Healthcare Improvement Scotland

Primary Care Phased Investment Programme

Evaluation update

Interim report

June 2025

NHS SCOTLAND

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List of Abbreviations and Terms

2c practice	Health board-run GP practice
A&E	Accident and emergency
ANP	Advanced nurse practitioner
ASCVD	Atherosclerotic cardiovascular disease
AWD	Antimicrobial wound dressing
CoC	Continuity of Care
BNF	British National Formulary
COPD	Chronic obstructive pulmonary disease
CTAC	Community treatment and care
DCAQ	Demand, capacity, activity and queue
EMIS	Egton medical information systems
FCP	First contact physiotherapist or physiotherapy
GLP-1	Glucagon-like peptide-1
GMS	General medical services
GMS contract	Refers to the GMS contract: 2018 between NHS boards and GP practices run by GP partners
GP	General practice or practitioner
GP cluster	Geographical grouping of GP practices, led by a GP who undertakes the role of cluster quality lead to facilitate peer-led quality improvement activity within and across practices and also contribute to the oversight and development of care within the wider healthcare system
GPN	General practice nursing or nurse
HbA1c	Glycated haemoglobin
HRMM	High risk medicines monitoring
HSCP	Health and social care partnership
HSR	Health services researcher
IDL	Immediate discharge letter
IT	Information technology
LTC	Long-term condition
MDT	Multi-disciplinary team
MRC	Medical Research Council
MSK	Musculoskeletal
NHS	National health service
NTI	National therapeutic indicators
OOH	Out of hours in healthcare context
OPL	Outpatient letter
Patient	Refers specifically in this report to patient data.
PC	Primary Care
PCPIP	Primary Care Phased Investment Programme
PHS	Public Health Scotland
PIS	Prescribing Information System

PSW	Pharmacy support worker
QI	Quality improvement - the application of a systematic approach that uses specific techniques to improve quality
SABA	Short-acting beta-2 agonists
Service user	Includes patients, family members and supporters accessing services
SG	Scottish Government
SGLT-2	Sodium glucose cotransporter-2
SIMD	Scottish Index of Multiple Deprivation
SLICC	St Leonards Index of Continuity of Care
STU	Scottish Therapeutic Utility
Task transfer	Most referred to as delegation of healthcare tasks. This involves a registered healthcare professional (such as a nurse or doctor) transferring the authority to perform a specific healthcare task to another MDT individual
UPC	Usual provider of care
WoCA	Week of care audit
WTE	Whole time equivalent

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Section 1: Evaluation progress summary

Introduction

The second interim report outlines progress made in evaluating the Primary Care Phased Investment Programme (PCPIP), with data collected up to May 2025. It builds on the first interim report published in March 2025, which introduced the evaluation framework and reviewed existing evidence. The first interim report is available on the Healthcare Improvement Scotland website. This report presents data from individual sources and evaluation workstreams, with final analysis and recommendations to be published in December 2025. This report consists of two key sections. The first section is a summary of key insights and progress in data collection for PCPIP. The second section contains detailed descriptions of methodology and data collected to date within the programme.

PCPIP aims to:

- support the implementation of key regulated priority areas of the GMS (General Medical Services) contract specifically pharmacotherapy and Community Treatment and Care (CTAC) services - while continuing to support other contract elements
- foster a culture of continuous improvement across primary care settings, and
- build a robust evidence base to better understand the national context for GMS contract implementation.

The evaluation of PCPIP aims to assess the impact of implementing multidisciplinary team (MDT) working in primary care, as outlined in the GMS contract. It focuses on understanding the effects on service users, the workforce, and the broader healthcare system. Additionally, the evaluation explores the role of quality improvement (QI) support to identify key factors that contribute to the successful implementation of MDTs.

The final report, due in December 2025, will integrate all data collected to describe the following key areas:

- What learning can we take from the QI approach embedded in PCPIP to support future implementation of the MDT and policy development?
- What are the key conditions for change and enablers required to support MDT working?
- Which MDT services should be prioritised for further development?
- What are the key attributes of a sustainable and effective model of MDT support?
- What is additionally required to support monitoring and evaluation of the impact of MDT working?
- What is required to ensure MDT working supports the reduction of health inequalities?

The evaluation employs a mixed-methods approach, incorporating qualitative, quantitative, and health economic data. The evaluation framework was published in October 2024, with initial progress on data planning and collection reported in March 2025. The evaluation is structured

around seven data collection workstreams (outlined in *Figure 1* below) and at this stage in the programme data collection and analysis is ongoing. Some workstreams have focused on developing detailed data collection plans and tools, while others have progressed to collecting and analysing initial data. This report details the progress made across all workstreams and the data collected to date in each workstream, including QI data collected from four demonstrator sites working with Healthcare Improvement Scotland on this programme, which provides examples of some of the work carried out in each area.

Figure 1: Data workstreams for PCPIP evaluation

Quality improvement data

Healthcare Improvement Scotland is working closely with four demonstrator sites: NHS Ayrshire & Arran, NHS Borders, Edinburgh City Health and Social Care Partnership (HSCP) and NHS Shetland to support the use of QI to design and deliver local improvement plans. Each demonstrator site received additional funding from Scottish Government to improve local CTAC and pharmacotherapy services, to contribute to the evaluation, and work with HIS to use QI tools and approaches. QI data is collected with demonstrator sites to provide a greater understanding of the local system, identify priorities for change, test changes across the system, and understand the impact of these tests of change. All sites are using QI to test changes and there are indications of improved task transfer. Some tests of change focus on improving quality and safety, and data is being collected to understand the impact of these changes. There are some common challenges observed for all sites including recruitment, accommodation, IT system issues and lack of local and national data to

support decision-making and monitor progress. Work with the demonstrator sites will continue until October 2025 to gain a greater understanding of improvements within local primary care systems.

Week of care audit

General practice teams in each demonstrator site are also participating in data collection in the first evaluation workstream, which is a national week of care audit (WoCA). This tool was developed to collect data on how MDT works in practice, considering the distribution of activity and potential task transfer affecting the workload of GPs, GPNs, and Pharmacy staff. In this report, task transfer refers to the delegation of healthcare tasks. This involves a registered healthcare professional (such as a nurse or doctor) transferring the authority to perform a specific healthcare task to another MDT individual. There will be three WoCAs carried out in the programme with the first completed in March 2025. The second WoCA was completed in June 2025 with data currently being analysed. The final WoCA will take place in September 2025. Collecting data over time will provide insights into changes at a practice level in demonstrator sites. Three practices, 18 in total, from each of the 6 HSCPs within PCPIP were identified to take part in the WoCA.

Progress includes:

- The first WoCA was completed by 18 participating practices, including data from 96 general practitioners (GPs), 25 general practice nurses (GPNs), and 76 pharmacotherapy staff.
- Data collected from the first WoCA identified that out of the 1,092 hours of GP consultations recorded, 19% of this time could have been saved if these consultations were carried out by another member of the MDT, which represents a potential saving of 204 hours.
- GPs indicated that out of the total of 594 hours of non-consultation (admin) time, 22% of this time could have been saved if another member of the MDT had undertaken the activity, with a potential saving of 130 hours.
- GPNs reported that out of the 341 hours of activity they recorded, 18% of this time could have been saved if these activities had been carried out by a member of the CTAC team, which represents a potential saving of 62 hours.
- Pharmacotherapy staff reported that the most frequent task they carried out was acute and repeat prescribing, followed by medicines reconciliation for outpatient letters (OPLs) and immediate discharge letters (IDLs).

There was variation in data recorded across practices and challenges ensuring that a consistent quality of data was submitted for analysis. All practices who participated in data collection were offered feedback sessions to review their practice data, provide additional context to inform analysis, and discuss how this data might be used at practice level to shape local improvements.

Economic analysis

The WoCA data is also used to inform the second evaluation workstream, which is an economic analysis. This analysis will examine the costs and benefits associated with tests of change for each

demonstrator site and will consider the system capacity for improvement. Analysis tools are being developed for each demonstrator site based on their individual QI measurement plans and tests of change. Data will be collected in July and August 2025 with data analysis starting in September 2025.

Qualitative data

Demonstrator sites are also involved in the third evaluation workstream to collect qualitative data with primary care staff and service users. Qualitative data is being gathered through interviews and focus groups to understand staff views of contract implementation and the MDT, and the experiences of staff and service users of primary care.

As of the beginning of April 2025, 96 interviews and 51 focus groups have been carried out with 266 participants from a range of primary care staff groups, and 20 service users. Thematic analysis is being carried out.

The following insights are based on early coding and high-level analysis discussions:

- challenges of integrating health board-employed and practice-employed staff
- increased demand on primary care
- MDT working - improving availability of appointments
- changes to GP role, and
- barriers to addressing inequality.

Full thematic analysis will be completed by September 2025. The qualitative insights discussed in this report are provisional insights into staff experiences and perspectives of the current primary care system and could change once analysis is completed.

Service user views

The fourth evaluation workstream focuses on understanding service user perspectives. To ensure a wide range of service user views are included within the PCPIP evaluation, we have submitted questions on experiences in primary care and continuity of care to a citizen panel. The citizen panel brings together views of around 1,000 members of the public from all over Scotland, representative of the Scottish population, and took place in June 2025. The citizen panel will provide more comprehensive data on a wide range of service user perspectives on experiences within the current primary care system. Data analysis of the output from the citizen panel is ongoing and will be reported on the Healthcare Improvement Scotland webpages at the end of November 2025.

Local systems and record sampling

The sixth evaluation workstream involves collecting data from local systems and record sampling to understand access to care, improved medicines management, continuity of care and impact of MDT

on the workforce. General practice teams within the demonstrator sites are working with Healthcare Improvement Scotland and Public Health Scotland (PHS) to develop more detailed data definitions and sources to support data extraction. Each practice is required to identify data collection specific to their local IT systems and context. Data collection and analysis will start in July 2025 and will provide a greater understanding of the impact of changes in demonstrator sites at a practice level. The data identified for collection in this workstream will also be used to inform a discussion on what is required to support monitoring and evaluation of MDT working in the longer term.

National board-wide data

The final evaluation workstream involves collecting board-wide data collection from existing national systems to explore the impact of MDT working on improved patient outcomes. Data is collected to indicate changes in primary care activity over time, improved care outcomes and changes to the use of unscheduled care.

Healthcare Improvement Scotland has received data reports from PHS including all data available for the programme delivery period (April 2024 onwards). The data collected through national systems have agreed collection and reporting timelines, which restrict the available data points. Therefore, at this point in the programme there are insufficient data points to allow interpretation of potential trends. Although additional data points will be available to inform the final evaluation report in December 2025, system-level changes may not be visible in this data because of the lag in data availability and the time required for changes to influence this population level data. This data will be used to illustrate which metrics may be beneficial to monitor longer term progress within primary care.

Summary

While it is too early to draw definitive conclusions, the data presented in this interim report offers valuable insights into MDT working within primary care, the implementation of the GMS contract, the context for improvement in primary care settings, and how known data challenges manifest in primary care settings. Data collection and analysis across all evaluation workstreams will continue in the coming months. An expert group will be convened in October 2025 to support the synthesis of findings and the development of recommendations for the final report in December 2025.

Section 2: Detailed evaluation updates

Programme overview

The following sections contain more detailed updates on the PCPIP evaluation including methodology, data collected and initial data analysis where appropriate.

PCPIP has the following aims:

- to develop a culture of continuous improvement across primary care settings
- to improve key regulated areas - pharmacotherapy and CTAC services - while maintaining other elements of the GMS contract, and
- to build evidence to understand the national context for implementation.

PCPIP is structured around four key components.

- **Demonstrator sites:** Supporting improvement work in four NHS (national health service) board areas which include six Health and Social Care Partnerships, using QI approaches.
- **Primary Care Improvement Collaborative:** Supporting local primary care teams across Scotland to improve services through rapid QI cycles, coaching and peer learning opportunities.
- **Learning system:** Facilitating shared learning from insights gathered throughout PCPIP.
- **Evaluation:** Conducting a realist evaluation of MDT working as described in the GMS contract.

This report details progress within the evaluation and the demonstrator site components of PCPIP.

Evaluation workstreams

The evaluation is structured around seven workstreams, including quality improvement data, qualitative data, quantitative data, and health economic data (*Figure 1*).

Figure 1: Data workstreams for PCPIP evaluation

Details on data collection timelines are included in Appendix 1. The following sections contain a more detailed description of each workstream, and QI data collected to inform the evaluation.

Workstream 1: Quality improvement data

Methodology

Healthcare Improvement Scotland is working closely with each demonstrator site to support the use of QI to inform the design and delivery of local improvement plans, following the steps of the quality improvement journey (*Figure 2*). All sites are now testing changes, and some elements of the work are moving towards implementation and spread. It is important to remember that QI does not follow a linear path, and efforts may sometimes require revisiting earlier steps in the journey. Throughout PCPIP, demonstrator sites have continued to deepen their understanding of their systems, using this knowledge to refine their plans, aims and change ideas.

Figure 2: The steps of the QI journey adopted in PCPIP

The following outlines the stages of QI work undertaken in each demonstrator site:

Creating conditions

Each demonstrator site worked on creating the conditions for change for PCPIP by establishing a project team, agreeing ways of working, and identifying and engaging with stakeholders. The primary care landscape is complex and includes a range of stakeholders working in different parts of the health and social care system, including independent contractors/practitioners. These groups have differing accountability and governance structures and time was needed to ensure conditions were created around the needs of each key stakeholder. Taking the time to establish these conditions has enabled the sites to clearly communicate their vision and collaborate effectively with stakeholders in their local contexts.

Understanding systems

All demonstrator sites carried out activities to understand the demand, capacity, activity and queue (DCAQ) in their current systems. This process involved employing QI tools such as process mapping

and cause-and-effect analysis, as well as collecting and organising data. There was limited system wide data noted in each demonstrator site and therefore some manual data collection was required. Understanding DCAQ also gave demonstrator sites the opportunity to explore overall demand for their services including from patients who face barriers to accessing care and may be missing from activity data. This helped sites to consider the potential impact of changes on health inequalities.

Developing aims

Following work to understand the system, each demonstrator site used driver diagrams to describe their theory of change. Each driver diagram included an overall aim, key drivers that would lead to change, and specific change ideas to be tested.

Testing changes

Demonstrator sites prioritised their change ideas for system-level improvement based on their data and local circumstances, including potential impact on health inequalities. All sites are now carrying out tests of change and collecting data to understand their impact.

Measurement for improvement

Each demonstrator site worked with Healthcare Improvement Scotland, and local QI teams where available, to develop a QI measurement plan which consists of three types of measures:

- outcome measures to show whether the aim of the tests of change is being achieved
- process measures to show how the test is progressing and,
- balancing measures to highlight any possible consequences of the test on other parts of the system.

Measurement for improvement is distinct from data used for research or assurance, as its primary purpose is to help the demonstrator sites understand the impact of their tests of change and make decisions about what to do next. QI data is often collected by staff carrying out the changes and careful consideration is therefore given to the data burden for staff.

Demonstrator teams have been encouraged to use data that is:

- specific to a particular tests of change
- small - just enough to inform their work and not too onerous to collect, and
- available over time.

Implement and spread

Some demonstrator sites have change ideas that have been successfully tested at a small scale and are now moving to implementation and spread to other areas. They are continuing to gather data to understand the impact of this work, although in some cases, this involves using a smaller dataset or collecting data less frequently than during the initial small-scale testing.

Examples of improvement

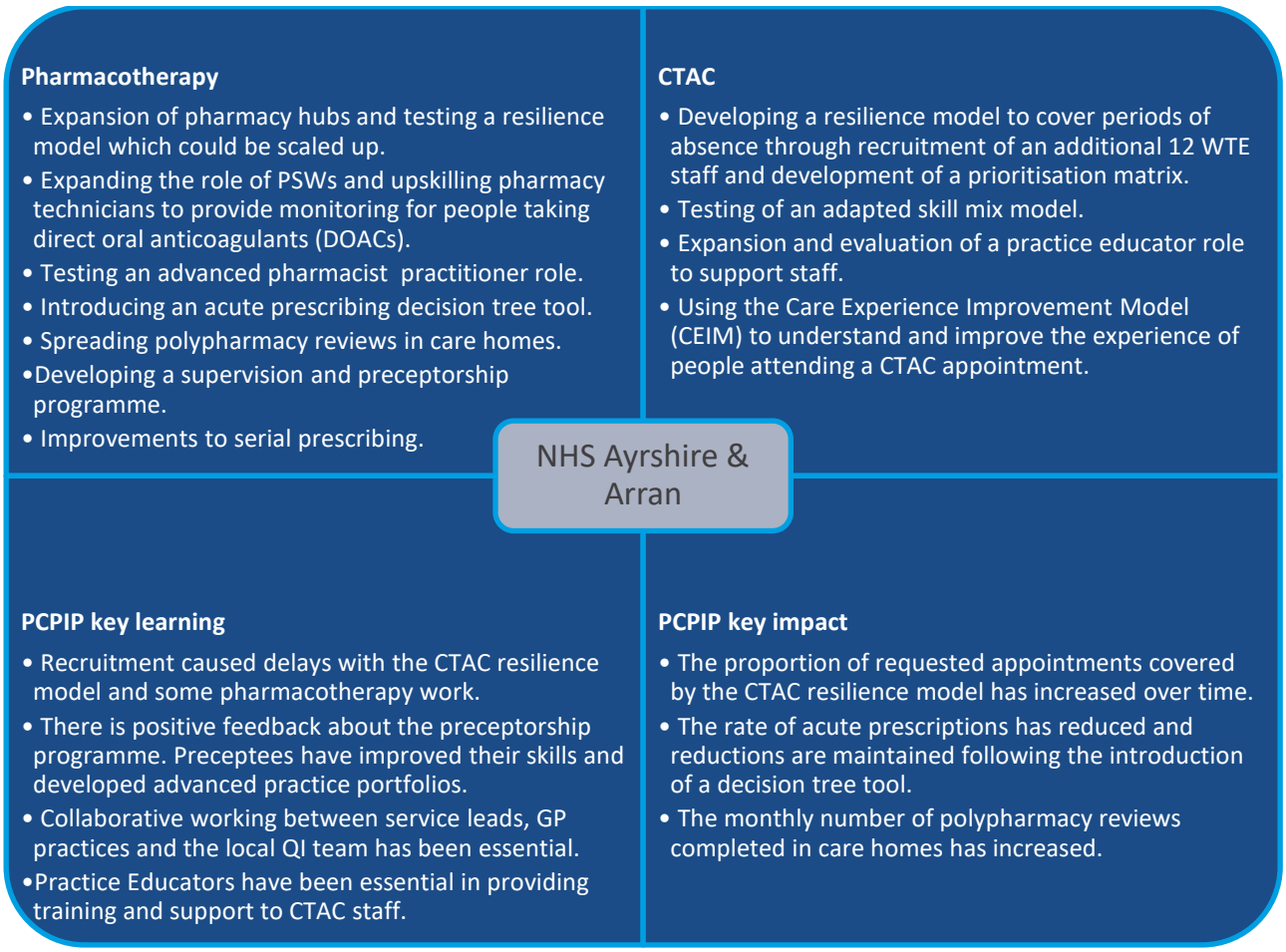
Progress has been made simultaneously across four demonstrator sites with indications of improved task transfer. This report contains selected examples of QI data to highlight areas of improvement in demonstrator sites. QI data is presented in run charts or statistical process control (SPC) charts, which highlight shifts and trends in data and are annotated to explore the relationship between the data and the change activity.

