are irregular and there is not much process see (38) Clinicians often cannot make time for Hub meetings.*
D7	*38*		*Are actions followed up? If not, has this caused problems?*	*Evidence from several people that Joy management meetings are irregular and there is not much process see (38)*
D8	*Effective Management*	*How well are GP performance management/ appraisal and clinical governance managed?*	*Give an example of good practice?*	*Good practice that there is a robust management process in place for employed GPs*
D9	*Effective Management*	*Are feedback forms for placements and practices being returned and reviewed?*	*Could the placement feedback forms be improved?*	*Feedback forms were planned to be an integral part of the process and one prepared ready for use in May 2019. Checking that process works and results are being collected or assessed.*
D10	*Effective Management*	*Do Joy management have a good enough skill set (either management or other) to run the programme?*	*If not, what is missing?*	*Good practice to reflect, clear addition to the team (MS) in May 2019 but are skill sets still considered?*
D11	*23*	*Does Joy Management have the capacity to manage the programme?*	*If not, what would be needed? What if the scheme expanded to 50, 60, 100 Joy GPs?*	*Important to consider with expansion of the scheme (23)*

D12	*Effective Management*	*Is there a Joy project risk register and is everyone in the team aware of what's on it?*	*How often is it reviewed?*	*Good practice that programme risks are considered and reviewed. Returns are made to SRMC board but process/responsibility for assessing project risks needs to be clear as well as an active process that reviews and acts upon risk assessment.*
D13	*Effective Management*	*How will the Annual event planned learn from the recruitment weekend of March 2019?*	*What would you hope is done differently?*	*Planning for the event underway Dec 2019 but are the lessons from the first recruitment weekend in Mar 2019 being considered?*
D14	*Effective Management*	*Have there been any efficiencies from the Joy?*	*Eg Reduction in locum fees, savings in staff time etc.?*	*Has the Joy been cheaper? Are there any benefits from this angle?*
We didn't know what we didn't know (E)				
E1	*9, 24, 26*	*Did Joy team know that some practices - that Joy GPs were going to - had problems (eg workload, lack of leadership, poor review systems)?*	*Was anything done to prepare Joy GPs for this?*	*Clear from GP VC and discussions with individuals that some practices are struggling and Joy GPs are going into a challenging situation/ high workloads - not in line with Joy philosophy.*
E2	*9,24,26*		*Will this cause future problems if GPs choose not to go to perceived struggling practices?*	*Problems if some practices get a poor reputation and cannot support a Joy philosophy.(9)(24)(26)*
E3	*9, 20*	*Was the Joy scheme to (short term) fill GP gaps or was it to improve practices with problems and/or preserve local morale of MDT professionals/ regular GPs?*	*Was it more about recruitment or retention?*	*Question to look at whether there is a conflict in Joy aims & values is the project primarily trying to get `bums on seats' - holding back a crisis. There could be a difficulty in keeping the Joy GP team cohesive if short term priorities take priority.*
E4	*18*		*Did Joy scheme fit into local primary care improvement initiatives?*	*Expressed by NHS Highland Director who was seeking re assurance that it was.*
E5	*Sustainability of Model*	*What has been the effect on other MDT members (incl. regular GPs)?*		*The question as to how the scheme affects practices who are engaged has not so far been considered*
E6	*Patient Aspects*	*Are local communities aware and do they have opinions?*	*What are the opinions?*	*Not so far been considered, may be a longer term aspect.*

E7	*9,19, 26*	*Was there a consideration that Joy GPs could act as practice management consultants originally?*	*Will this feature as an aspect of Joy GP recruitment in the future?*	*Consideration of the problems at Wick (and one or two other practices) led onto to discussions on the GP VC about the Joy GP role in addressing problems they came across where practices were struggling and was it their role to address these and how (9)(19)(26)*
E8	*9,19, 26*	*Do you think Joy GPs will have the motivation of confidence to help sort out problems with the way practices operate?*		*See above (9)(19) (26)*
E9	*Development of the Joy*	*Joy GPs brought forward several ideas during the Joy VCs, which ones have been taken forward?*	*2 x GP at Wick, an initial over employment at Wick, Standardised induction programme, Video to help GP induction?*	*Wick problems discussed on Joy GP VCs regularly, did Joy management take account of these ideas? (9)(19) (26)*
E10	*29*	*Has the addition of VAT to Hub charges been a problem?*		*VAT ruling has inflated the Joy charges making Joy GPs less competitive than locums for practices.*
Limitations of the Joy ? (F)				
F1	*12*	*Has the HrHub had the capacity and capability to support the project in its first year? With say, 30 Joy GPs and an active recruitment programme?*	*What are the implications if the joy was to increase the number of Joy GPs to 40, 50, 60, 100?*	*Capacity if project scales up*
F2	*12*	*What capacity would be required?*		*Capacity if project scales up*
F3	*20*	*Can the current Joy operate an effective system to fill very short term (1/2 day) placement requests ? More like a locum agency.*		*Possible service that could be offered*
F4	*Recruitment*	*Will some practices become difficult to recruit Joy GPs to?*	*Will Joy GPs become too selective in where they want to work?*	*Testing if the Joy model can support all rural general practices in Scotland or are there limits?*
			Is reputation a problem?	*Testing if some practices have a reputational problem.*
F5		*How close are we to a wider oil rig model taking place in any location?*	*Would this be realistically necessary?*	*Oil rig model based on Orkney (OINOC) Model, default model if sustainability of regular services becomes downgraded in a location.*