NHS Ayrshire & Arran

NHS Ayrshire & Arran have undertaken a whole-system approach to PCPIP working with GP practices across all three HSCPs. At the start of PCPIP they identified the need to improve workforce resilience, develop and define staff roles, and improve processes to more fully deliver their services in line with the GMS contract.

A summary of the key CTAC and pharmacotherapy work carried out in NHS Ayrshire & Arran and some key learning and impact is presented in *Figure 3* below.

Figure 3: Summary of work carried out in NHS Ayrshire & Arran



Selected examples of the QI work carried out in CTAC and pharmacotherapy services are explored in more detail below.

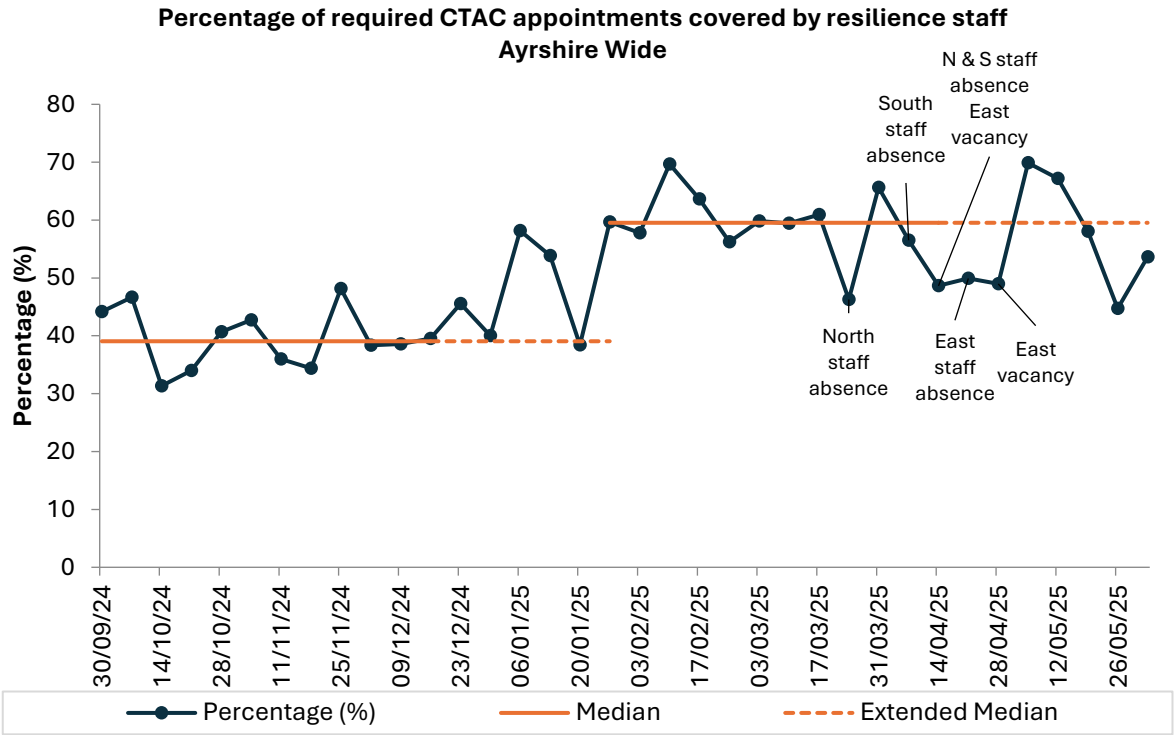
CTAC

At the outset of PCPIP, NHS Ayrshire & Arran identified that 28% of CTAC interventions were being provided by GP staff. One reason for this was a lack of cover for CTAC staff during periods of leave. To address these gaps in service NHS Ayrshire & Arran developed a resilience model to cover periods of long-term absence, vacancies, maternity leave and Open University placements. Where possible, cover may also be provided for short-term absence.

The team recruited additional CTAC staff to provide cover where it is required and test the resilience model. The first new staff members joined the team in November 2024 and recruitment has been ongoing throughout PCPIP. The CTAC team also undertook further work to understand demand for CTAC interventions and develop a prioritisation matrix. The model prioritises cover for key interventions including wound care.

An outcome measure for this work is the percentage of appointments requiring resilience cover which can be covered by resilience staff. As shown in *Figure 4*, since September 2024, the median has increased from 39.1% to 59.5% of required CTAC appointments being provided by CTAC resilience staff. The increase in appointments covered by resilience staff suggests that fewer appointments will be cancelled or provided by general practice.

Figure 4: Percentage of CTAC appointments requiring resilience support covered by resilience staff in NHS Ayrshire & Arran between September 2024 to May 2025



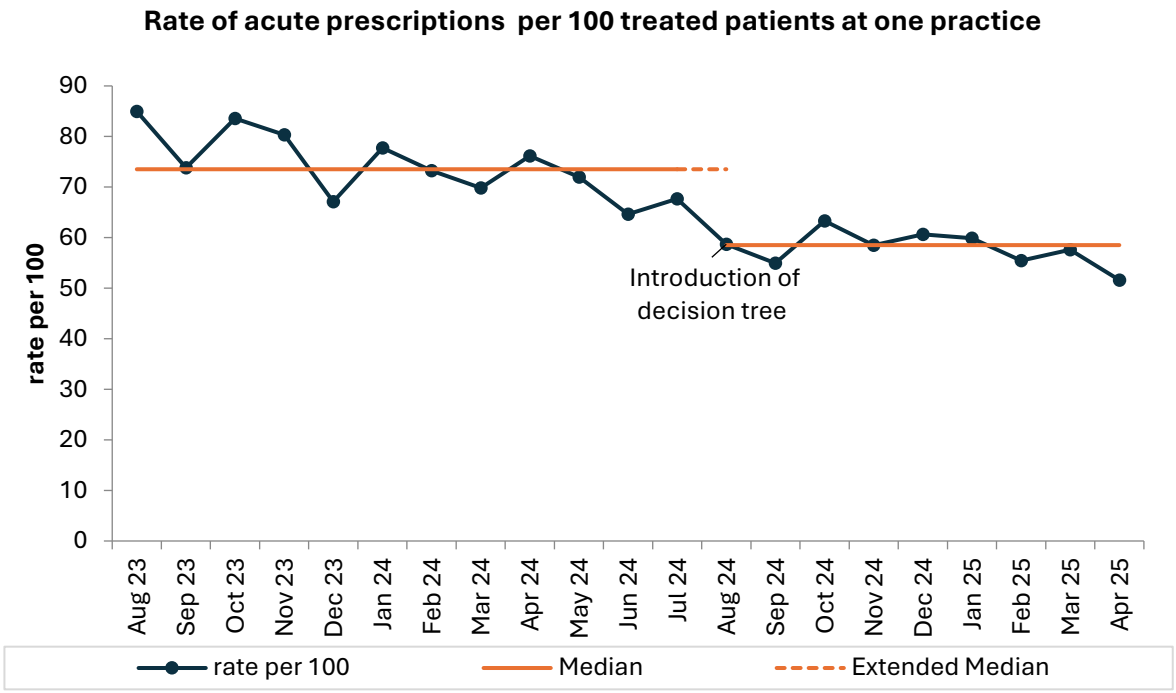
Pharmacotherapy

At the start of PCPIP, NHS Ayrshire & Arran identified significant variation between practices in prescribing processes and the total number of acute prescriptions being issued. They aimed to reduce the number of acute prescriptions in some practices by changing processes to improve safe access to medication for patients and address prescribing workload issues.

In one practice, the team introduced a framework to support prescribing decision-making using a decision tree tool developed in NHS Forth Valley. This supports staff to move medication to repeat prescription where appropriate or record key prescribing parameters to clarify next steps when issuing an acute prescription. Data collected shows a 20% reduction in the rate of acute prescriptions issued per 100 treated patients from a median of 73.5 to 58.5 which has been maintained over a period of 9 months.

The decision tree tool is now being shared across other practices to spread this improvement work.

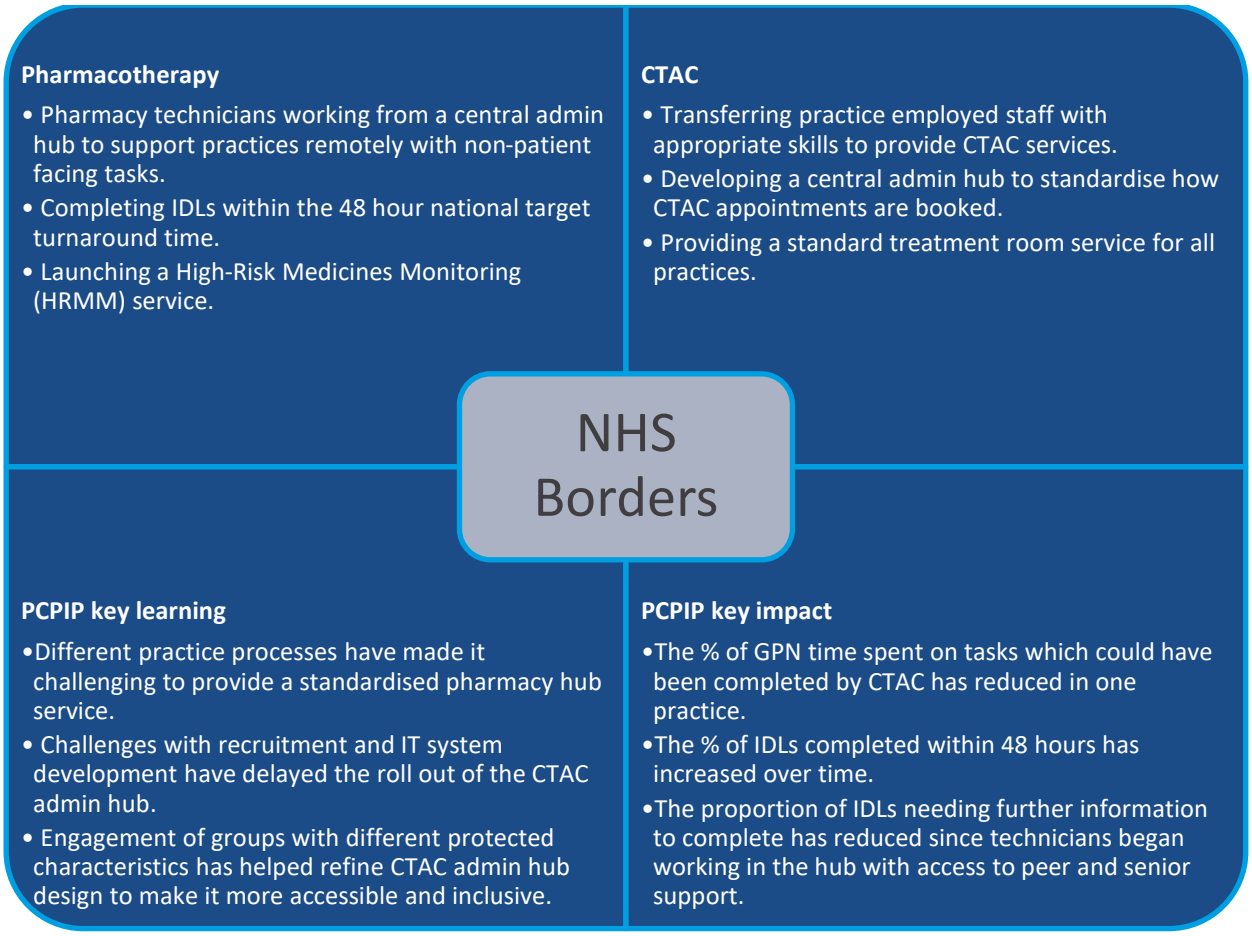
Figure 5: Rate of acute prescriptions per 100 patients in one NHS Ayrshire & Arran practice between August 2023 to April 2025



NHS Borders

A summary of the work carried out in NHS Borders is highlighted in *Figure 6* below.

Figure 6: Summary of work carried out in NHS Borders



Selected examples of the QI work carried out in CTAC and pharmacotherapy services are explored in more detail below.

CTAC

At the start of PCPIP, NHS Borders had an existing treatment room service. Service provision varied across the health board. Initial proposals for CTAC focused on enhancing treatment room services to include provision of phlebotomy, creation of an admin hub and standardisation of the treatment room service. Practice-employed staff with the appropriate skills were transferred to the CTAC service to create further capacity.

The CTAC focus for PCPIP aims to support GPNs as expert nursing generalists by providing specific interventions within their service specification with an initial focus on phlebotomy services. Transfer of other interventions has been delayed because of accommodation, recruitment and IT issues and limited data is available. In the meantime, the NHS Borders team allocated specific staff resource to consulting local groups of people with protected characteristics about the CTAC changes enabling the team to adapt their plans to support reducing health inequalities.

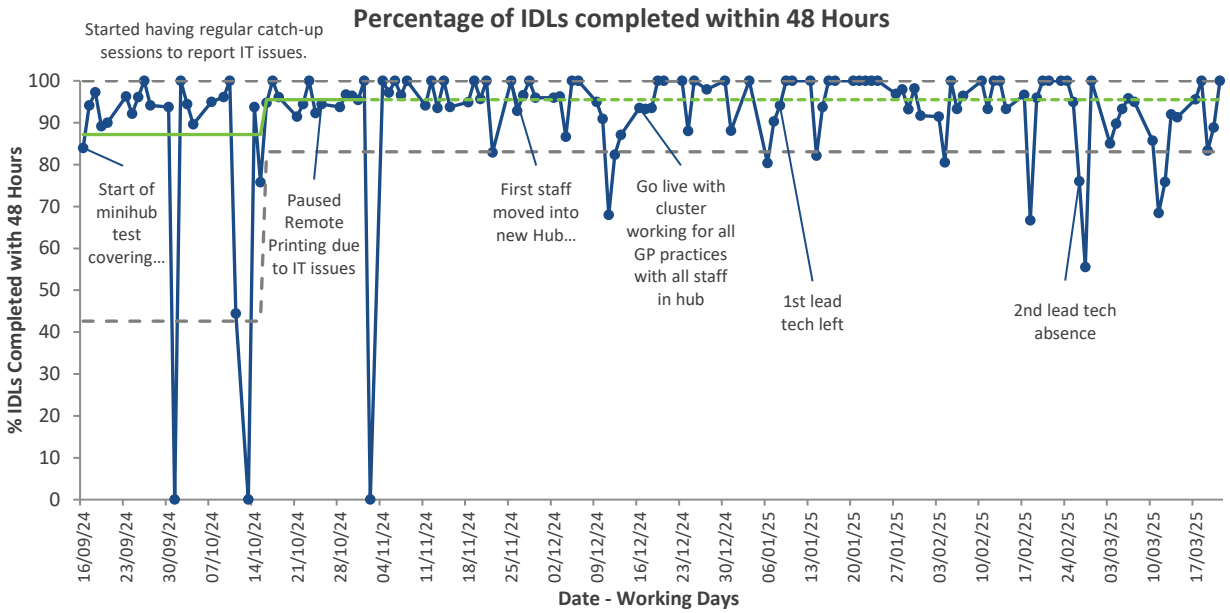
There are some signs of improvement within CTAC task transfer as the initial data collection carried out in September 2024 showed that in one practice, 34% of GPN time was spent on tasks that could be completed by CTAC, this has now reduced to 7%. Further analysis of this data is being undertaken by NHS Borders to understand the impact of CTAC in other practices and identify how these improvements could be spread.

Pharmacotherapy

At the start of PCPIP, the pharmacotherapy service in NHS Borders was delivered in practices and focused on level 1 services as outlined in the GMS contract. There was significant travel time for staff covering multiple practices and allocated staffing made it difficult to cover periods of leave leading to variable cover for practices. NHS Borders initial proposal for PCPIP focused on establishing a pharmacy hub to improve quality and efficiency in pharmacotherapy services by reducing travel time and making it easier to provide a consistent service. The team also planned to increase the use of serial prescriptions and develop a high-risk medicine monitoring service.

NHS Borders identified the need to improve the turnaround time for completing medication reconciliation for IDLs in line with the national target of 48 hours from the IDL being received. This ensures patients have timely access to medications they require after discharge and improves patient safety. To achieve this aim, they recruited additional staff and moved pharmacy technicians into a central pharmacy hub. Improvement for IDL turnaround time was tested in a 'mini hub' which covered nine practices. Data was collected to monitor the outcome of the percentage of IDLs completed within 48 hours, and the team has used an SPC chart to monitor this work since testing of the hub concept started. This data has been collected daily which can make it difficult to assess patterns over time. *Figure 7* highlights that the mean percentage completed within 48 hours increased from 87% to 96% towards the end of 2024. Since then, the team has experienced some vacancies and absences, which are causing higher variation, but the system is relatively stable and mainly achieving the target outcome.

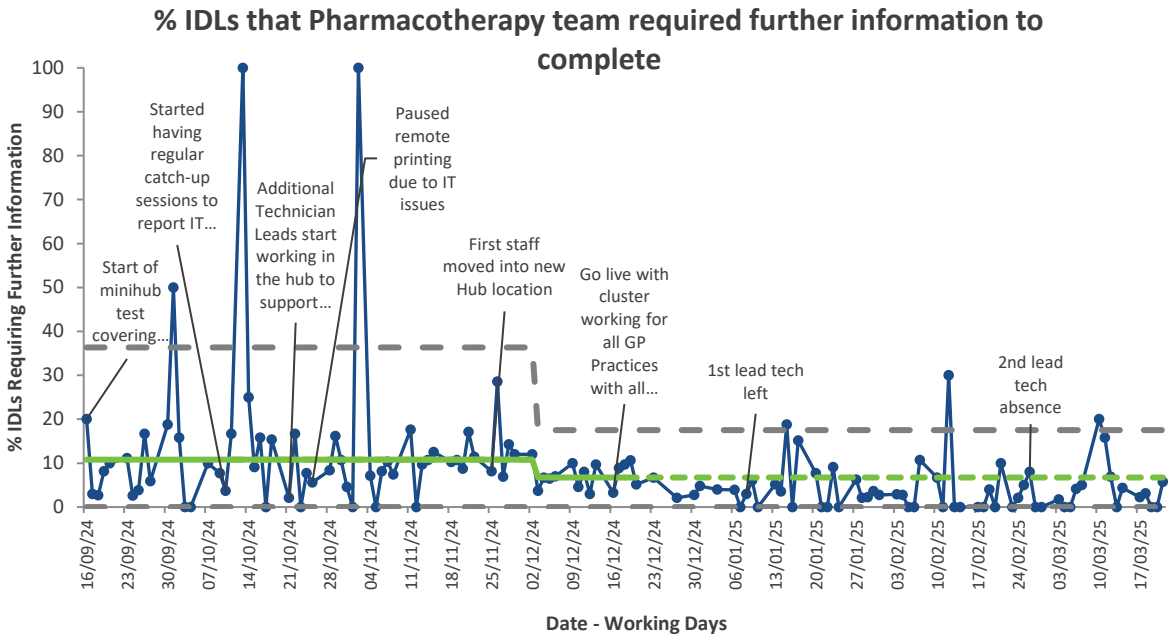
Figure 7: Percentage of IDLs completed within 48 hours by the hub in NHS Borders between September 2024 and March 2025



Some IDLs require additional information before they can be completed by the pharmacy team, leading to delays in processing. While these requests for further information may reflect the quality of the initial IDL submissions, NHS Borders aimed to test whether a hub-based pharmacotherapy team approach - offering peer and senior support - could help reduce them. Data collected from the hub showed a decrease in the average percentage of IDLs requiring further information, from 11% to 7% (*Figure 8*).

To build on this improvement, the team is now collecting data on the specific specialties and wards from which these IDLs originate. This insight will be used to target quality improvements in the information provided within IDLs.