F6	*19, 42*	*Will joy GPs have the capability, confidence or motivation to develop practices? Should the NHS look for other solutions?*	*Is there Joy management/ primary care leadership available to make that happen?*	*Does the current model actually lead to practice development?*
F7	*27*	*Is NHS Shetland willing to keep taking the risk of employing Joy GPs?*	*Does a new hub need to be created? Could some roles be delegated/ shopped out to another health board?*	*Financial and legal risk to NHS Shetland if model/ operation of the Joy breaks down.*
F8	*Effective Management & Governance*	*Evidence suggest that communications are not always effective, does this put a constraint on the Joy model?*	*Irregular Meetings, Delays in getting responses from Joy Management and clinicians, lack of discussion on developments, disruptions for leave etc.*	*Anecdotal notes that communications, availability and meetings are not always optimum.*
	33	*Has there been effective feedback?*	*Between practices/ Joy GPs/ HrHub, Joy Management*	
F9	*17*	*Can funding be found post 2021 for the existing model?*		*Longer term issue, but current Hub funding runs out in September 2020.*
F10	*39*	*Will Joy GPs make longer term arrangements with practices?*	*Are problems foreseen?*	*Anticipated.*
F11		*What are your ideas on how or if the Joy should be developed now?*		*Longer term issue, but current funding needs to be considered.*
Compared to Values, Philosophy and original intentions (J)				
J1	*Values, philosophy & Original intentions*	*Has the scheme supported GPs', MDT's & Administrators in Rural care in the 4 health board areas?*	*How could we demonstrate that?*	*Related to stated values, philosophy and original intentions (per website)*
			Has the oil rig model from OINC been a useful model to follow?	*Related to stated values, philosophy and original intentions (per website)*
J2	*Values, philosophy & Original intentions*	*So far, has the project been successful in terms of what it was originally set up to do?*	*Why do you say that?*	*Related to stated values, philosophy and original intentions (per website)*
J3	*Values, philosophy & Original*	*Has the project moved away from its original vision or values?*	*In what way?*	*Related to stated values, philosophy and original intentions (per website)*

	intentions			
J4	*Values, philosophy & Original intentions*	*Has knowledge & expertise been Shared?*	*Where would I find evidence of that?*	*Related to stated values, philosophy and original intentions (per website)*
J5	*Values, philosophy & Original intentions*	*Has a creative, cohesive, supportive team of GPs been created?*	*How do you know?*	*Related to stated values, philosophy and original intentions (per website)*
J6	*Values, philosophy & Original intentions*	*How many Joy GPs have been through a recruitment/ selection weekend?*	*A significant number haven't, is this problem?*	*Related to stated values, philosophy and original intentions (per website)*
J7	*Values, philosophy & Original intentions*	*How many take part in the weekly VCs?*	*Numbers are low, is this a problem?*	*Related to stated values, philosophy and original intentions (per website)*
	Values, philosophy & Original intentions		*VC have spent a long time dealing with administration and management issues, have they been effective at all in building a team?*	
J9	*Values, philosophy & Original intentions*	*How many use the smartphone messaging group or what's App group ?*		
J10	*Values, philosophy & Original intentions*	*How closely do they work with the clinical lead?*		
J11	*Values, philosophy & Original intentions*	*Have the practices been supportive in providing data for annual appraisal?*	*Has there been any support for appraisal/ revalidation from Joy practices?*	*Related to stated values, philosophy and original intentions (per website)*
J12	*Values, philosophy & Original intentions*	*Is there any other point that you wish to make over the Joy project are there any lessons you feel we should be aware of?*		*Have we missed anything?*
J13	*Values, philosophy & Original intentions*	*In terms of diversity, most Joy GPs are white, 2/3 men, over 50 mostly, does this create an issue?*		*Have we missed anything?*

J14	*Values, philosophy & Original intentions*	*What if there had not been a Joy?*		*Have we missed anything?*
Joy GPs Experience (K)				
K1		*Did the Joy experience live up to expectation?*		
K2		*Were you aware of the GP promotional video on the SRMC Website?*		
K3		*How do you feel you were treated by the practices you worked for?*		
K4		*Were the contractual terms & conditions attractive enough?*		
K5		*Were you aware of local clinical guidelines and protocols?*		
K6		*Did you get a quality induction in all practices?*		
K7		*Did you feel appreciated by the practices/ patients?*		
K8		*Are there any lessons that can be learned from your experience?*		

Appendix C.