Figure 8: Percentage of IDLs requiring further information to complete by the hub in NHS Borders between September 2024 and March 2025

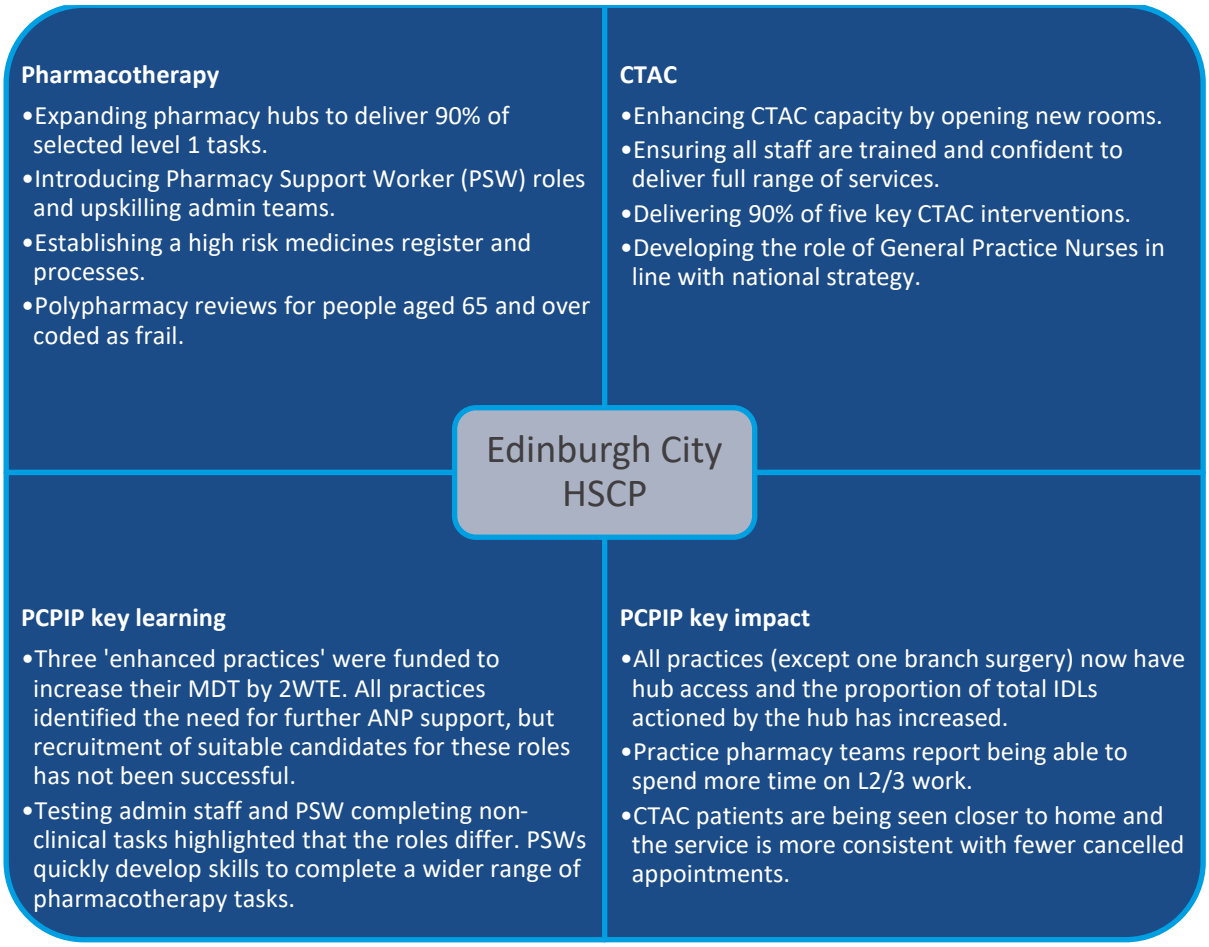


Edinburgh City HSCP

Edinburgh City HSCP's demonstrator site is a sub-cluster area comprising nine GP practices in the south-east of the city, with a rapidly growing population. Prior to PCPIP, primary care services were struggling to meet demand from the expanding population and several practices had closed their lists to new registrations.

A summary of the work carried out by Edinburgh City HSCP is included in *Figure 9*.

Figure 9: Summary of work carried out in Edinburgh City HSCP



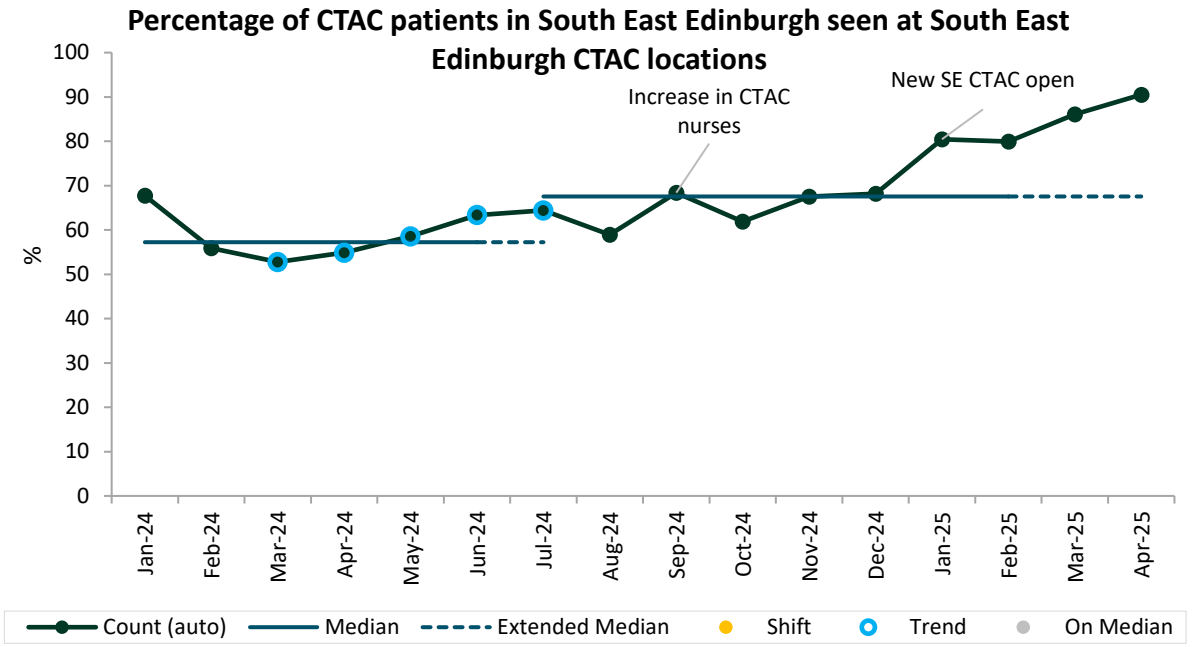
Selected examples of the QI work carried out in CTAC and pharmacotherapy services are explored in more detail below.

CTAC

Prior to PCPIP, all practices had access to CTAC but demand outstripped capacity leading to patients having to travel to further for an available appointment, and extensive wait times, particularly for ear irrigation treatment. The initial proposal focused on expanding capacity by opening new rooms, recruiting additional staff, improving staff induction and training, and introducing daily safety huddles. Work to understand the system identified that it was not possible to accurately understand overall demand for CTAC.

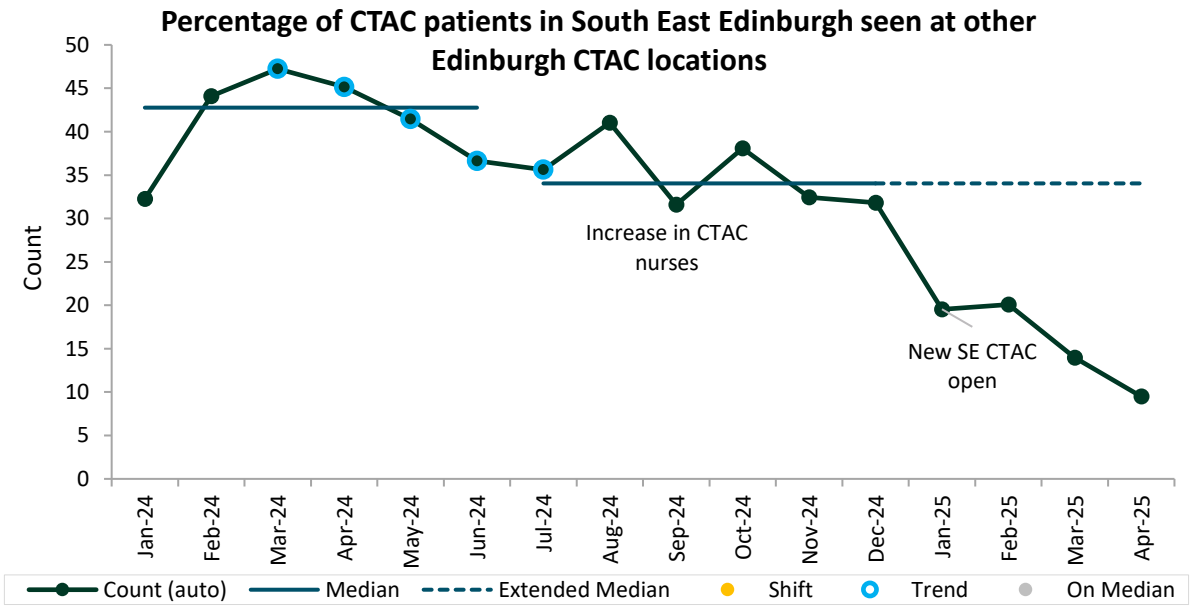
A primary aim of the CTAC work is to improve patients' access to CTAC services within the demonstrator site area. To support this the team have recruited an additional four WTE (whole time equivalent) Band 5 CTAC nurse and opened two additional CTAC rooms in South East Edinburgh. One outcome measure for this work is the percentage of CTAC patients in the demonstrator site area seen at CTAC rooms in South East Edinburgh. Since PCPIP started, the median percentage of patients seen per month has increased from 57% to 67%, indicating that additional capacity has been created (*Figure 10*). The data continues to trend upwards now that the new CTAC rooms are open.

Figure 10: Percentage of CTAC patients in South East Edinburgh seen at South East Edinburgh CTAC locations between January 2024 and April 2025



The Edinburgh City HSCP team identified a balancing measure to monitor the percentage of demonstrator site patients being seen at other Edinburgh City HSCP CTAC locations. Since introducing the changes, the median percentage of patients needing to travel has reduced from 43% to 34%, indicating that more people are able to access care closer to home (*Figure 11*). The data continues to trend downwards now the new CTAC rooms are open. This has potential to reduce health inequalities for certain groups of people who find it difficult or impossible to travel to other parts of the city to access CTAC.

Figure 11: Percentage of CTAC patients in South East Edinburgh seen at other Edinburgh City HSCP CTAC locations between January 2024 and April 2025



Pharmacotherapy

At the start of PCPIP, pharmacotherapy was delivered in practices by allocated pharmacists with some pharmacy technician support. The volume of level 1 work made it difficult for pharmacists to provide level 2 and level 3 services. The initial proposal for PCPIP focused on establishing pharmacy hub access for all practices, introducing the role of pharmacy support worker (PSW), and recruiting lead pharmacists to support the development of pharmacist and pharmacy technician roles in practice.

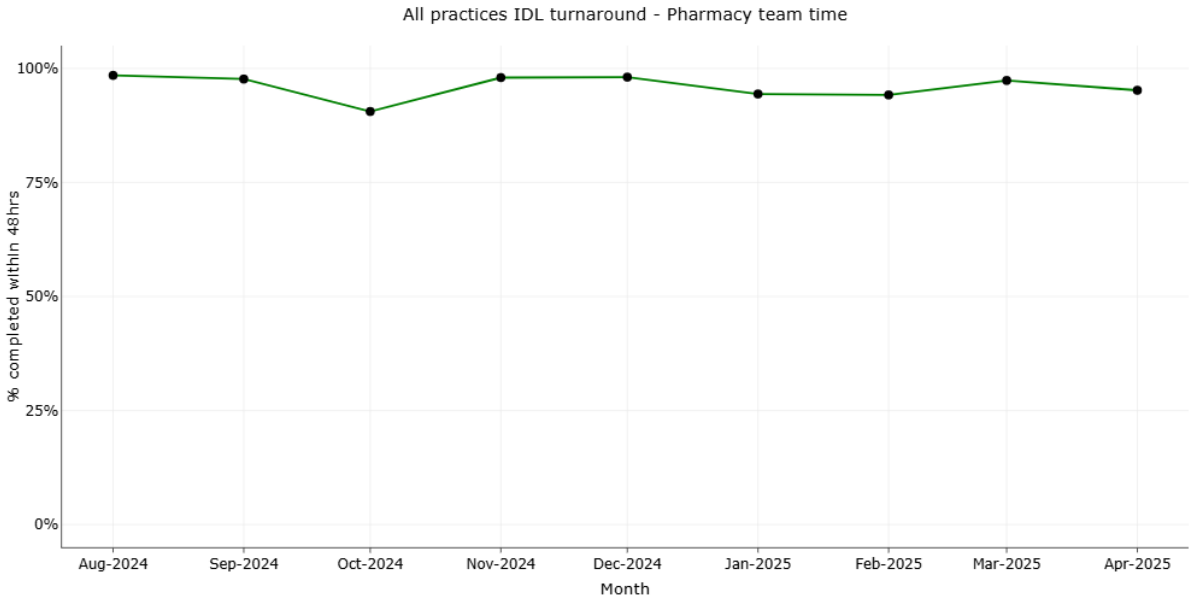
The Edinburgh City HSCP team expanded an existing pharmacy hub, and this service is now available to all but one demonstrator site practices. The hub focuses on actioning IDLs and OPLs with aims to increase the proportion of IDLs and OPLs actioned by the hub and to process 90% of IDLs within the national target 48-hour turnaround time. Moving this work should create capacity for practice pharmacy teams to focus on other priorities.

To measure the impact of this change the Edinburgh City HSCP team recognised that they needed to understand where work was being completed and how long it was taking. In partnership with PHS, the team developed a dashboard to provide monthly information on where IDLs and OPLs were processed and turnaround times. This uses data from Docman systems in practices and the team worked with practices to agree data sharing and improve coding by refining a list of drop-down options. Two practices were initially added to the dashboard, and this has been expanded over time. The dashboard also includes data on some non-demonstrator site practices also served by the South East Edinburgh hub as a balancing measure to ensure that PCPIP work is not having a negative impact on the existing hub service. All dashboard data is from the version updated on 8 May 2025 and includes these additional practices.

The data included in the pharmacotherapy dashboard is dependent on data recording and so may not include all activity if not recorded correctly. If completed workflow items are deleted prior to data extraction this will also affect data completeness.

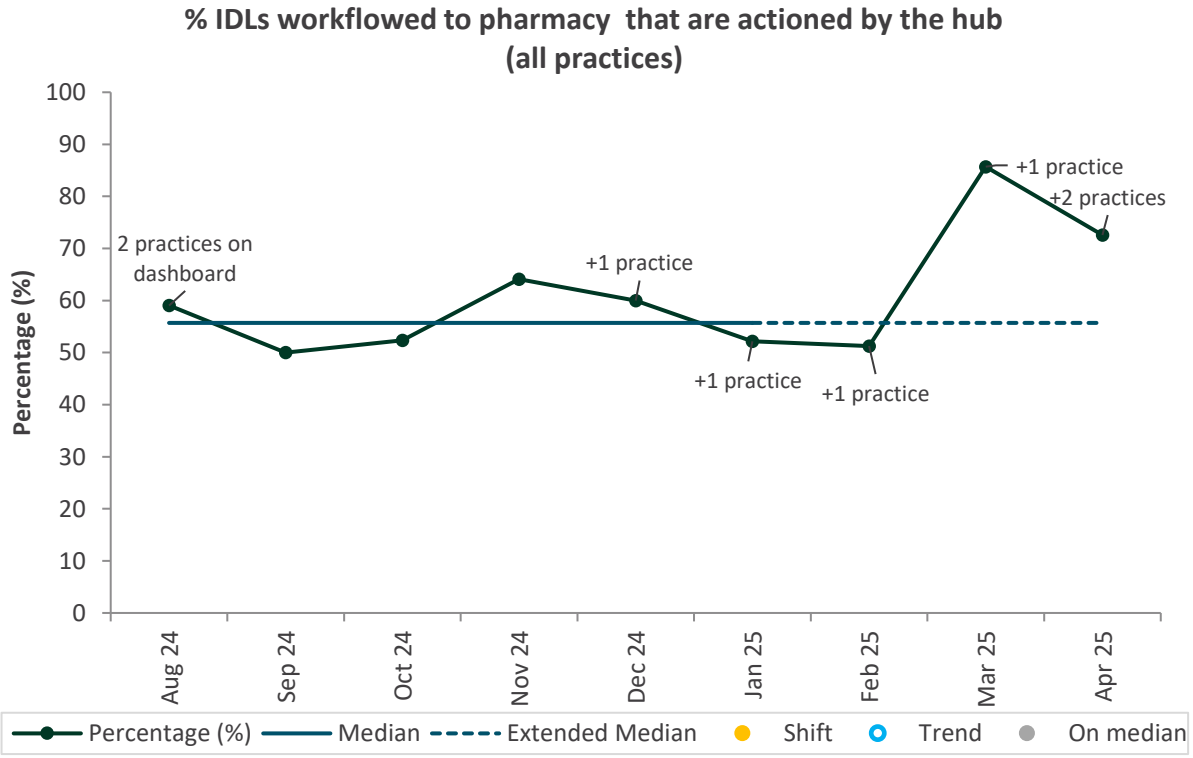
Data from the dashboard shows that the hub is consistently achieving their aim of processing 90% of IDLs within the 48-hour turnaround time despite processing increasing numbers of IDLs as more practices gain access to the service (*Figure 12*).

Figure 12: Percentage of IDLs completed within 48 hours by the pharmacy team for all dashboard practices August 2024 - April 2025, screenshot from dashboard



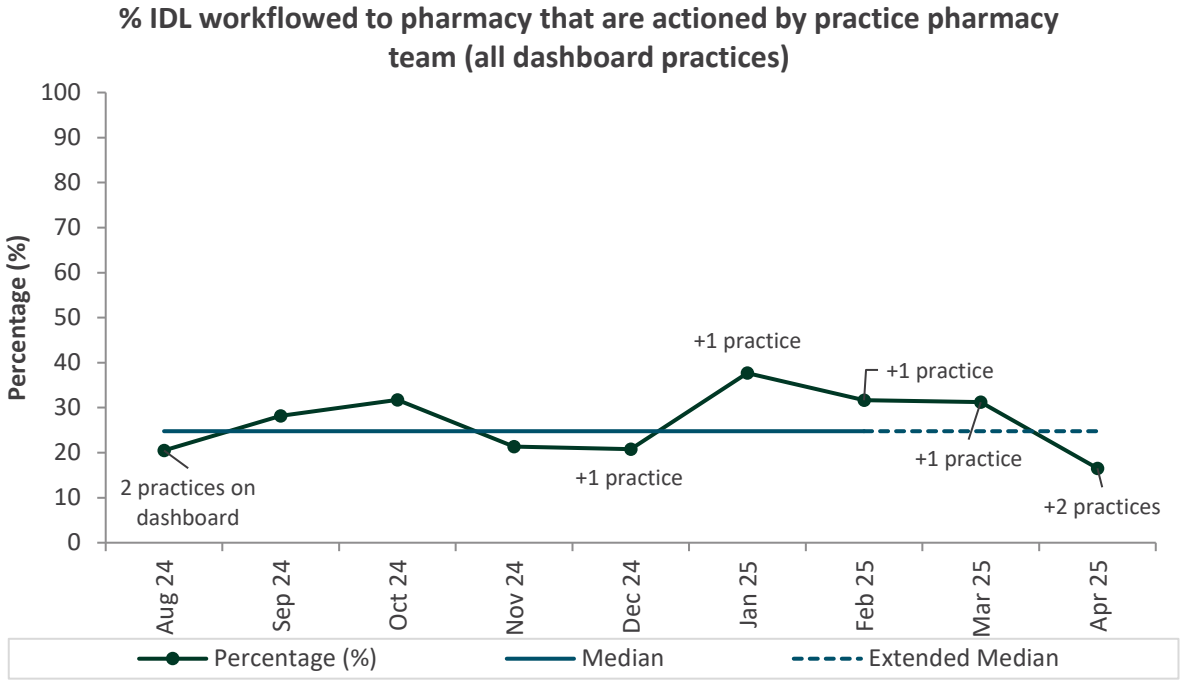
A process measure for this work is the percentage of IDLs actioned by the pharmacy hub. Data from the dashboard shows an upward trend in the percentage of IDLs completed by the hub over the data collection period despite the increasing number of practices using the service and included on the dashboard (*Figure 13*).