Evaluation Sample Participant Consent Form (V2.0)

IRAS ID: 270115

Centre Number:

Study Number:

Participant Identification Number for this trial:

CONSENT FORM

Title of Project: **Evaluation of Rediscover the Joy of Holistic General Practice**

Name of Researcher: David Priest Contact: david.priest@nhs.net

Please initial box

1. I confirm that I have read the information sheet dated Feb 2020 (version 2.1) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my legal rights being affected. ☐

3. I agree to take part in the above study. ☐

This study is undertaken by the Scottish Rural Medicine Collaborative (SRMC) https://www.srmc.scot.nhs.uk/ and sponsored by NHS Highland R&D Dept.https://www.nhshighland.scot.nhs.uk/Research/Pages/Home.aspx.

As part of the study it is necessary for us to hold a limited amount of personal data, typically name, e-mail address and contact details, if you do not want us to hold these details please tick the box ☐

If you require more information please follow the link to the NHS Highland Data Protection Notice https://www.nhshighland.scot.nhs.uk/Pages/YourRights.aspx If you are unhappy with the way in which we use your personal information please tell the NHS Highland Data Protection officer at;

Donald Peterkin (Data Protection Officer)
NHS Highland
Assynt House
Beechwood Park, Inverness, IV2 3BW

Contact Number – 01463 717123
high-uhb.dpohighland@nhs.net

Name of Participant	Date	Signature
Name of Person taking consent	Date	Signature

Appendix D.

Evaluation Sample Project Information Sheet (V2.1)

Participant Information Sheet (PIS)

Study title

Evaluation of Rediscover the Joy of Holistic General Practice

Invitation and brief summary

This is an invitation to take part in the evaluation of the Joy project.

Rediscover The Joy (The Joy) is a project developed by key medical directors, primary care managers and HR staff at 4 Scottish health boards (Shetland, Orkney, Western Isles and Highland) from 2018. It had arisen as a response to, problems recruiting to regular GP vacancies in rural areas across Scotland, this has been particularly serious for the 4 island and Highland health board areas. The project team, a collaboration between the 4 health boards, sought, during 2019, to recruit GPs for fixed short term placements of 12, 16 or more weeks to primary care medical practices in remote and rural areas. The aim being to ease problems from covering long term vacancies as well as practice short notice absence cover also providing, fresh opportunities for participating GPs to reconnect with a more rewarding, hands on and holistic experience of rural medicine and communities. The study is being undertaken by the Scottish Rural Medicine Collaborative (SRMC) a Scottish Government funded organisation that looks at ways to improve recruitment and retention of primary care health professionals. The study is sponsored by NHS Highland R&D department.

What's involved?

The evaluation will consider both quantitative and qualitative information on the Joy project covering the period from inception, in 2018, to recruitment of the initial cohort of placement GP candidates through to the completion of the first series of placements in early 2020. The point of the evaluation is to look at lessons learned in practical, administrative, recruitment, financial, service quality and strategic areas and will provide recommendations for good practice and scheme development.

What would taking part involve?

Anticipated, a one hour telephone call with the researcher using pre-set and notified questions. Responses will be noted, recorded and used to evidence the evaluation finding. There may be a short follow up telephone call/ e-mails to assist with clarification and checks on accuracy. Most questions will relate to impressions on the operation and effectiveness of aspects of the Joy project.

What are the possible benefits of taking part?

Satisfaction of having contributed to wider development and improvement of the scheme and making a contribution to the improvement of primary care services for patients in rural Scotland. The study will help decide which initiatives we can develop in future. It is anticipated that participants can get access to the final report. The information generated will also support further publications and studies.

What are the possible disadvantages and risks of taking part?

None really, it is just a time commitment. It is possible that other staff may find some opinions and issues challenging to accept and this will be considered during the preparation of the final report, but the findings will be anonymised as far as possible.

There is no compulsion, if you feel uncomfortable with taking part, please let the researcher know by e-mail and we can remove you as a participant.

Use of data and data protection

In this research study we will use information provided by you. We will only use information that we need for the research study. We will let very few people know your name or contact details, and only if they really need it for this study.

Everyone involved in this study will keep your data safe and secure. We will also follow all privacy rules. At the end of the study we will save some of the data in case we need to check it. We will make sure no-one can work out who you are from the reports we write. This information will include your name, initials and contact details. People will use this information to do the research or to check your records to make sure that the research is being done properly.

People who do not need to know who you are will not be able to see your name or contact details. Your data will have a code number instead. We will keep all information about you safe and secure.

Once we have finished the study, we will keep some of the data so we can check the results. We will write our reports in a way that no-one can work out that you took part in the study.

What are your choices about how your information is used?

- *You can stop being part of the study at any time, without giving a reason, but we will keep information about you that we already have.*
- *We need to manage your records in specific ways for the research to be reliable. This means that we won't be able to let you see or change the data we hold about you.*

Where can you find out more about how your information is used?

- *By asking the researcher david.priest@nhs.net , telephone 07970 943508.*
- *Link to NHS Highland Data Protection Notice and NHS Highland Data Protection Officer https://www.nhshighland.scot.nhs.uk/Pages/YourRights.aspx*
- *Link to NHS Highland R&D Department https://www.nhshighland.scot.nhs.uk/Research/Pages/Home.aspx.*

Consent

A separate consent form will be enclosed, please let the researcher know on this form if you have any concerns on SRMC holding your name and contact details.

Appendix E.

Principal Investigating Officer CV (Mar 2020)

Principal Investigating Officer (PIO) – Project Evaluation of Rediscover the Joy of Holistic General Practice

CV

1978 – 1989 HMRC Coventry, Leamington, Banbury

1991 – 1995 CCH Publications Ltd, Hong Kong

1995 – 1998 Pendleside Medical Practice, NHS East Lancashire Health Authority

– Practice/ Fundholding Manager

1998 – 2008 British Forces Germany Health Service/ SSAFA

– Primary Care Operations Manager (RGM)

2008 – 2009 NHS Shetland – Director of Service Improvement

2009 – 2019 Highlands & Islands Enterprise – Development Manager

2019 – Present

Scottish Rural Medicine Collaborative (SRMC)/ NHS Highland – Project Manager

Academic

BA Applied Economics (Hons) – Coventry University (1988)

MA Business Administration (MBA) – Strathclyde University (1990)

Post Grad Diploma – Primary Care Clinical Governance – Warwick University (2003)

Professional

2001 – Prince 2 Project Methodology

2001 – 2008 – HAQU Health Service Quality Assessor

2012 – National Diploma in Occupational Safety and Health (NEEBOSH)

2020 – Agile Project Methodology

Appendix F.

The Joy GP Placement History (July 2019 – March 2020)

*Note – See March 2020 for cumulative column for figures for the whole scheme July 2019 – Mar 2020 & Appendix F (1).[20]

Appendix F.

Placement History - The Joy, July 2019 - March 2020

Placement Weeks Provided by Joy GPs (July 2019 - March 2020) by health board region and practice

Code

	Placement Request unfulfilled
	Requests filled
	See notes - placement unfilled, not counted
Cum.	Cumulative totals by practice/ health board region since placements commenced.

		Jul-19							Aug-19					
	Week Commencing Monday;	01/07/2019	08/07/2019	15/07/2019	22/07/2019	29/07/2019	Month totals		05/08/2019	12/08/2019	19/08/2019	26/08/2019	Month totals	Cum.
Practices	**Highland**							**Highland**						
	Wick		1	1	1	1	4	Wick					0	4
							0	Acharacle					0	0
							0						0	0
							0						0	0
Highland	Sum	0	1	1	1	1	4	Sum	0	0	0	0	0	4
Practices	**Orkney**							**Orkney**						
							0	OHAC (OOH)					0	0
							0						0	0
Orkney	Sum	0	0	0	0	0	0	Sum	0	0	0	0	0	0
Practices	**Shetland**							**Shetland**						
	Brae		1	1			2	Brae					0	2
	Scalloway		1				1	Scalloway		1	1		2	3
	Walls			1	1	1	3	Walls				1	1	4
													0	0
Shetland	Sum	0	2	2	1	1	6	Sum	0	1	1	1	3	9
Practices	**Western Isles**							**Western Isles**						0
	Broadbay						0	Broadbay					0	0
							0						0	0
Western I	Sum	0	0	0	0	0	0	Sum	0	0	0	0	0	0
15.33333		0	3	3	2	2	10		0	1	1	1	3	**13**
					Unfulfilled		*1*					*Unfulfilled*	*7*	*8*

[20] Thank you to HrHub staff for helping supply this information.

Appendix F.

Placement History - The Joy, July 2019 - March 2020

Placement Weeks Provided by Joy GPs (July 2019 - March 2020) by health board region and practice

Code

	Placement Request unfulfilled
	Requests filled
	See notes - placement unfilled, not counted
Cum.	Cumulative totals by practice/ health board region since placements commenced.