Figure 13: Percentage of IDLs actioned by the South East Edinburgh pharmacy hub between August 2024 and April 2025, data taken from dashboard updated 8 May 2025



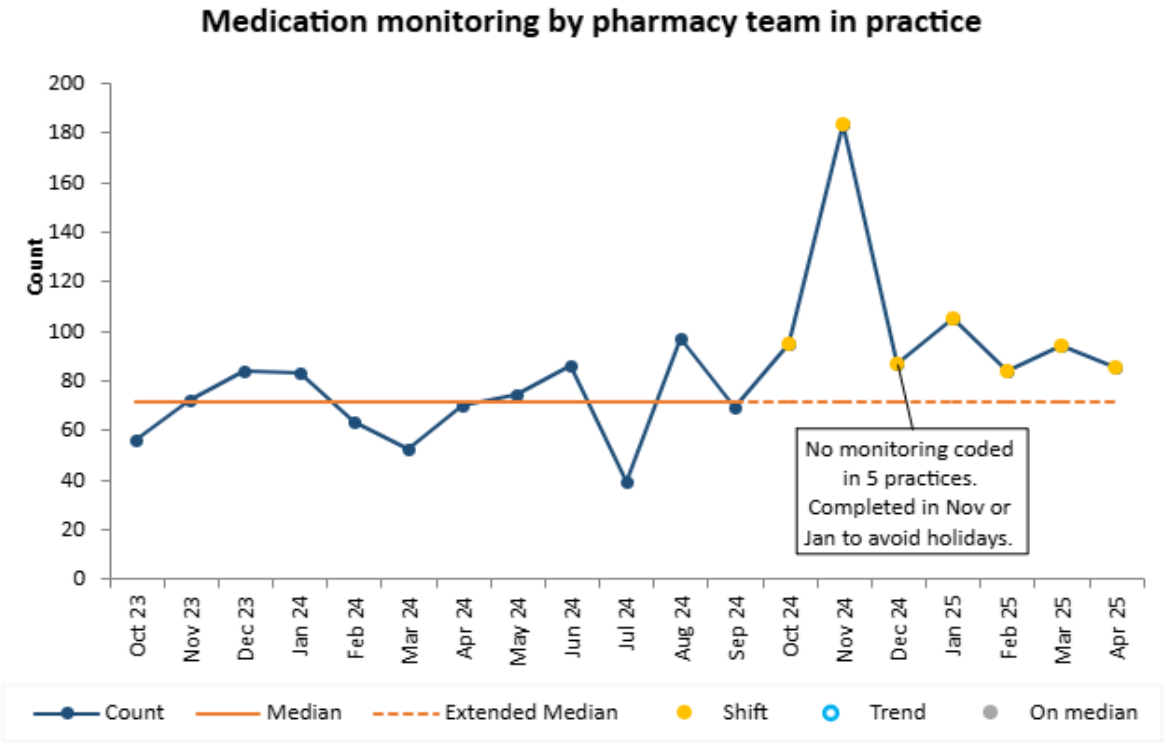
A balancing measure for this work is the percentage of IDLs which continue to be actioned by practice pharmacy teams. As the percentage actioned by the hub has increased this has trended downwards indicating a transfer of work which is enabling pharmacists and pharmacy technicians working in practices to start focusing on other priorities (*Figure 14*).

Figure 14: Percentage of IDLs actioned by practice pharmacy teams in South East Edinburgh between August 2024 and April 2025



Having developed the hub and introduced the PSW role, the Edinburgh City HSCP team is focusing on developing the roles of pharmacists and pharmacy technicians within practices. They are seeing early signs that the work done by the hub is enabling practice pharmacy teams to focus on other priorities. An example is the number of episodes of high-risk medicine monitoring completed by the pharmacy team which shows the beginning of an upward shift (*Figure 15*).

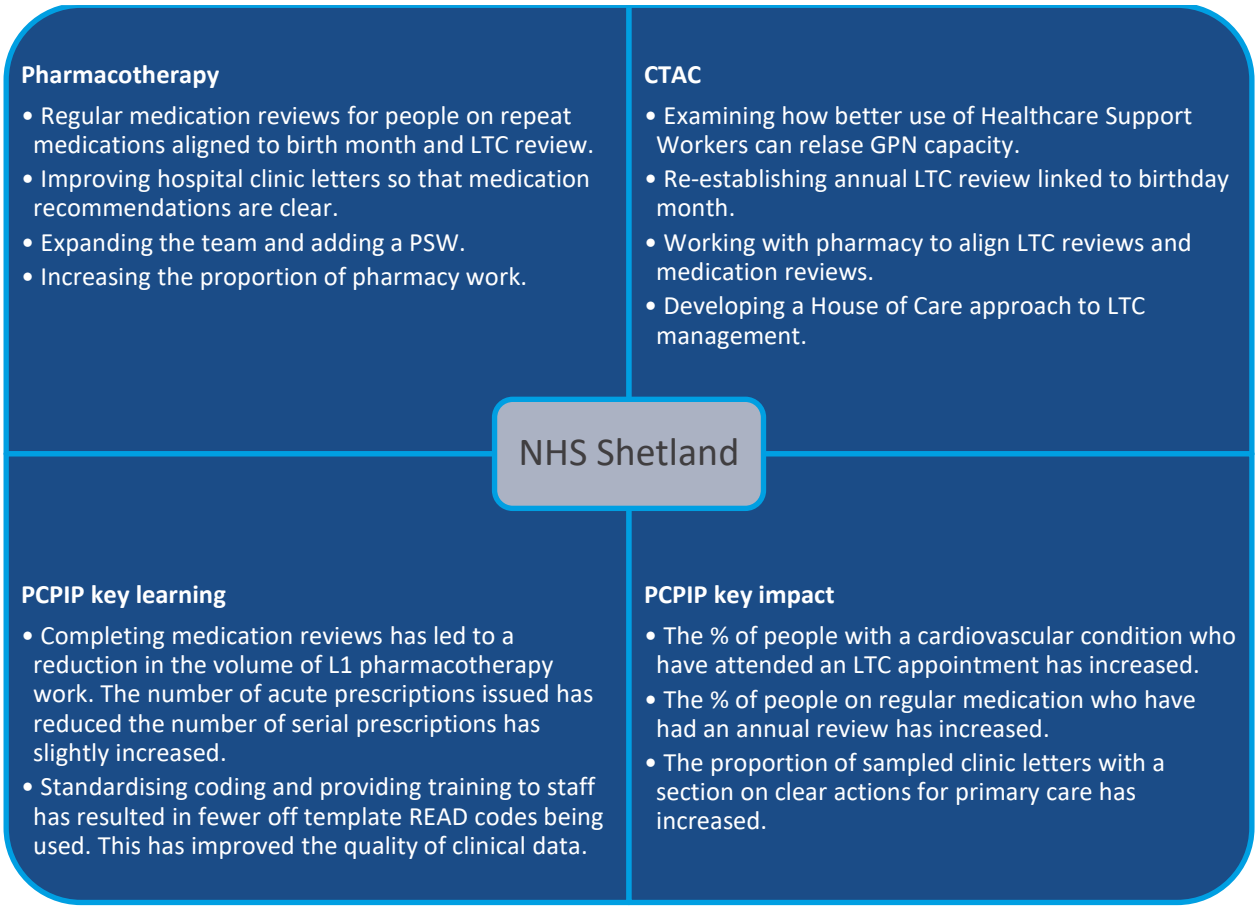
Figure 15: Medication monitoring completed by pharmacy team in Edinburgh City HSCP between October 2023 and March 2025



NHS Shetland

There is one health board and one HSCP for NHS Shetland which includes 10 GP practices, nine of which are 2c practices - operated by the health board. Prior to PCPIP, resource scarcity and the need to serve a dispersed remote and rural population made it difficult to provide an equitable service across NHS Shetland. The initial NHS Shetland proposal described an aim to improve consistency of service provision across NHS Shetland. Work to understand the system confirmed that this was an appropriate area of focus and highlighted inconsistencies in processes and coding which also needed to be addressed to enable equitable service provision. NHS Shetland adopted a co-ordinated approach across CTAC and pharmacotherapy services with the aim to improve long-term condition (LTC) monitoring and review, to provide an equitable service across NHS Shetland. A summary of this work is highlighted in *Figure 16*.

Figure 16: Summary of work carried out in NHS Shetland



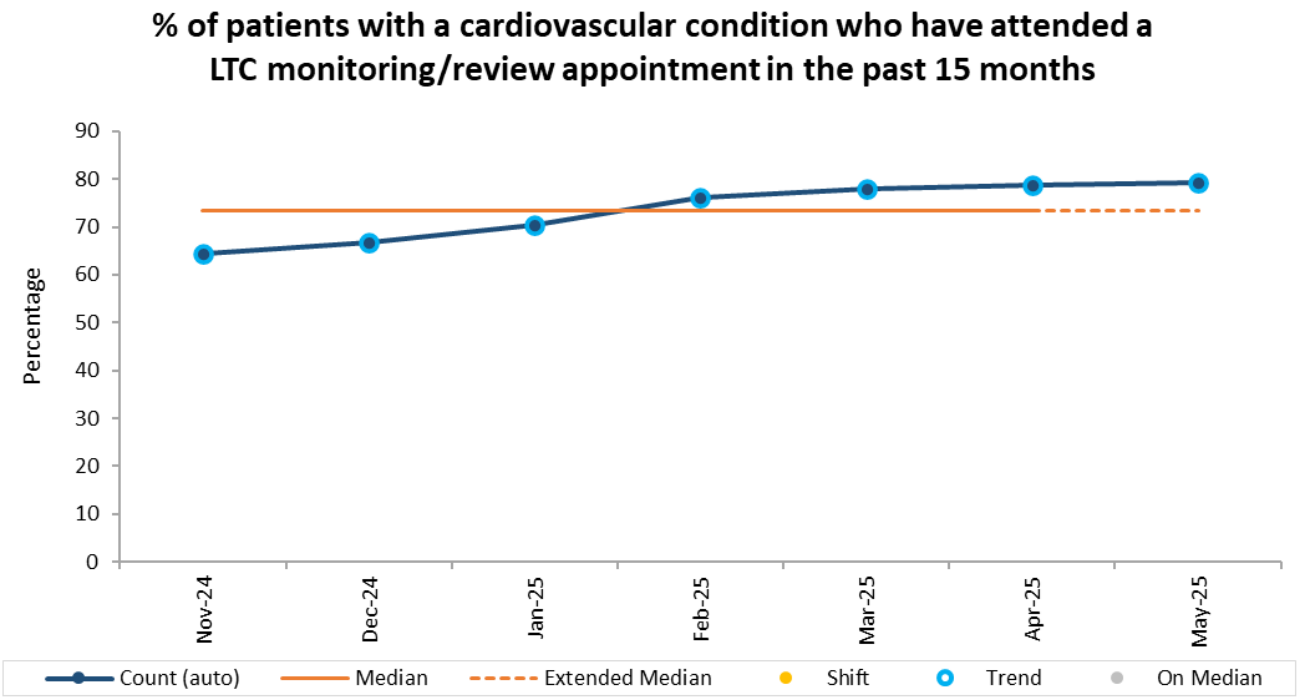
Selected examples of the QI work carried out in CTAC and pharmacotherapy services are explored in more detail below.

CTAC

To achieve their aim of improving access to LTC monitoring and review, NHS Shetland established a CTAC service concentrating on providing reviews across the health board. This work has a particular focus on patients with cardiovascular conditions.

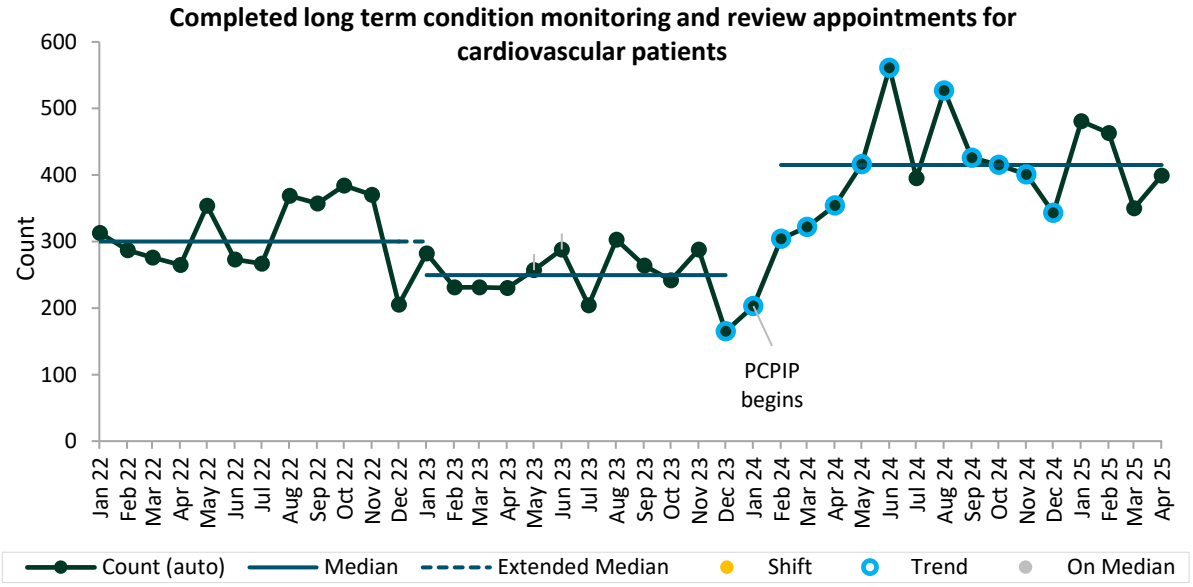
The outcome measure is the percentage of patients with a cardiovascular condition who have attended a monitoring or review appointment in the past 15 months. Data for this measure shows an upward trend, indicating that an increasing number of patients are receiving support to monitor and manage their cardiovascular LTCs (*Figure 17*).

Figure 17: Patients with a cardiovascular condition who have attended an LTC monitoring or review appointments in NHS Shetland between November 2024 and May 2025.



A process measure for this work is the number of reviews completed. This data shows the rapid increase in appointments completed since the outset of PCPIP. The median count of completed appointments has increased from 250 per month pre-programme to 415 per month (*Figure 18*).

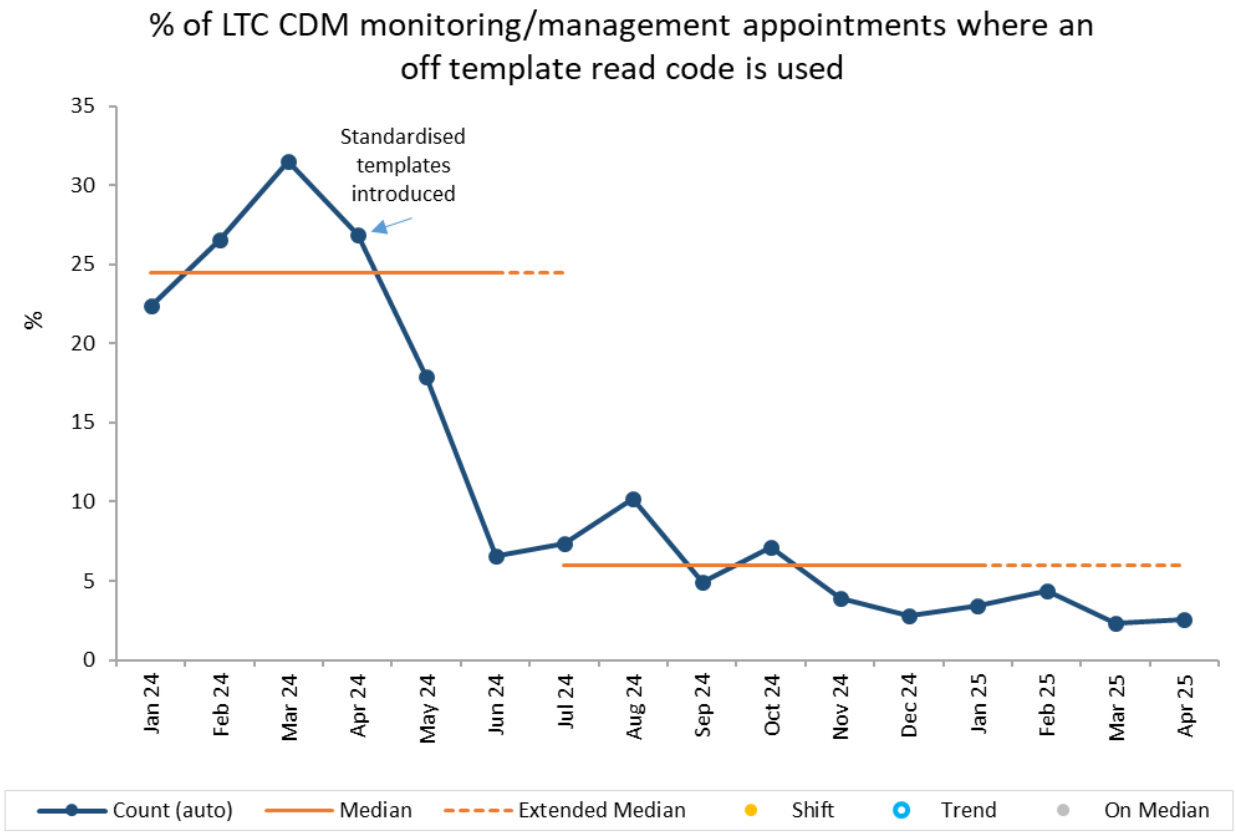
Figure 18: Long-term condition monitoring or review appointments completed for patients with a cardiovascular condition in NHS Shetland between January 2022 and April 2025



A key driver for change in NHS Shetland was ensuring a consistent approach to coding across all practices. They aimed to improve data quality to improve understanding of DCAQ, which would enable effective follow-up and continuity of care. At the start of PCPIP 25% of codes used for LTC monitoring and review appointments were 'off template'. NHS Shetland introduced standardised

templates across all practices, and provided staff with information, training and support to understand how codes were used to improve services. The introduction of a dedicated analyst role enabled regular data reporting that helped practices identify inconsistencies, track progress and better understand the impact of their coding practices. The median number of off template codes used in LTC monitoring and review has reduced from 25% to 6% during PCPIP (*Figure 19*). This indicates that coding is being used more consistently, enabling better data quality and ensuring patients can be offered timely and appropriate care.

Figure 19: Long-term condition monitoring or management appointments where an off template read code is used in NHS Shetland between January 2024 and April 2025



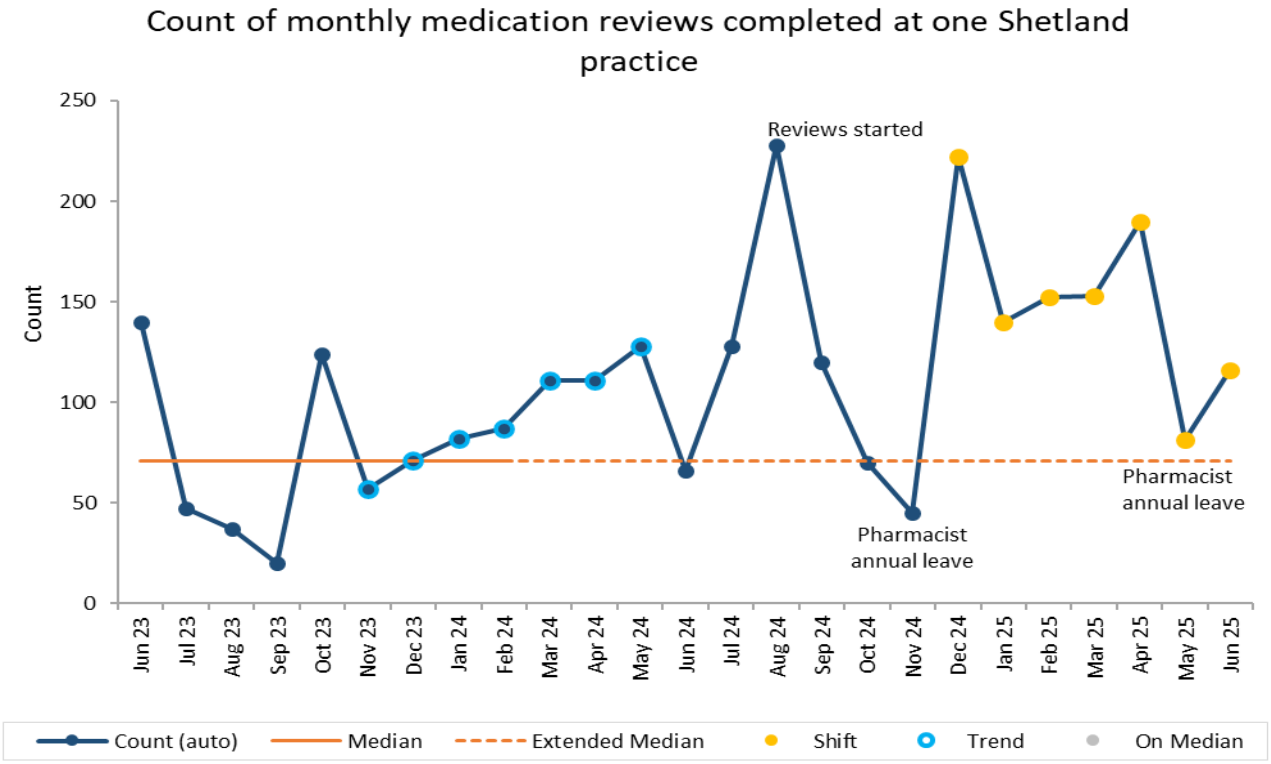
Pharmacotherapy

Pharmacotherapy work is focused on delivering an equitable service using remote and hybrid working solutions and ensuring all patients prescribed regular medication have an annual medication review. NHS Shetland has targeted level 2 and level 3 pharmacotherapy functions outlined in the GMS contract, believing that efficient work in these areas provides 'trickle-down' benefits on level 1 service provision.

A key aim of the pharmacotherapy work is to ensure that all patients prescribed regular medication have access to an annual medication review. This ensures that the medication-related healthcare needs of patients are being proactively addressed, that monitoring needs are met, and that medication advice is given where required.

As part of PCPIP, one practice was allocated an additional 7.5 hours per week of advanced clinical pharmacist time to implement a pharmacist-led annual medication review process. Patients in need of review were identified and prioritised using a local data intelligence system. This work has helped to identify missing patients in the system who had not been ordering, or were struggling with, their medications. The progress of this work is being tracked by looking at the count of medication reviews per month in the practice, using read codes extracted by the local health intelligence platform. Monthly data over time shows an increase in the number of reviews carried out each month in the practice, with a shift apparent from December 2024 onwards (*Figure 20*).

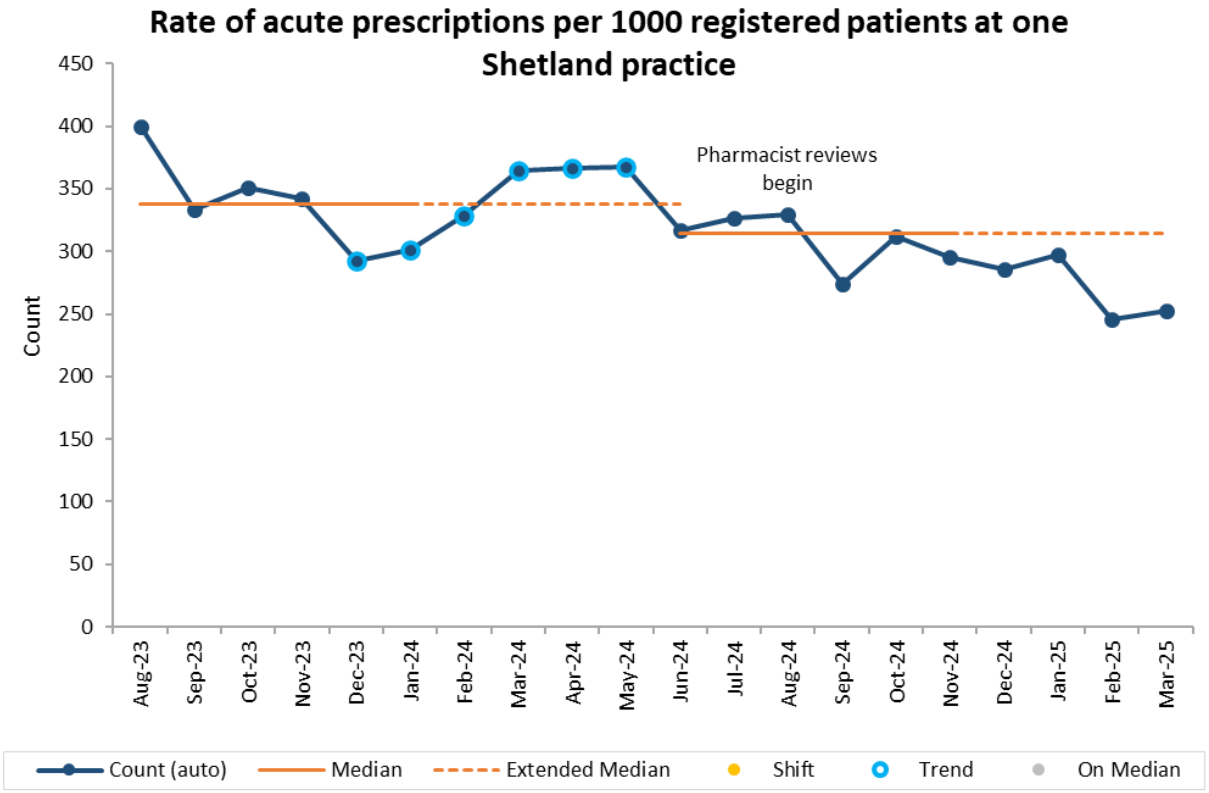
Figure 20: Monthly medication reviews completed at one NHS Shetland practice June 2023 - June 2025



The outcome measure for this work is percentage of people on regular medication who have had a medication review completed within 180 days of birth month. Data for this measure is being developed but February to April 2024 audit data showed that an average of 39% of people had had a medication review completed within the last 12 months. In September to November 2024 this rose to 91% indicating progress towards the aim.

Although the focus of NHS Shetland was to improve the number of people who had received a medication review, data was also collected on the impact this had on acute prescriptions. *Figure 21* shows the rate of acute prescriptions issued per 1,000 practice population at this practice. The median has reduced from 337 per month to 315, which suggests that the new review process is helping to reduce the number of acute prescriptions issued.

Figure 21: Acute prescriptions issued per 1,000 practice population in one NHS Shetland practice between August 2023 and March 2025



Challenges and limitations

As each of the four demonstrator sites was at a different point of maturity for its CTAC and pharmacotherapy provision, each site has undertaken bespoke QI approaches based on the improvement journey.

There have been several challenges and limitations experienced by the teams.

- **Recruitment:** Some significant delays to recruitment based on local health board priorities.
- **Data and IT systems:** The availability and access to data sets and limitations to local IT systems have meant that the teams have had to manually collect QI data, creating additional workload.
- **Premises:** Some demonstrator sites have been restricted from implementing change ideas that require additional or longer access to premises in GP practices and health board venues.
- **Local QI capacity:** Each demonstrator site has had varying access to local QI support and capacity in boards, determining how quickly they could initiate local QI measurement plans, capture data and begin testing.

Next steps

Demonstrator sites are actively working to access and present data over time, particularly in areas where data is currently unavailable. They are also considering the implications of the data collected during the national WoCA to inform and guide their improvement initiatives. In addition to focusing on QI data, progress is being made in capturing broader insights to ensure that these learnings can be shared as part of the wider PCPIP evaluation.

Workstream 2: Week of care audit

Background

A national WoCA tool has been developed to explore MDT working as described in the GMS contract. The national WoCA collected data on distribution of activity within practices and potential task transfer within MDT working. This section includes data from the first WoCA which took place in March 2025.

Methodology

Description of the week of care audit

The WoCA provides insights into the current workload for GPs and GPNs and to what extent these professionals are working as expert medical or nursing generalists. It also explores the activities undertaken by pharmacotherapy teams in participating areas and provides insights into potential wider use of MDT working in line with the GMS contract. For all other staff members including occupational therapist, physiotherapist, and mental health nurse, data were requested on their working hours and appointment numbers to evaluate the staffing levels and activity of these groups. This approach avoids overburdening practices with a comprehensive data collection process. The WoCA tool was designed to provide data on MDT working as described in the GMS contract and does not take into account individual services available in each HSCP area.

Tool development process

The WoCA tool was based on work carried out in each demonstrator site to understand the system. This tool was developed in collaboration with national clinical leads and tested by clinicians working in general practice. The WoCA tools are designed to facilitate the collection of high-quality data, while minimising the data collection burden on participating clinicians and to ensure data analysis could be completed in line with agreed programme timelines. The tools used in the first WoCA are included in Appendix 2.

The WoCA asked GPs, GPNs, pharmacotherapy staff and practice managers to record information over a 5-day period.

GPs recorded consultations including:

- the main reason for the appointment
- the time spent on the appointment, and
- whether they were the most appropriate person to conduct the consultation. If not, they were asked to record which member of a full MDT could be more appropriate for the consultation.

GPs also recorded non-consultation activities, including:

- the type of task and the approximate number (for example, 10 acute prescriptions)
- the time spent on each task, and
- whether they were the most appropriate person to perform the task. If not, they should specify which member of a full MDT could carry out the task.

GPNs recorded activities including:

- the main activity or reason for the appointment
- the time spent on those appointments
- admin tasks carried out, and
- whether a full CTAC team could have completed the activity.

Pharmacists, pharmacy technicians, and PSWs documented the number of activities of different types they carried out in both practices and pharmacy hubs.
Practice managers were asked to complete information on usual practice staffing and staff availability during the audit week for all staff.

Data collection techniques

Information sessions to describe and share the WoCA tools were held for all participating practices with support offered during the data collection period. Each practice received a summary of their data analysis and participated in discussions to reflect on the data collected for their practice.

Analysis plan

Once Healthcare Improvement Scotland received the data, it was reviewed for accuracy and completeness before being entered into MS Excel-based visualisation tools. These tools display each practice's data and highlight key insights across the four areas: GP consultations, GP non-consultations, GPN and pharmacotherapy. A guidance document for data entry and analysis is available upon request.

Data collection

Each demonstrator site selected three practices per HSCP and included practices that varied in size, location, practice population and demographics wherever possible. *Table 1* below provides an overview of key characteristics of the practices who participated in the WoCA. We are not reporting practice level data in PCPIP and therefore some characteristics have not been included to ensure anonymity is protected.

Table 1: Description of participating practices for Week of Care Audit

Practice	Practice size			Deprivation	Demographic (Ageing population)
	Small	Medium	Large	Over a third of patients in Quintile 1?	Percentage of practice population 65+
P1	✓			✓	23%
P2		✓		X	24%
P3			✓	X	22%
P4			✓	✓	16%
P5			✓	X	35%
P6			✓	✓	24%
P7		✓		X	19%
P8	✓			X	25%
P9			✓	X	32%

P10	✓			X	22%
P11	✓			X	25%
P12		✓		X	28%
P13			✓	X	4%
P14		✓		✓	17%
P15		✓		X	20%
P16	✓			X	20%
P17	✓			X	24%
P18	✓			X	33%

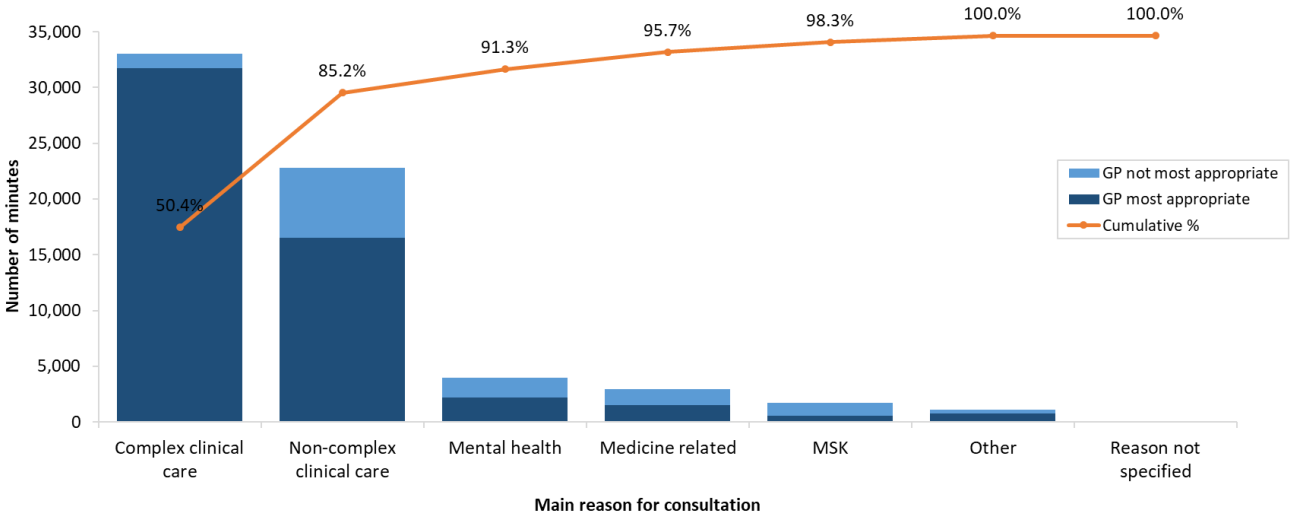
First week of care audit data

The first WoCA recorded approximately 5,000 GP consultations and 20,000 non-patient-facing GP activities, which equates to over 1,600 GP hours. The audit recorded over 2,000 GPN activities, which equates to over 590 GPN hours, and around 5,000 pharmacotherapy activities.

GP consultations

Across the 18 participating practices, 96 GPs submitted data for the WoCA and this is shown in a Pareto chart (*Figure 22*). While some submissions were incomplete, the available data captured 5,084 GP consultations, totalling 1,091 hours and 59 minutes of GP time. For consultations where time was recorded, the average duration was just under 13 minutes. Over 50% of this time was spent on complex clinical care, with 95% of those consultations deemed appropriate for a GP. However, overall, GPs reported that 22% of consultations they recorded could have been more appropriately handled by another member of the MDT, representing 19% of total GP time. This is equivalent to a potential saving of 204 hours and 14 minutes of the total time recorded.

Figure 22: Pareto chart showing the number of minutes spent on different GP consultation types, by whether the GP was the most appropriate person to take the consultation



The heat map in *Figure 23* illustrates the potential use of MDT members. This chart shows the number and type of GP consultations which could have been carried out by another member of the MDT. This does not reflect whether continuity of care would be impacted. Non-complex clinical care was the most frequently cited type of consultation that could be carried out by alternative MDT

members, with advanced nurse practitioners (ANPs) considered the most appropriate professional group. When combining practice and community pharmacy staff, pharmacy staff emerged as the second most frequently recommended MDT professional group for GP consultations overall, after ANPs.

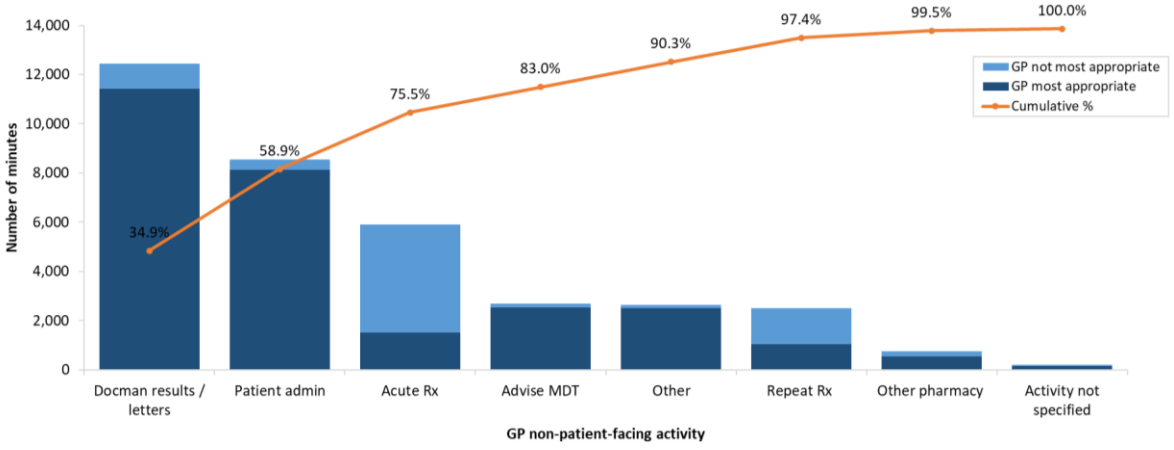
Figure 23: Heat map showing GP consultation types, by which member of the MDT would have been more appropriate for the consultation.

MDT Member	GP Consultation Type: Complex clinical care	Non-complex clinical care	Mental health	MSK	Medicine related	Other	Reason not specified
ANP	34	302	1	2	1	2	0
GPN	5	48	0	0	3	4	0
CTAC	2	6	0	0	0	1	0
Practice pharmacy	15	65	1	2	112	2	0
Comm. pharmacy	10	78	0	1	14	3	0
MSK physio / APP	10	49	4	89	2	3	0
MH nurse	7	17	123	0	7	7	0
Link worker	1	5	0	0	0	2	0
Other role	16	35	4	2	1	22	0
Role not specified	5	5	1	1	4	0	0

GP non-consultation

The Pareto chart in *Figure 24* illustrates the non-patient-facing activities reported by GPs. A total of 20,612 such activities were recorded, accounting for 593 hours and 57 minutes of GP time. Of this, 58.9% was spent on either Docman results and letters or patient administration tasks - such as reviewing lab results, responding to outpatient correspondence and making referrals. Overall, GPs reported that 33% of their non-consultation activity could have been more appropriately carried out by another member of the MDT, representing 22% of total time and a potential saving of 130 hours and 10 minutes of the time recorded.