Sep-19

	02/09/2019	09/09/2019	16/09/2019	23/09/2019	30/09/2019	Month totals	Cum.
Highland							
Wick				1		1	5
Acharacle	1	1	1	1		4	4
Aultbea & Gairloch			1			1	1
Lybster						0	0
Riverbank						0	0
Sum	1	1	2	2	0	6	10
Orkney							
OHAC (OOH)						0	0
Orcades (HOY)						0	0
Sum	0	0	0	0	0	0	0
Shetland							
Brae						0	2
Scalloway						0	3
Walls						0	4
Unst						0	0
Yell						0	0
Sum	0	0	0	0	0	0	9
Western Isles							
Broadbay	1	1	2	2		6	6
						0	0
Sum	1	1	2	2	0	6	6
	2	2	4	4	0	12	25
					Unfulfilled	*9*	***17***

Oct-19

	07/10/2019	14/10/2019	21/10/2019	28/10/2019	Month totals	Cum.
Highland						
Wick		1	1	1	3	8
Acharacle			1	1	2	6
Aultbea & Gairloch					0	1
Lybster					0	0
Riverbank		1			1	1
Carbost			1		1	1
Tarbert					0	0
Kinlochbervie	1			1	2	2
Port Appin						
Easdale						
					0	0
						0
Sum	1	2	3	3	9	19
Orkney						
OHAC (OOH)					0	0
Orcades (Hoy)					0	0
Eday					0	0
Sum	0	0	0	0	0	0
Shetland						
Brae			1	1	2	4
Scalloway		1	1	1	3	6
Walls					0	4
Unst					0	0
Yell					0	0
Sum	0	1	2	2	5	14
Western Isles						
Broadbay	1	1		1	3	9
South Uist		1	1		2	2
Sum	1	2	1	1	5	11
	2	5	6	6	19	44
				Unfulfilled	*5*	***22***

Appendix F.

Placement History - The Joy, July 2019 - March 2020

Placement Weeks Provided by Joy GPs (July 2019 - March 2020) by health board region and practice

Code

	Placement Request unfulfilled
	Requests filled
	See notes - placement unfilled, not counted
Cum.	Cumulative totals by practice/ health board region since placements commenced.

Nov-19

	04/11/2019	11/11/2019	18/11/2019	25/11/2019	Month totals	Cum.
Highland						
Wick	1				1	9
Acharacle	1			1	2	8
Aultbea & Gairloch					0	1
Lybster					0	0
Riverbank	1		1	1	3	4
Carbost					0	1
Tarbert					0	0
Kinlochbervie					0	2
Port Appin		1			1	1
Easdale					0	0
Applecross					0	0
					0	0
Sum	3	1	1	2	7	26
Orkney						
OHAC (OOH)					0	0
Orcades (Hoy)					0	0
Eday					0	0
Skerryvore	1	1	1	1	4	4
					0	0
Sum	1	1	1	1	4	4
Shetland						
Brae	1	1	1		3	7
Scalloway	1	1	1	1	4	10
Walls					0	4
Unst					0	0
Yell					0	0
Sum	2	2	2	1	7	21
Western Isles						
Broadbay				1	1	10
South Uist					0	2
Sum	0	0	0	1	1	12
	6	4	4	5	19	63
				Unfulfilled	*11*	*33*

Dec-19

	02/12/2019	09/12/2019	16/12/2019	23/12/2019	30/12/2019	Month totals	Cum.
Highland							
Wick						0	9
Acharacle	1	1				2	10
Aultbea & Gairloch						0	1
Lybster						0	0
Riverbank						0	4
Carbost						0	1
Tarbert				1	1	2	2
Kinlochbervie						0	2
Port Appin						0	1
Easdale						0	0
Applecross						0	0
Jura						0	0
Sum	1	1	0	1	1	4	30
Orkney							
OHAC (OOH)						0	0
Orcades (Hoy)						0	0
Eday						0	0
Skerryvore	1	1	1	1	1	5	9
Stronsay						0	0
Sum	1	1	1	1	1	5	9
Shetland							
Brae						0	7
Scalloway	1	1	1	1	1	5	15
Walls						0	4
Unst				1	1	2	2
Yell						0	0
Sum	1	1	1	2	2	7	28
Western Isles							
Broadbay	1	1				2	12
South Uist						0	2
North Harris						0	0
Sum	1	1	0	0	0	2	14
	4	4	2	4	4	18	81
					Unfulfilled	*22*	*55*

Appendix F.

Placement History - The Joy, July 2019 - March 2020

Placement Weeks Provided by Joy GPs (July 2019 - March 2020) by health board region and practice

Code

	Placement Request unfulfilled
	Requests filled
	See notes - placement unfilled, not counted
Cum.	Cumulative totals by practice/ health board region since placements commenced.