Figure 24: Pareto chart showing the number of minutes spent on different GP non-consultation activities, by whether the GP was the most appropriate person to carry out the activity



The heat map in *Figure 25* details the potential GP time that could be saved if non-patient-facing activities were carried out by different MDT members. It also shows the type of activities for which a

member of the MDT was considered more appropriate. Acute and repeat prescriptions were the most frequently recorded type of activity that could have been completed by another member of the MDT. Pharmacy staff were the most cited alternative members of the MDT who could complete these tasks.

Figure 25: Heat map showing time taken for GP non-patient-facing activity, by which member of the MDT would have been more appropriate to complete the activity.

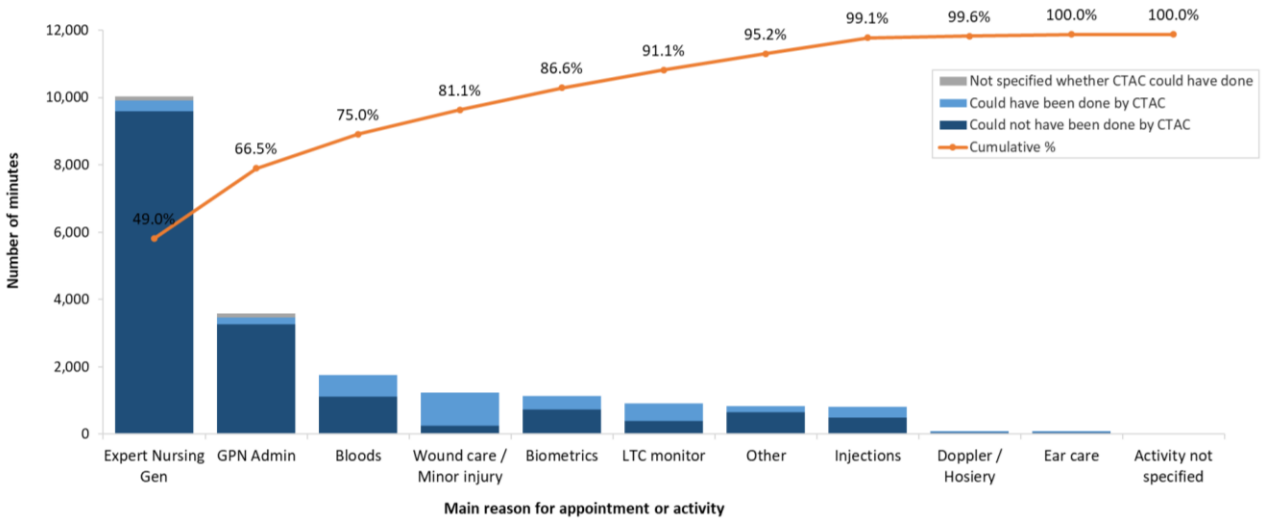
GP Non-Patient-Facing Activity

MDT Member	Acute Rx	Repeat Rx	Other pharmacy	Docman results / letters	Patient admin	Advise MDT	Other	Activity not specified
ANP	0h21m	0	0	2h9m	0h51m	1h10m	0h15m	0
GPN	0	0h15m	0	0h42m	0	0h10m	0h6m	0
CTAC	0	0	0	0	0	0	0	0
Practice pharmacy	71h35m	21h52m	3h22m	3h27m	2h3m	0h33m	0h15m	0h34m
Comm. pharmacy	1h21m	0h22m	0	0	0h10m	0	0h7m	0
MSK physio / APP	0	0	0	0	0h7m	0	0	0
MH nurse	0	0h6m	0h10m	0h3m	0h4m	0h10m	0	0h10m
Link worker	0	0	0	0	0	0	0	0
Other role	0	1h30m	0	0	0h50m	0h13m	0h40m	0
Admin	0	0h35m	0	10h9m	2h38m	0h5m	0h35m	0
Role not specified	0	0	0	0h25m	0	0	0	0

GPN

Across the 18 participating practices, 25 GPNs submitted data, recording a total of 2,061 activities - equivalent to 341 hours and 11 minutes of GPN time. This data is illustrated in the Pareto chart in *Figure 26*. Overall, GPNs reported that 16% of these activities could have been completed by CTAC staff, potentially saving 61 hours and 31 minutes (18%) of the total recorded GPN time.
Analysis of this data showed that 27% of recorded activities fell outside the core responsibilities defined in the expert nursing generalist role. This suggests an even greater proportion of tasks could be delegated to CTAC staff, with a potential time saving of 114 hours and 18 minutes.

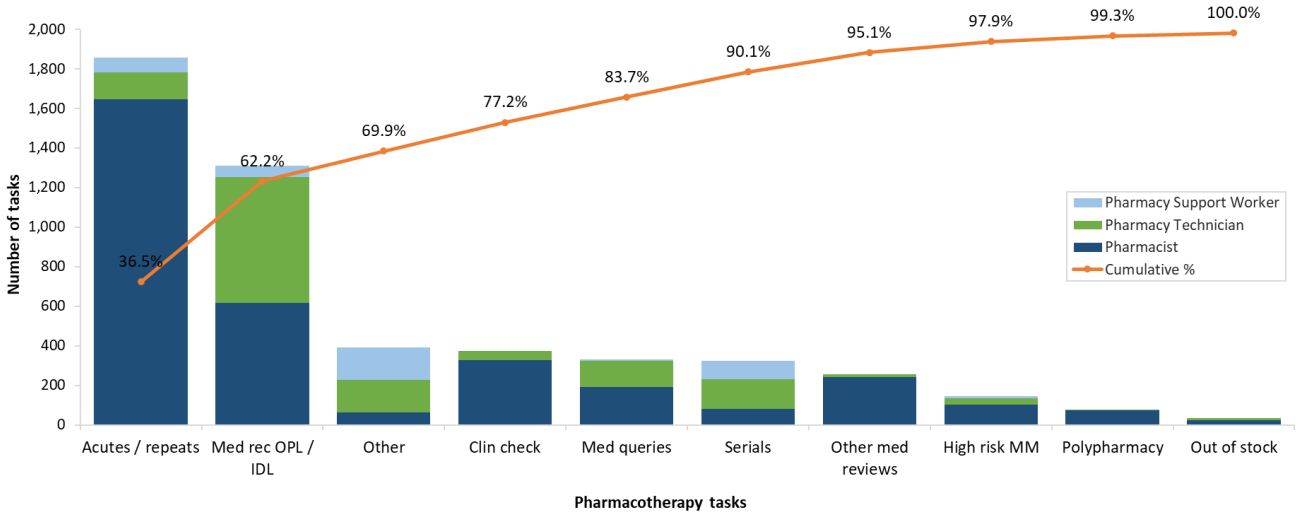
Figure 26: Pareto chart showing the number of minutes spent on GPN activities and appointments, by whether CTAC could have carried out the activity



Pharmacotherapy

The Pareto chart in *Figure 27* presents data collected by pharmacotherapy staff across the 18 participating practices. A total of 76 staff members completed the WoCA including 33 pharmacists, 34 pharmacy technicians, and 9 pharmacy support workers, with 24 of these staff based in a pharmacotherapy hub. Together they recorded 5,085 tasks: 3,367 by pharmacists, 1,316 by pharmacy technicians, and 402 by support workers. The most frequently recorded task type was acute and repeat prescribing which represent 36.5% of tasks (1,857 tasks) followed by medicines reconciliation (meds rec) for OPLs and IDLs which represent 25.7% of tasks (1,308 tasks). From these data, acute and repeat prescribing is mainly completed by pharmacists and medicines reconciliation are predominately completed by pharmacists or pharmacy technicians. There were low numbers of polypharmacy reviews and high-risk medicines monitoring recorded during this WoCA.

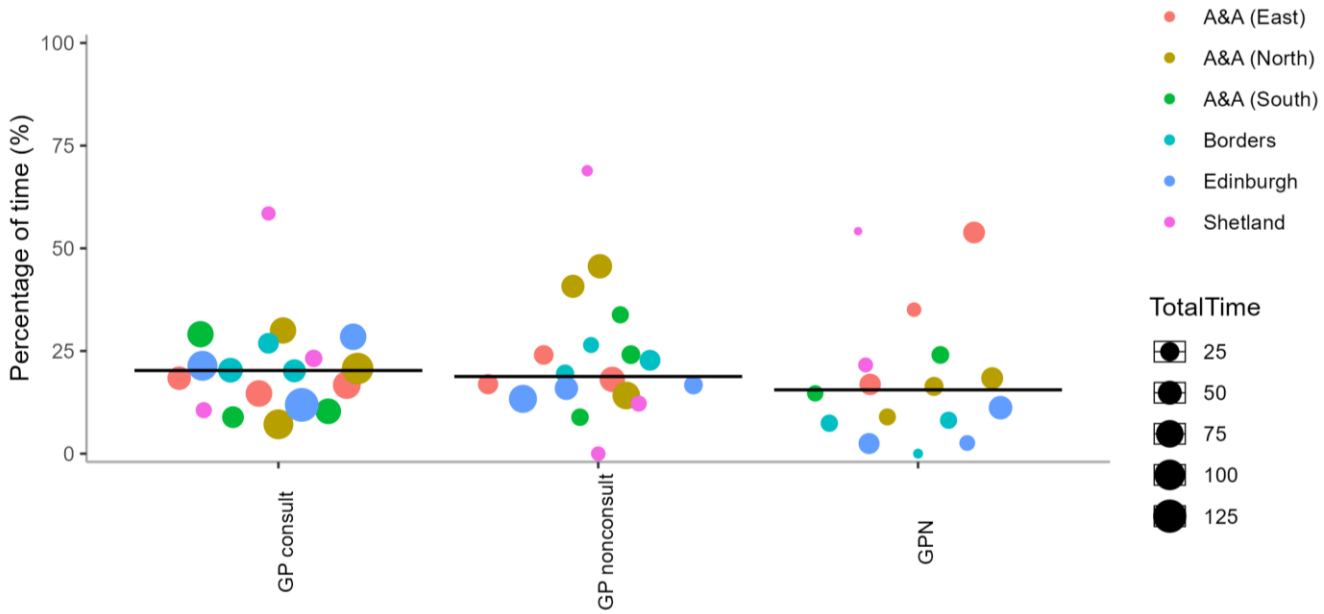
Figure 27: Type of pharmacotherapy task completed by role



Variation between practices

Figure 28 is a bee swarm chart which illustrates the variation in reporting across practices. The dots show the percentage of time that could have been saved if tasks had been carried out by other members of the MDT. This includes data on potential task transfers either from GPs to other MDT members, or from GPNs to CTAC staff. In this chart, each point represents a single practice.
The colour indicates the HSCP, while the size of the point reflects the total number of minutes recorded for activities - the larger the circle, the more time was recorded. Note that two practices did not submit GPN data: one in South Ayrshire HSCP and one in Shetland HSCP and are therefore excluded from this plot.

Figure 28: Percentage of time that could potentially have been saved by another member of the MDT carrying out the task, by practice, March 2025



Challenges and limitations

- Data completeness and quality was difficult to assess, due to manual data collection/input and incomplete information about staffing levels. It is likely that this varied considerably between sites.
- Practices varied enormously in size, staff composition and local context, so the aggregate figures do not accurately represent the experience of every practice.
- The sample size of three practices per HSCP is small and therefore may not be representative of the wider population.

Next steps

Data from the first WoCA suggests potential use of MDTs and task transfer in participating practices. The second WoCA was completed in June 2025 and the final WoCA is planned for September 2025. These will be used to provide insights of data over time in demonstrator site teams and will be used to understand use of MDT in participating areas and suggest potential task transfer to MDT.

Workstream 3: Economic analysis

The PCPIP economic analysis evaluates the value of the tests of change carried out in each demonstrator site, by examining both their costs and outcomes as well as the preferences of different staff groups regarding the tasks performed by GPs, GPNs and the wider MDT workforce supporting GMS. The economic analysis requires data from WoCAs and QI data submissions from each demonstrator sites. At this stage in the programme, the focus is on designing individual analysis tools and this section provides update on the process used to develop the economic analysis tools.

The economic evaluation includes:

- an assessment of the tests of change developed by each demonstrator site
- use of WoCA data to construct hypothetical scenarios that reflect the actual caseloads of GPs, GPNs, and other MDT staff in primary care, and
- exploration of how staff allocate their time and their preferences for different tasks, given the competing demands on their time during the workday.

Together these elements will provide insights into the system's capacity for improvement and its limitations. The analysis will generate economic estimates of the costs and benefits associated with each test of change and will highlight how support for MDT staff - and the pressures they face - can influence the potential to enhance capacity within the system.

Methodology

Data collection techniques

Economists are gathering cost data from routine published sources, published academic studies and relevant local accounts or estimates when appropriate. Outcomes will be derived from the demonstrator site QI data submissions to Healthcare Improvement Scotland for each outcome measure specified in the individual measurement plans. If additional information is necessary, it will be obtained locally (for instance, if local teams possess audit data) or from the wider literature.

Definition of measures

Outcome measures are outlined in the QI measurement plans which have been developed locally by each demonstrator site. Costs will be measured in Pounds Sterling for the most recent price year available. Appropriate standard inflation indexes will be used to adjust older prices to reflect the most recent price year. The analysis perspective will focus exclusively on NHS boards and HSCPs only; wider public sector or societal costs and benefits will not be considered.

The staff preference work will likely be assessed through a dichotomous response from staff members (either yes or no to a hypothetical scenario or the choice between hypothetical scenario 1 versus hypothetical scenario 2).

Analysis plan

For the demonstrator sites, the costs and consequences of the tests of change delivered by each demonstrator site will be summarised to evaluate their cost-effectiveness in terms of (at the very least) the direction and magnitude of each change.

The number of tests of change may vary between sites, and some tests of change may be assessed within the same model framework. If multiple demonstrator sites have collected the same outcome(s) (in addition to cost), it may be possible to combine the economic evaluations of these demonstrator sites for each of these consistent outcomes into a single cost-effectiveness assessment. This will provide an example of the value of investing in improvement for that particular outcome within different contexts.

Efficiency in terms of capacity within the system will also be considered through local sampling of staff regarding their preferences for choosing between standardised hypothetical examples of caseload scenarios including the time taken to complete tasks.

If staff do not consider it feasible to undertake this using quantitative methods, a narrative summary of the factors influencing capacity (expanding the preliminary qualitative work to inform this component of health economics) will be provided instead; however, the aim remains to use a questionnaire-based design.

Health economists will consult as many experts as possible within the timeframe to validate data on caseload examples and any available quantitative data on capacity gains, including the second and third WoCA data. Microsoft Excel and RStudio will be used to analyse the health economics data.

Progress in data collection

Most of the data collected so far has been used for the preparation plans for analysis. Economic analysis plans have been developed for two demonstrator sites and work is ongoing across the other demonstrator sites to ensure appropriate real-life caseload examples and ensure the questions included in the economic evaluation plans are realistic. Planning analyses for all four demonstrator sites simultaneously have not been feasible and therefore plans are being developed for each individual demonstrator site.

Workstream 4: Qualitative data

Background

The qualitative workstream of the PCPIP evaluation consists of interviews and focus groups and aims to address gaps in existing evidence by exploring how the GMS contract has been implemented and experienced by primary care staff and patients across the four demonstrator sites. It also examines the roles of CTAC services, Pharmacotherapy and QI support for primary care in more fully implementing the contract. Considering previous findings, the health services researchers (HSRs) working on the qualitative evaluation have been gathering data on the views and experiences of GPs and the wider MDT, including practice administrative, pharmacotherapy and CTAC staff, to better understand how the contract is being implemented locally and the broader impact of MDT collaboration. Qualitative data is also being collected to gather the views and experiences of service users.

Methodology

A multi-strategy and pragmatic approach is being adopted to identify, access and recruit samples of the primary care workforce and service users across the demonstrator sites, as outlined in the evaluation proposal. The HSRs have collaborated with demonstrator site leads, representatives from general practice and existing clinical networks to facilitate staff engagement and recruitment for interviews. Overall, this has proven to be a successful approach, as evidenced by the high levels of engagement and recruitment.

Primary care workforce

Semi-structured interviews and uni-disciplinary focus groups were conducted both online and in person with primary care staff and PCPIP leadership teams across the four demonstrator sites. The recruited participants included GPs, ANPs, GPNs, practice managers, administrative personnel, pharmacotherapy staff and CTAC staff. Additionally, focus groups and interviews were organised with other service personnel, such as first contact physiotherapists (FCPs), community mental health service staff, and community link workers, as outlined in the proposal.

Service users

Semi-structured telephone interviews have been conducted with service users, with their identification primarily carried out by practice managers and staff. To enhance recruitment rates, alternative recruitment methods are now being used and the exploration of text messaging to service users is currently in progress.

Data management

Data is collected, stored and managed in accordance with the Healthcare Improvement Scotland Data Protection Regulation.

Analysis plan

Transcripts are coded using NVivo (version 15). Researchers meet regularly to discuss the coding process, identify emerging themes and assess data saturation. After coding all interviews and focus groups and performing thematic analysis within a comprehensive framework for each demonstrator site, the team will collectively review, reflect on and categorise themes across the four demonstrator sites. The findings presented in future reports will be structured thematically as a whole, rather than by individual demonstrator site, to maintain anonymity. Contextual factors relevant to the findings from the demonstrator sites will be examined within these themes, with particular emphasis on factors related to delivery models, staffing levels and work practices, as applicable.

Progress in data collection

A total of 96 interviews (including 20 service users) and 51 focus groups have been conducted to collect qualitative data from staff across the demonstrator sites and the wider MDT, and service users. Staff members are highly engaged in these activities (*Table 2*). The sample is a convenience sample; clinical networks and practices in each demonstrator site were informed about the evaluation, and participants and practices opted in based on their willingness and availability.
Data collection for the staff groups began in October 2024, while data collection for service users commenced in November 2024. Primary care staff data collection has been completed at NHS Borders, Edinburgh City HSCP and NHS Shetland and ongoing for NHS Ayrshire & Arran. Service user data collection is ongoing at NHS Shetland and NHS Ayrshire & Arran (*Table 3*).

Table 2: Total number of staff and service user participants in an interview or focus group (as at 1 May 2025)

Staff group	Participants
GPs (including locums)	32
General practice nurses	11
Advanced nurse practitioners	12
Pharmacotherapy staff	55
CTAC staff (including CTAC support workers)	38
Practice managers	19
Administration staff	22
Additional services staff*	15
Total staff	**204**
Service users	20
Members of leadership team	42
Total	**266**

*Community link workers, mental health workers, first contact physiotherapists.

Table 3: Total number of staff and service user participants in an interview or focus group, by demonstrator site (as at May 1 2025)

Demonstrator site	Staff	Leadership team	Service users	Total
NHS Ayrshire & Arran	33	21	0	54
NHS Borders	54	8	9	71
Edinburgh City HSCP	63	7	10	79
NHS Shetland	54	6	1	61
Total	**204**	**42**	**20**	**266**

Areas explored in data collection

Initial interpretation of the data and coding has occurred regarding staff perspectives on:

- the impact of the GMS contract and MDT expansion on staff roles, responsibilities, workload, and wellbeing
- the impact of MDT expansion on GP practice and the primary care system. Perspectives of barriers and facilitators to MDT working
- potential risks and safety related to the implementation of the GMS contract and MDT expansion
- the impact of contract implementation and MDT expansion on service users
- the implementation of the GMS contract and associated changes, and
- recommendations for improvements and future changes in primary care.