	Jan-20						Feb-20					
	06/01/2020	13/01/2020	20/01/2020	27/01/2020	Month totals	Cum.	03/02/2020	10/02/2020	17/02/2020	24/02/2020	Month totals	Cum.
Highland												
Wick					0	9					0	9
Acharacle		1	1	1	3	13					0	13
Aultbea & Gairloch					0	1					0	1
Lybster					0	0					0	0
Riverbank					0	4	1	1	1		3	7
Carbost		1	1		2	3					0	3
Tarbert					0	2					0	2
Kinlochbervie					0	2					0	2
Port Appin			1	1	2	3					0	3
Easdale					0	0					0	0
Applecross					0	0					0	0
Jura					0	0					0	0
Broadford											0	0
Glenelg								1	1	1	3	3
Sum	0	2	3	2	7	37	1	2	2	1	6	43
Orkney												
OHAC (OOH)					0	0					0	0
Orcades (Hoy)					0	0					0	0
Eday					0	0					0	0
Skerryvore	1	1	1	1	4	13	1	1	1	1	4	17
Stronsay					0	0		1			1	1
Sanday											0	0
Sum	1	1	1	1	4	13	1	2	1	1	5	18
Shetland												
Brae					0	7					0	7
Scalloway	2	2	2	1	7	22			1		1	23
Walls					0	4					0	4
Unst	1				1	3					0	3
Yell					0	0					0	0
Lerwick				1	1	1					0	1
Whalsay										1	1	1
Sum	3	2	2	2	9	37	0	0	1	1	2	39
Western Isles												
Broadbay					0	12					0	12
South Uist					0	2					0	2
North Harris					0	0					0	0
Benbecula											0	0
Sum	0	0	0	0	0	14	0	0	0	0	0	14
	4	5	6	5	20	101	2	4	4	3	13	114
				Unfulfilled	*13*	*68*				*Unfulfilled*	*16*	*84*

Appendix F.

Placement History - The Joy, July 2019 - March 2020

Placement Weeks Provided by Joy GPs (July 2019 - March 2020) by health board region and practice

Code

	Placement Request unfulfilled
	Requests filled
	See notes - placement unfilled, not counted
Cum.	Cumulative totals by practice/ health board region since placements commenced.

Mar-20

	02/03/2020	09/03/2020	16/03/2020	23/03/2020	30/03/2020	Month totals	Cum.
Highland							
Wick						0	9
Acharacle			2	2	1	5	18
Aultbea & Gairloch						0	1
Lybster						0	0
Riverbank			1	1		2	9
Carbost						0	3
Tarbert						0	2
Kinlochbervie						0	2
Port Appin						0	3
Easdale						0	0
Applecross						0	0
Jura						0	0
Broadford						0	0
Glenelg						0	3
Mallaig						0	0
Salen, Mull						0	0
Bunessan, Mull						0	0
Sum	0	0	3	3	1	7	50
Orkney							
OHAC (OOH)						0	0
Orcades (HOY)						0	0
Eday						0	0
Skerryvore	1	1	1	1	1	5	22
Stronsay						0	1
Sanday			1	1	1	3	3
Sum	1	1	2	2	2	8	26
Shetland							
Brae	1	1	1	1	1	5	12
Scalloway					1	1	24
Walls						0	4
Unst						0	3
Yell						0	0
Lerwick						0	1
Whalsay	1					1	2
Bixter	1				1	2	2
Sum	3	1	1	1	3	9	48
Western Isles							
Broadbay						0	12
South Uist						0	2
North Harris						0	0
Benbecula						0	0
Sum	0	0	0	0	0	0	14
	4	2	6	6	6	24	138
					Unfulfilled	*15*	*99*

Appendix F. (1)

Summary of Joy Placement Information (from The Joy GP Placement History (Appendix F.)

Summary of Joy Placement Information

Appendix F. (1)

Placement Weeks Completed By Month	
Jul	10
Aug	3
Sep	12
Oct	19
Nov	19
Dec	18
Jan	20
Feb	13
Mar	24
Total	**138**

Practices	Placements	Unfullfilled Placement Weeks	Filled Placement Weeks
Highland			
Wick	3	12	9
Acharacle	8	13	18
Aultbea & Gairloch	1	0	1
Lybster	0	2	0
Riverbank	5	8	9
Carbost	2	1	3
Tarbert	1	0	2
Kinlochbervie	2	2	2
Port Appin	2	3	3
Easdale	0	1	0
Applecross	0	3	0
Jura	0	3	0
Broadford	0	1	0
Glenelg	1	0	3
Mallaig	0	3	0
Salen, Mull	0	1	0
Bunessan, Mull	0	1	0
Highland Total	**25**	**54**	**50**
Orkney			
OHAC (OOH)	0	3	0
Orcades (HOY)	0	3	0
Eday	0	1	0
Skerryvore	1	1	22
Stronsay	1	4	1
Sanday	1	2	3
Orkney Total	**3**	**14**	**26**
Shetland			
Brae	4	14	12
Scalloway	7	1	24
Walls	3	0	4
Unst	2	0	3
Yell	0	2	0
Lerwick	1	2	1
Whalsay	2	0	2
Bixter	1	0	2
Shetland Total	**20**	**19**	**48**
Western Isles			
Broadbay	6	8	12
South Uist	1	1	2
North Harris	0	2	0
Benbecula	0	1	0
W. Isles Total	**7**	**12**	**14**
Overall Totals	**55**	**99**	**138**

Appendix G.

Sampling Analysis of Vacancy Returns

Appendix G.						
Sampling Analysis of Vacancy Returns						
(Also see vdzl·yűűl·ű‰Ŝ Analysis QA14)						
Data taken from 3 Vacancy returns						
Table A.		Highland	Orkney	Shetland	W.Isles	Overall
		Placement Weeks available				
20/09/2019	Sample 1	10	2.5	3.5	0	16
15/11/2019	Sample 2	21	1	4	8	34
17/01/2020	Sample 3	15.5	4	6.5	0.5	26.5
Total		46.5	7.5	14	8.5	76.5
	Average	15.50	2.50	4.67	2.83	25.50
Table B.		Highland	Orkney	Shetland	W.Isles	Overall
		Weeks that were confirmed as unfilled (from Table A.)*				
20/09/2019	Sample 1	8	2.5	2	0	12
15/11/2019	Sample 2	14	1	1.5	8	24.5
17/01/2020	Sample 3	14	4	0.5	0.5	18.5
Unfulfilled Vacancy Weeks		35	7.5	4	8.5	55
	Average	**11.67**	**2.50**	**1.33**	**2.83**	**18.33**
Average Placement Weeks Available		15.50	2.50	4.67	2.83	25.50
Average Placement Weeks Unfulfilled		11.67	2.50	1.33	2.83	18.33
	Difference	3.83	0.00	3.33	0.00	7.17
**Checked with placement history*						

Appendix H.

Recruitment and Retention, Collaboration and Cohesion - The Islands Challenge

Dr Kirsty Brightwell – September 2018

Recruitment and Retention
Collaboration and Cohesion

The Islands' Challenge

High Pressure in the Western Isles

- 9 independent practices
- 5 practices with vacancies some long term
- All practices are vulnerable
- 14/28 GPs >55
- 4 GPs leaving daytime practice within 12/12 (only 1 >55 years)
- 1 practice has given 5 years' notice
- The others aren't saying

Work so far

- PCIP: we can collaborate
- One practice from 4 practice merger
- All practice Cluster meetings established
- Discussions with practices re mutual support started
- Reinvigoration of PM network
- But what's in it for me?

Orkney General Practices

Orkney Mainland Practices (GMS)

Skerryvore	7949
Heilendi	3850
Shapinsay (NP)	*240*
North Ronaldsay (NP)	*57*
Stromness	3015
Flotta (NP)	*70*
Dounby	2779
Rousay (NP)	*227*
St Margaret's Hope	1453

Orcades Practice (2c)
(1959)

Westray (GP)	*550*
Papa Westray (NP)	*83*
Sanday (GP)	*469*
Stronsay (GP)	*340*
Eday (NP)	*116*
Hoy (GP)	*400*

2009 Unable to Recruit Isles GPs

8 Isles Single-Handed GP Practices Vacant 2 Isles had Nursing Models of Care

New Model of Care: Isles Network of Care (INOC)

Salaried Practitioners (GPs and Nurse Practitioners)
Linked by weekly VC for mutual support

- Community Engagement
  - *Consulted on Model*
    - ***Emergency Care*** was greatest concern of communities
  - Communities Involvement in Recruitment Campaign
    - Production of information to send candidates. Hosting candidates and selling their isle
- Advert
  - Vision: To become a Centre of Excellence in Remote and Rural Healthcare
  - The challenge: Do you want to join us to help us achieve this?
  - Unique Selling Point: Having time to deliver holistic, exemplary care. "Old Fashioned General Practice"
- Enquiry
  - Comprehensive information pack
  - Early contact with Senior Clinician.>1hr telephone call , What are ***they*** looking for? What we have to offer.
  - Interested applicant's greatest concern:
    - ***Emergency Care***

GP Contracts 2009: 35 weeks and 17 weeks 24/7
2015: 16: 12:12:12 weeks 24/7
2016: 18: 17:17 weeks 24/7

Demographic and Recruitment Through Training

Orkney Mainland GPs		Isles GPs	
30 – 40	8	30-40	0
40 – 50	11	40-50	1
50 – 60	9	50 – 60	6
60 – 65	1	60 – 65	3
Total	**29**	**Total**	**10**