Data saturation

The approach to assessing data saturation has been pragmatic and responsive. By utilising existing evidence on the required sample sizes for data saturation in qualitative research, alongside high-level data coding and analysis discussions, data saturation has thus far been assessed as achieved for the following staff groups across the demonstrator sites: GPs, ANPs, CTAC staff, pharmacotherapy staff, practice managers and administration staff.

High-level insight

Qualitative data collection is progressing well. Coding of the data is a first step to informing the full thematic analysis for the final report. Some provisional insights from this initial coding are set out below. These are based on high level analysis discussions which took place in April 2025.
These selected insights should not be considered definitive, as they will be subject to change as thematic analysis progresses and is completed in September 2025.

Insights from initial coding about challenges of integrating health board-employed and practice-employed staff

A range of staff groups reported that the integration of health board employed staff is creating challenges for GP practices.

Some examples included:

- issues with staff allocation to practices which can impact on staff continuity
- lack of control over external recruitment and line management of health board employed staff

- issues with workforce planning of health board staff (for example, annual leave, sick days) which can impact on the daily functioning of practices
- increased workload resulting from induction and training of health board employed staff, who are often subsequently not retained within the practice
- variation in role specifications, responsibilities, and skillset of staff within each of the health board roles
- absence of defined objectives and a collective working agreement, both between practices and the health board and within practices
- differences in Continuing Professional Development (CPD) time between health board and practice-employed staff, and
- additional financial strain created by resource requirements for health board employed staff, for example medical and administrative supplies, which are supplied by practices.

Insights from initial coding about increased demand on primary care

Primary care staff described growing pressure linked to rising demand, evolving service use, and unintended impacts of new care models. Examples include:

- Primary care staff perceive that rising patient demand quickly absorbs any increase in service capacity, contributing to sustained pressure on the system and workforce.
- the addition of contract services appears to have increased demand as the use of the different services grows and patient awareness for options such as self-referral becomes more established (potentially an unintended consequence of the contract).
- some primary care services regulated under the contract are reportedly becoming overwhelmed and now have waiting lists. This includes, for example, FCP services in some areas.
- pressure on the secondary care system is perceived to be directly impacting on demand in primary care. This includes multiple primary care appointment requests from patients on secondary care waiting lists.

Insights from initial coding about MDT working improving availability of appointments

Although significant challenges emerged because of the operational interface between health board-employed and practice-employed staff (as noted above in challenges of separate health board and practice-employed staff) MDT expansion was viewed as improving access for some practices in certain clinical areas.

Some interviewees described:

- Examples of CTAC services improving access by increasing the number of appointments, especially for patients requiring blood tests or wound care.
- Examples of Pharmacotherapy services providing patients with more regular contact through routine medicine reviews and follow-up, supporting safer prescribing and more person-centred care.
- Examples of ANPs providing quicker access especially for patients with acute health needs and when there are no GPs available.

- Examples of referral pathways for FCPs are improving with more musculoskeletal patients being seen by Physiotherapists at first point of contact and a reduced need for onward referral, for example to secondary care.

Insights from initial coding about changes to GP role

GPs reported changes to the type of patient group that they treat and the nature of their role. Examples included:

- increasing focus on those with more complex needs, such as long-term or multiple health conditions. This increases the mental and emotional burden on GPs.
- a sense of loss for managing the simpler patient issues and more relational aspects of care that once defined their role.
- being 'busier than ever,' with no reduction in workload following contract implementation.
- supervision and oversight of health board staff that can be time consuming and emotionally taxing, particularly when responsibility for safety or follow-up still ultimately falls with them.
- The high GP workload, complex patient cohort and decline in job satisfaction could be expected to have negative implications for future retention and recruitment of GPs.

Barriers to addressing inequality

A number of barriers to addressing inequalities have been discussed. Examples include:

- inequitable distribution of financial and staffing resource
- lack of time and capacity to address access needs, and
- limited understanding of how to address inequalities in individual groups.

Limitations

There are some limitations to the qualitative data collection which should be taken into consideration.

- The demographic characteristics of the recruited service users have varied little to date, resulting in a homogeneous sample.
- An in-depth exploration of health inequalities is limited by the lack of ethical approval to recruit service users based on protected characteristics.
- Sampling bias may exist in patient recruitment.
- There may also be potential bias in staff recruitment in some areas as a result of variations in recruitment strategies across staff groups in demonstrator sites.

Next steps

Data collection with primary care staff and service users in all demonstrator sites concluded by the end of May 2025 and June 2025 respectively. There will be a second round of interviews with leadership at each demonstrator site during June and July 2025 and all coding and thematic analysis will be completed by September 2025.

The timeline for qualitative evaluation activities (May–December) is included in Appendix 1.

Workstream 5: Service user views

We have submitted questions to Healthcare Improvement Scotland's citizen panel to gather wider views from patients on continuity of care and access in primary care. The citizen panel took place in June 2025 and will be reported on the Healthcare Improvement Scotland webpages at the end of November 2025.

Workstream 6: Local systems and record sampling

Background

There is currently no national system to collect and share operational data within primary care. To evaluate the impact of MDT working under the GMS contract, we have sampled data from local IT systems and records. PHS are supporting this data collection by working with local services, HSCPs and their associated GP clusters to access and extract relevant data from local systems to inform the evaluation. The operational data for evaluation through local sampling will encompass data on access to care, continuity of care, improved medicine management and the impact of MDT services on the workforce.

Methodology

Data from local IT systems and records are being collected from three practices per HSCP in each demonstrator site. This also includes services delivered by the HSCP, such as CTAC and pharmacotherapy services.

Each area that is being considered in the evaluation use different data and sources. For the access to care and continuity of care indicators, encounter data (involving some form of direct contact for clinical care between clinical staff and a patient, for example face-to-face or telephone consultations) will be obtained from the practice's Egton Medical Information Systems (EMIS) or Vision Systems. Data to understand improved medicine management will be sourced from the national Prescribing Information System (PIS) and the Scottish Therapeutic Utility (STU) and the data sources for workforce indicators are yet to be confirmed.

Progress in data collection

A Joint Measures Specification Workshop was held between PHS and Healthcare Improvement Scotland, which assessed the specifications and requirements for local IT system sampling and gathering recorded data.

PHS has undertaken work to further specify and confirm data definitions and data sources, validating aspects with Healthcare Improvement Scotland clinical leads and discussing them with colleagues in national teams as necessary, along with the demonstrator sites. Information governance wording has been compiled to assist practices in understanding what is requested and to obtain their consent for data sharing for this evaluation.

Discussions have taken place with local primary care representatives, and all participating practices have been identified. A preliminary data specification document has been shared with practices for information (Appendix 3) and data collection will start in June 2025.

Challenges and limitations

There are a number of challenges and limitations to collecting local system data with primary care teams.

Challenges

- Identification of GP practices to participate with the local IT data extraction has been challenging in some areas.
- Identifying staff with sufficient resources to support data extraction and quality assurance across all partnerships.
- The complexity of data extraction varies between practices, which may mean several different solutions are required for the same metric.
- Variations in approaches to system coding between practices will have to be explored to understand the comparability of data.
- The specification and extraction plan may change after initial engagement with GP practices.
- Identifying data sources for the workforce indicators.

Limitations

- Limited data infrastructure may restrict the ability to fully collect all measures.

Next steps

In the coming months, meetings will be held with each demonstrator site to formalise the approach and determine the local capacity needed to support data extraction. The outputs will undergo quality assurance and analysis in partnership with local stakeholders to ensure the data is accurate and suitable for inclusion in the national evaluation. Finally, aggregated and anonymised data and findings will be shared with Healthcare Improvement Scotland for inclusion in the final evaluation report.

Workstream 7: Board-wide data collection

Data available from national reporting systems have been requested from PHS. We expect these data to provide high-level indicators of changes in practice over time, leading to changes in patient outcomes. The detail of each measure selected is described in the evaluation proposal. Healthcare Improvement Scotland has received data reports from PHS including all data available for the programme delivery period (April 2024 onwards). The data collected through national systems have agreed collection and reporting timelines which restrict the available data points. Therefore, as this point in the programme there are insufficient data points to allow interpretation of potential trends. Data presented here help us learn about the current data landscape for these long-term indicators and demonstrate proof of concept for the collection of these national metrics for potential future regular reporting.

Although additional data points will be available to inform the final evaluation report in December 2025, system-level changes still may not be visible in these data because of the lag in data availability and the time required for changes to influence this population level data. Whilst tests of change have been introduced locally within demonstrator sites during the lifecycle of the programme, the scale and spread of these changes, and consequent changes in behaviour, take time to embed, and we do not necessarily expect to see the effects in these high-level indicators within the timescales of the programme.

Methodology

Data and measures

Data from the national reporting system will be used to explore three key areas:

- Changes in primary care activity
- The impact of MDTs on improving patient outcomes, and
- The extent to which enhanced primary care has reduced the need for unscheduled care.

The specific measures related to these concepts are detailed in the first interim report and can also be found in Appendix 4 of this report.

Data criteria

Data was requested from PHS for the measures using the following criteria:

- data is only from the beginning of 2022 onwards as a result of the impact of COVID-19 on earlier results
- data from whole demonstrator sites includes the entire Edinburgh City HSCP rather than data from individual practices within Edinburgh City HSCP that are part of PCPIP, and
- data covers all of Scotland, as well as data excluding the demonstrator sites.

For this report data for Edinburgh City is presented for the entire HSCP, with the comparator being the whole of Scotland. The data for each measure are presented in a line chart that includes a line for each demonstrator site as well as for Scotland as a whole.

Primary care activity data

Data on the number of service user contacts for GPs and GPNs is collected to explore changes in primary care activity and is presented in the following charts.

Number of service user contacts for GPs and GPNs

General practice activity data is extracted from approximately 94% of practices across Scotland, including data on direct and indirect encounters. The data shown below for GPs (*Figure 29*) and GPNs (*Figure 30*) includes all activity at the demonstrator sites and Scotland.

Figure 29: Rate per 1,000 registered patients of all activity by GPs

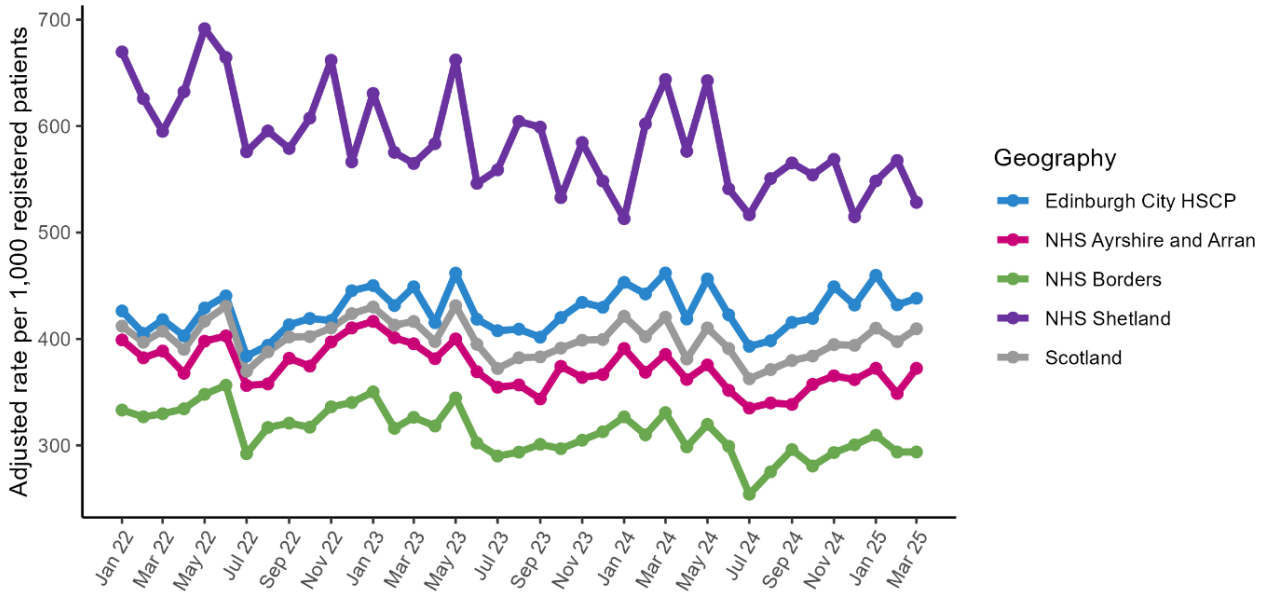
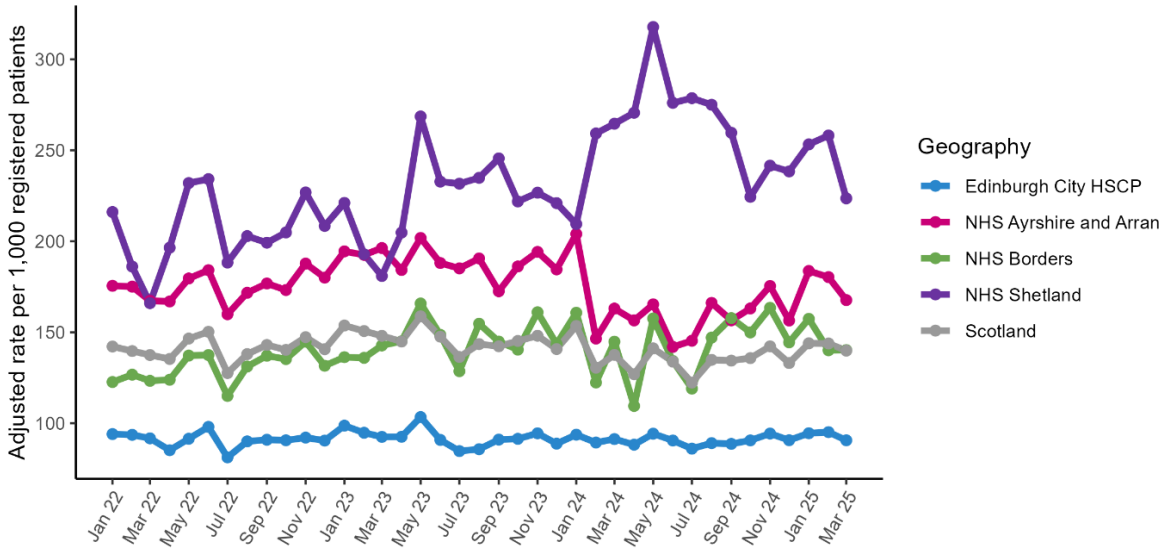


Figure 30: Rate per 1,000 registered patients of all activity by GPNs



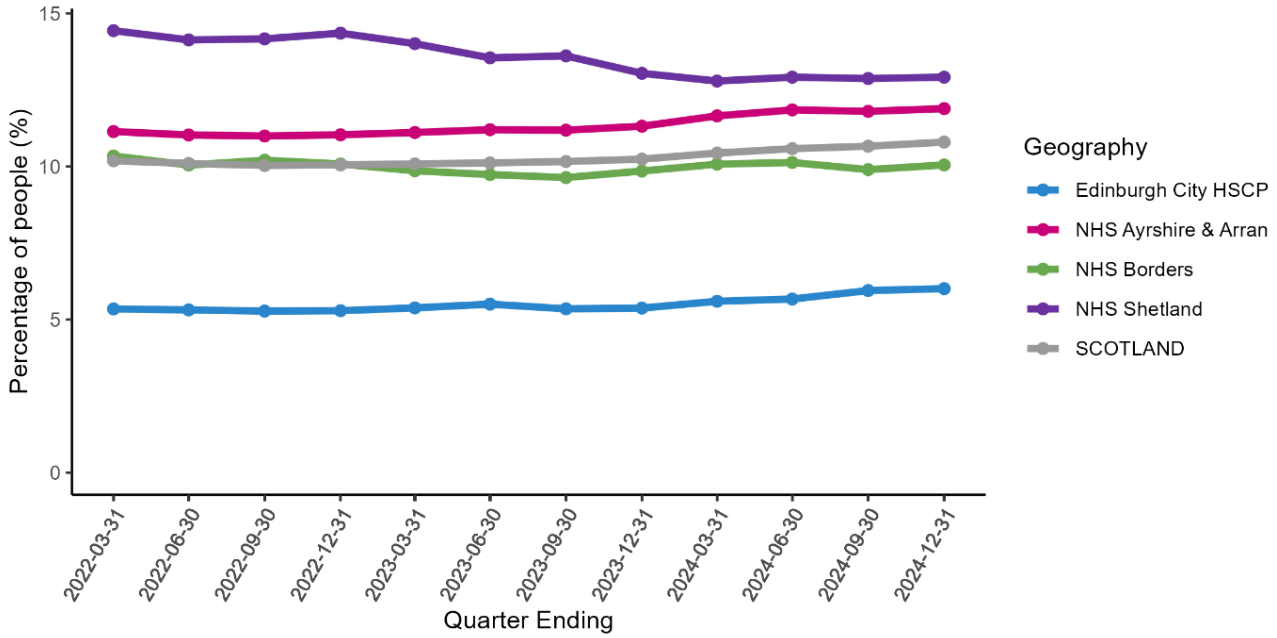
Patient outcome data

NTI data was downloaded from PHS to explore possible impact of MDT on improving patient outcomes. Out of the 75 primary care indicators published by PHS, five have been selected to enhance improvement and ensure quality and effective prescribing practices. The evaluation proposal offers further justification for choosing these specific five NTIs.

NTI - falls, fractures and delirium (anticholinergics older people %)

Medications with anticholinergic properties can lead to medication-related harm, particularly causing temporary short-term cognitive impairment, increasing the risk of falls, cardiovascular events, and higher mortality rates among older adults (>=75 years). Reduced use of anticholinergic medication will reduce risks for this population. This graph shows the percentage of older people who are prescribed >10 items of strong anticholinergic medication per year (*Figure 31*).

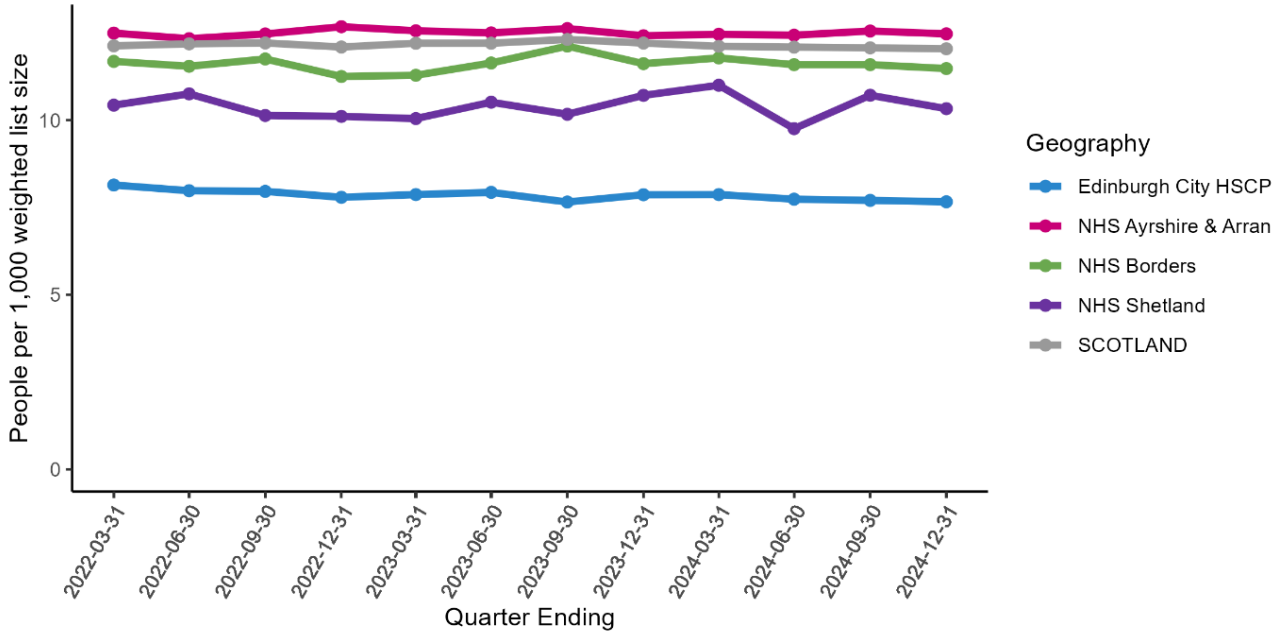
Figure 31: NTI measure of falls, fractures and delirium (% older people prescribed > 10 anticholinergics)



NTI - mental health triple whammy

Figure 32 shows the number of people on a combination of three or more medications, such as benzodiazepines, Z-drugs, opioids (including Tramadol), gabapentinoids, antidepressants or antipsychotics. This medication combination called the 'mental health triple whammy' significantly increases the risk of medicine-related harm, including sedation and respiratory depression.