Undertook SHO/GPST Training in Orkney
7 (23%)
Rural / Paediatric Fellowship in Orkney
8 (28%)
School Education in Orkney
9 (31%)

Ex- GP Trainers
5 (50%)
Undergraduate Trainers
3 (33%)

Orkney School Students into Medicine
12 in the last 5 years

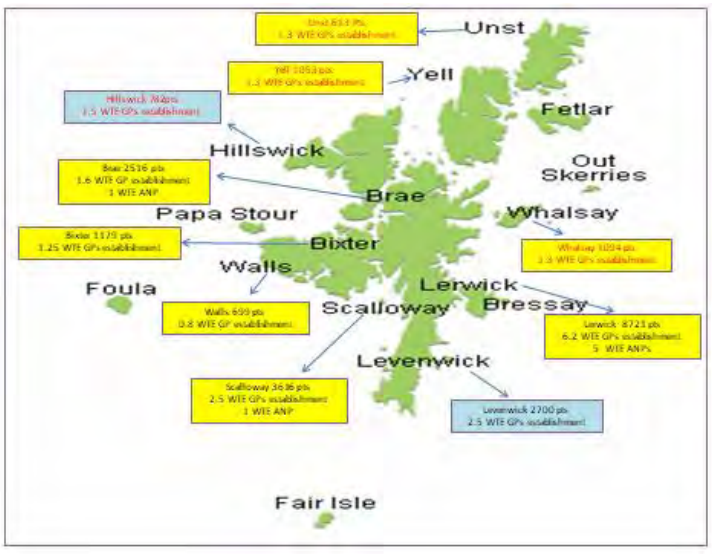
Collaboration and Cohesion

Isles Network of Care

- Weekly VC between the 10 different island practices
  Mutual support, Clinical Governance, Education (GPs, NPs and Community Nurses)
- Mainland GMS practices linked to isles as a branch practice
  Isles Branch Practices with 24/7 Board employed NP
- 2016 Remaining 6 Isles joined together as one "virtual practice" called Orcades
  Unified computer system and drawing together of procedures
- 2018 Increased autonomy for Orcades with own "management team"
- 2018 NHSO took over employing SAS First Responders on Rousay
  After extensive discussions with community
  Mainland GMS Practice incorporating them into their team
- Future Development of INOC educational programme

Orkney-Wide

- IJB Representation / Invigorated LMC / Cluster / New GP Sub Committee
  Development of "Primary Care Opinion" not individual practice opinions
- Weekly 8:00am M&M meeting with Hospital Clinicians
- Ad hoc Educational Events



Some of our challenges

- We may be small but all our practices are different;
- GP recruitment issues led to five practices becoming salaried in two years (half our practices);
- GP training was initially slow to start with little interest in remote & rural setting;
- Changing island demographic with a notable increase in over 65s;
- Recruitment difficulties extend to social care and other professions e.g. Teaching;
- Costs of relocating to Shetland are very high and thanks to a gas plant boom, house prices are also high

However.....

- Introduction of ANPs into our largest practice in 2014 has been a real success and this is being expanded to encompass ANP trainees;
- GP training is now a success story, the Rural Track has made a difference;
- Two more GPs now becoming GP trainers;
- Our two largest practices are now fully staffed, through recruitment of our own trainees and contact with a GP Returner;
- Opportunities to network amongst practices being explored to reduce single-handed working.

What have we learned?

- "Last ten" and "first five" appear to be the people we are attracting to Shetland;
- Enabling flexibility around posts and role has been positive;
- Educational events and networking are "must haves" – SWIDDER, GP Cluster, Medical Symposium, Scenario Planning;
- GP Training can be helpful but it very much depends on the trainer and trainee;
- Teamwork is key when speaking to prospective candidates – they need clinical input on the post/s, information on relocation etc

Themes

- R&R success and challenges
  - Single-handed practices: threat and risk
  - Island life: step beyond remote
    - Significant others, family, travel, weather?
  - Opportunity to do things differently
- GP Training and Education (person dependent?)
- Cohesion/Collaboration
  - Independent Practice vs Board employed
- Don't let a good crisis go to waste
  - Do we let the inevitable happen?

Some of our challenges

- We may be small but all our practices are different;
- GP recruitment issues led to five practices becoming salaried in two years (half our practices);
- GP training was initially slow to start with little interest in remote & rural setting;
- Changing island demographic with a notable increase in over 65s;
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Top Challenges

- Is it easier to recruit into Board administered systems?
  - What have we learnt from 2c recruitment that would support independent practice recruitment?
- How do we develop supportive, collaborative systems between small, geographically isolated practices?
  - Whose remit?
  - Who's paying?
- How do we develop a sustainable, cohesive, mutually supportive Island Primary Care system which supports and nurtures the evolving MDT, including GPs?