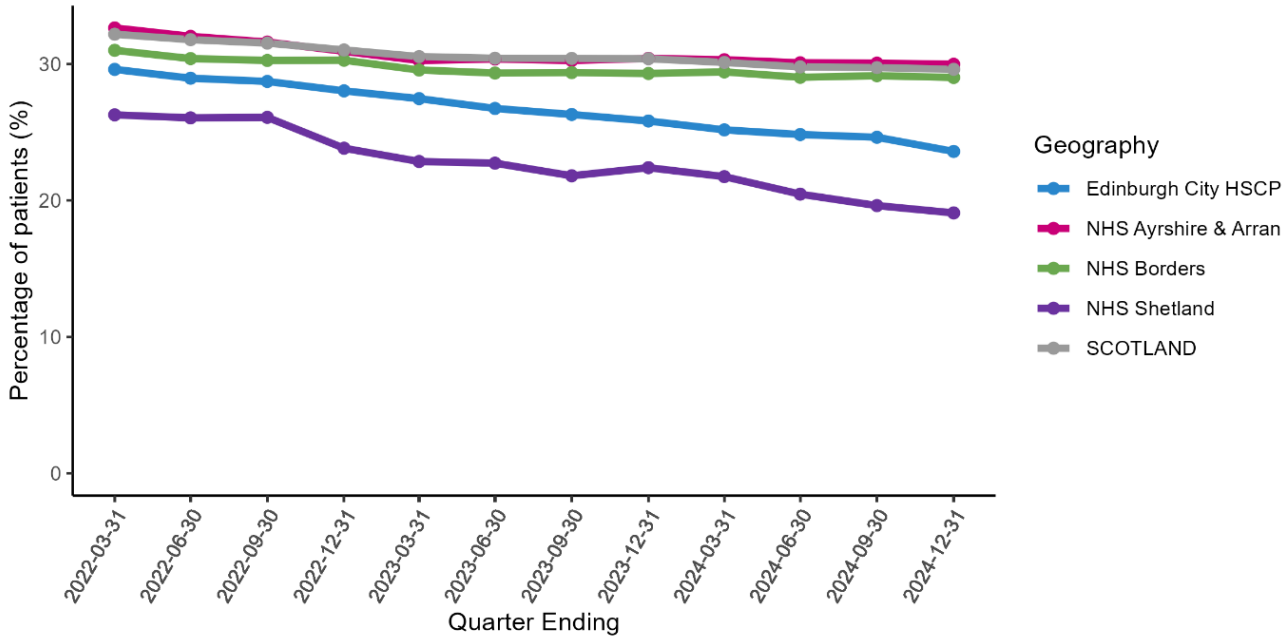
Figure 32: Mental health triple whammy



NTI - poor asthma control

Good asthma management at practice level should be associated with fewer people prescribed six or more short-acting beta-agonists (SABA) per year. *Figure 33* illustrates the percentage of patients prescribed >=6 SABA annually at the demonstrator sites and across Scotland.

Figure 33: Poor asthma control (6 or more SABA %)

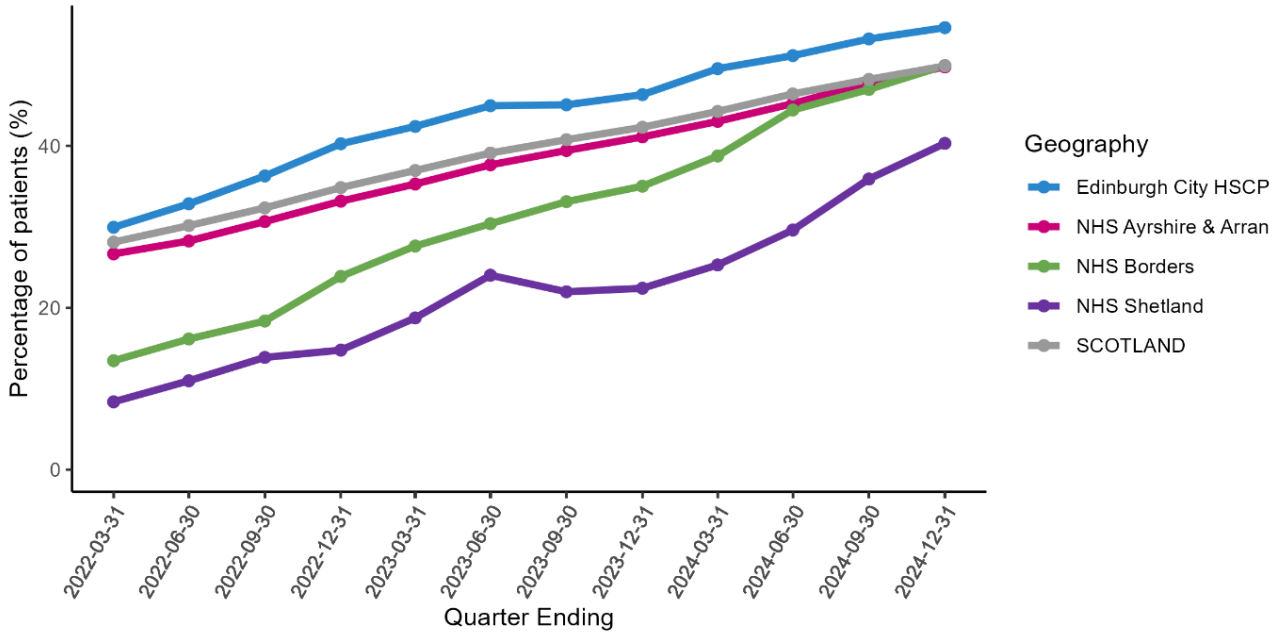


NTI - type 2 diabetes and atherosclerotic cardiovascular disease (ASCVD) management

People with diabetes and established atherosclerotic cardiovascular disease, heart failure, renal disease or a combination of these conditions are known to benefit from SGLT-2 (sodium glucose cotransporter-2) inhibitors or GLP-1 (glucagon-like peptide-1) receptor agonists regardless of HbA1c (glycated haemoglobin). Good care should result in a higher proportion of suitable patients being

prescribed these medicines. *Figure 34* presents the percentage of patients with diabetes and atherosclerotic cardiovascular disease who were prescribed SGLT-2 inhibitors or GLP-1 receptor agonists at the demonstrator sites and across Scotland.

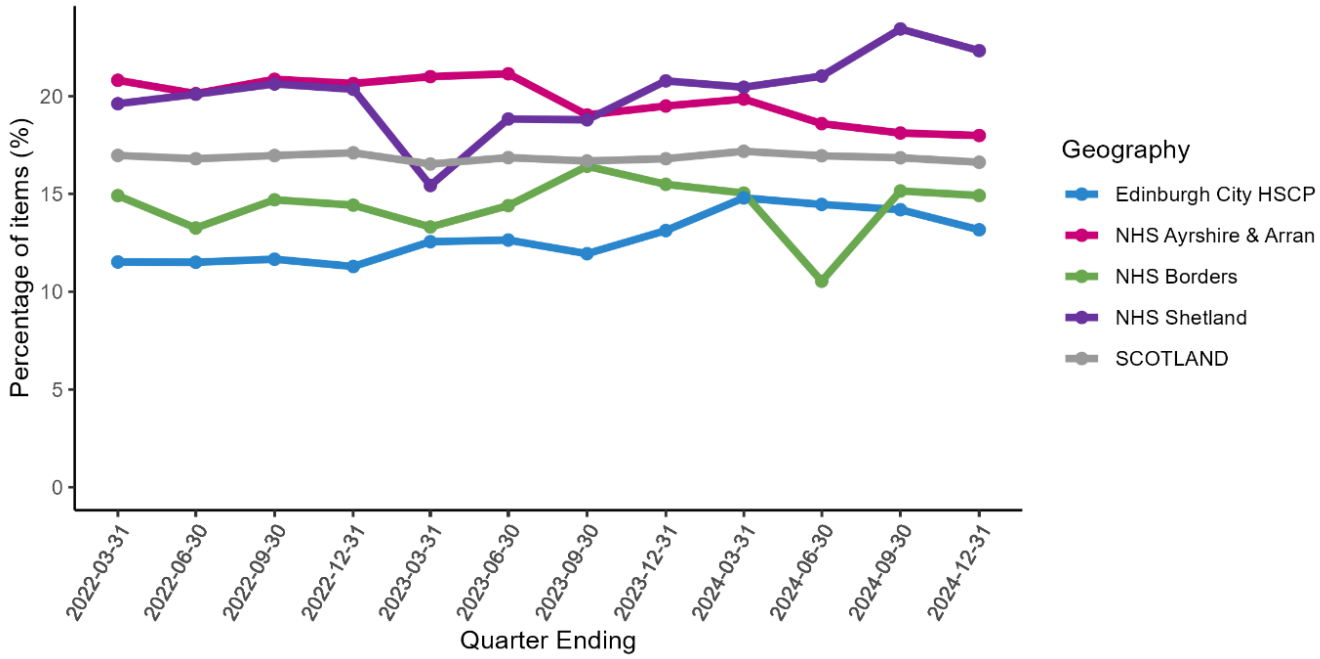
Figure 34: Type 2 Diabetes and atherosclerotic cardiovascular disease management (ASCVD)



NTI - wound care

The regular use of antimicrobial wound dressings (AWDs) for treating chronic wounds in NHS Scotland is not recommended because of insufficient evidence supporting their effectiveness compared to non-antimicrobial dressings. Consequently, a lower percentage of AWDs use indicates a higher quality of care. *Figure 35* shows the percentage of antimicrobial wound products used at the demonstrator sites and across Scotland.

Figure 35: Antimicrobial wound products (%)



Data on use of unscheduled care

Data was requested and received from PHS to explore the extent to which enhanced primary care has reduced the need for unscheduled care or referrals to elective care.

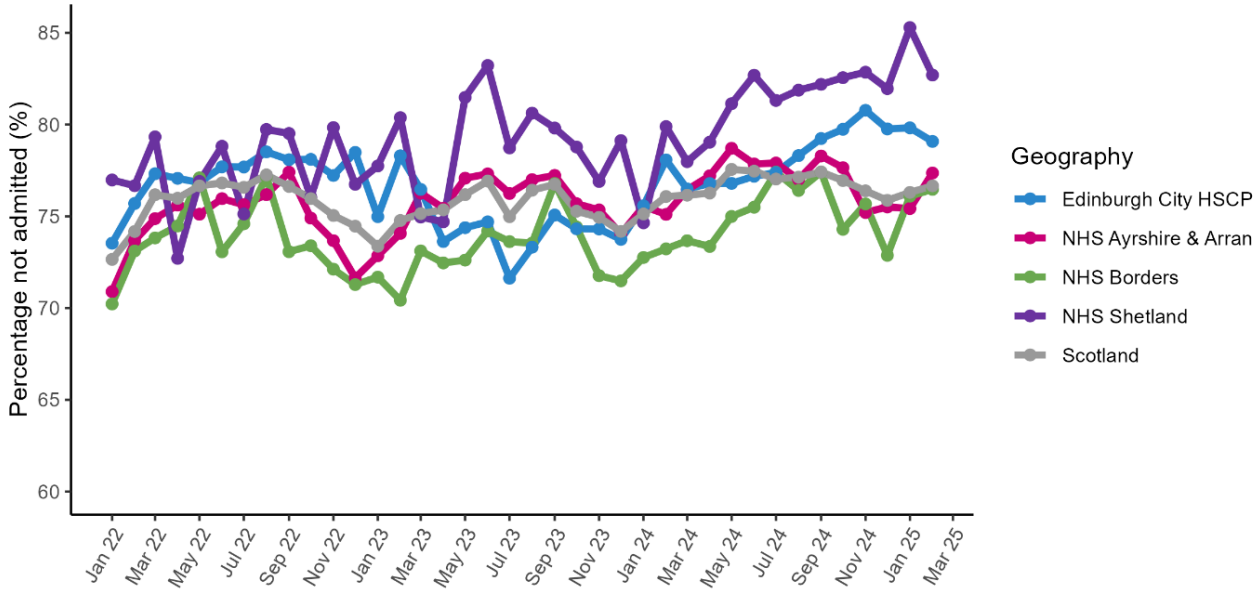
Use of unscheduled care

Improved care management through GMS may reduce attendance and admissions for people with LTCs and therefore the use of unscheduled care has been identified as a key indicator for primary care. There are three different measures collected to review this for PCPIP - the percentage of people who attend A&E who are not admitted to hospital, the rate of potentially preventable admissions, and rate of NHS24 and out of hours care pathways.

A&E attendees who are not admitted to hospital

Difficulty accessing a GP practice appointment may lead to higher attendance within A&E. While there is a drive to reduce unnecessary admission to hospital following A&E attendance, very low hospital admission rates may indicate that the patient could have been seen elsewhere, including general practice. *Figure 36* shows the percentage of A&E visits that did not result in admission.

Figure 36: Percentage of A&E attendances which did not result in admittance

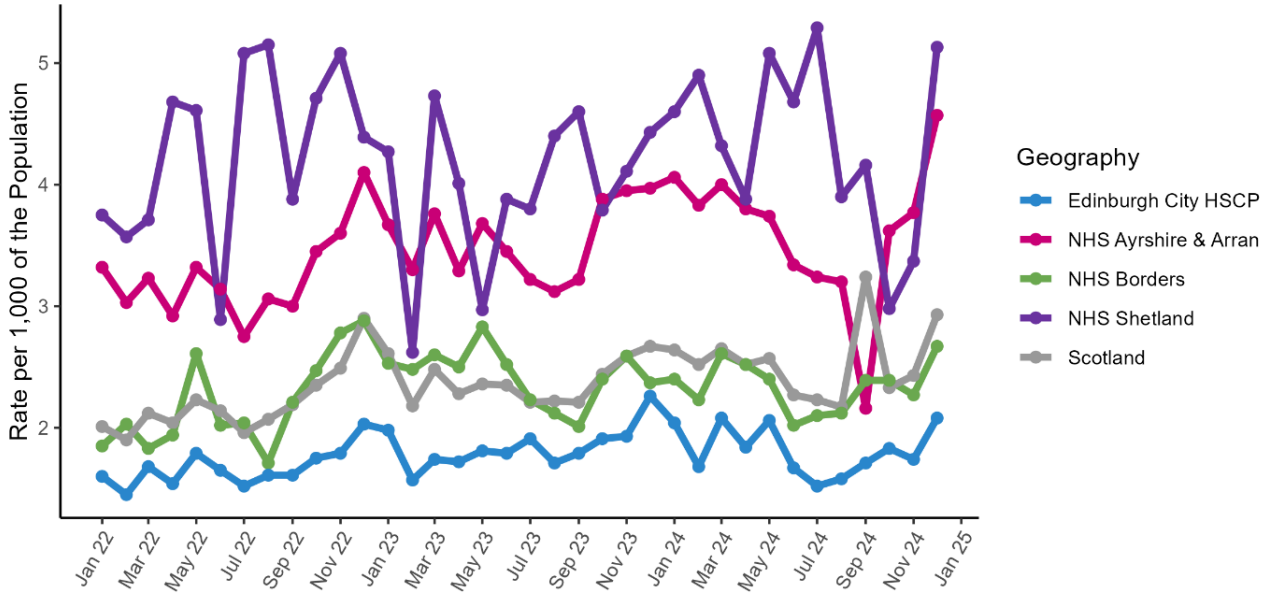


Note: y axis starts at 60

Potentially preventable admissions

Preventable admissions reflect how often people with specific LTCs are emergently hospitalised when they typically should not need to be. *Figure 37* presents the age-sex standardised rate of these potentially preventable admissions.

Figure 37: Age-Sex standardised rate of potentially preventable admissions per 1,000 of the population



Pathways including NHS 24 and out of hours

Unscheduled care pathways, including services like NHS 24 and OOH care, are vital in the healthcare system by providing timely support for urgent health needs that arise outside regular service hours. *Figures 38* and *39* present the continuous pathways for unscheduled care, which include at least one NHS 24 pathway and one OOH pathway, presented as a rate per 100,000 people at the demonstrator sites and across Scotland.

Figure 38: Continuous unscheduled care pathways including at least one NHS 24 pathway as a rate per 100,000 population.

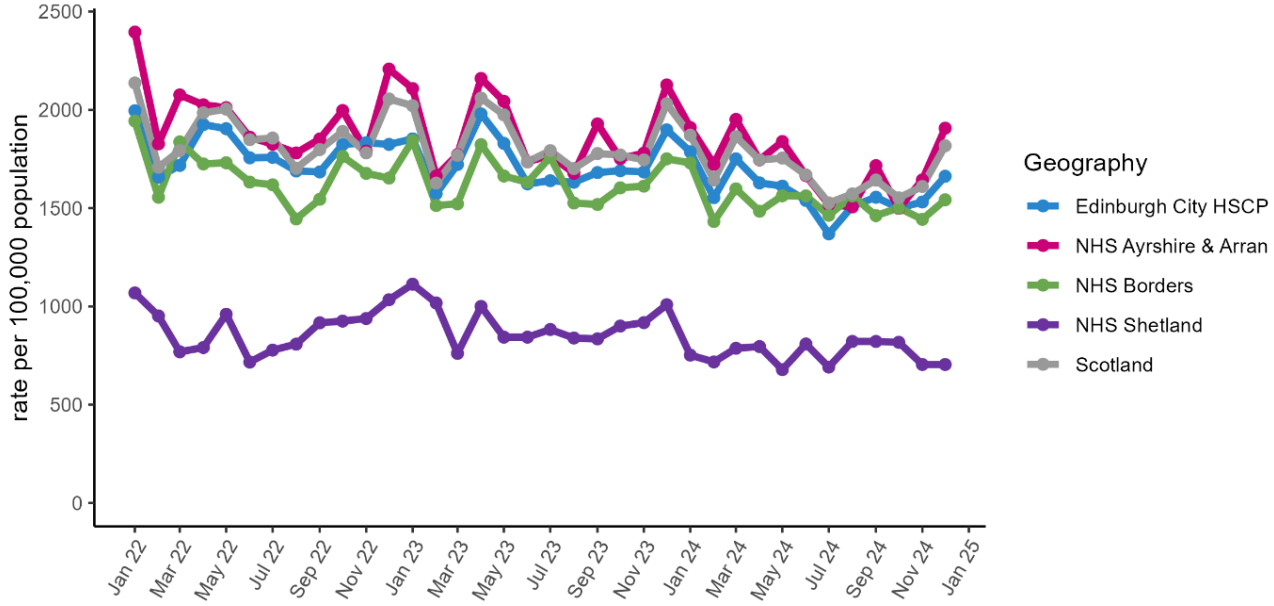
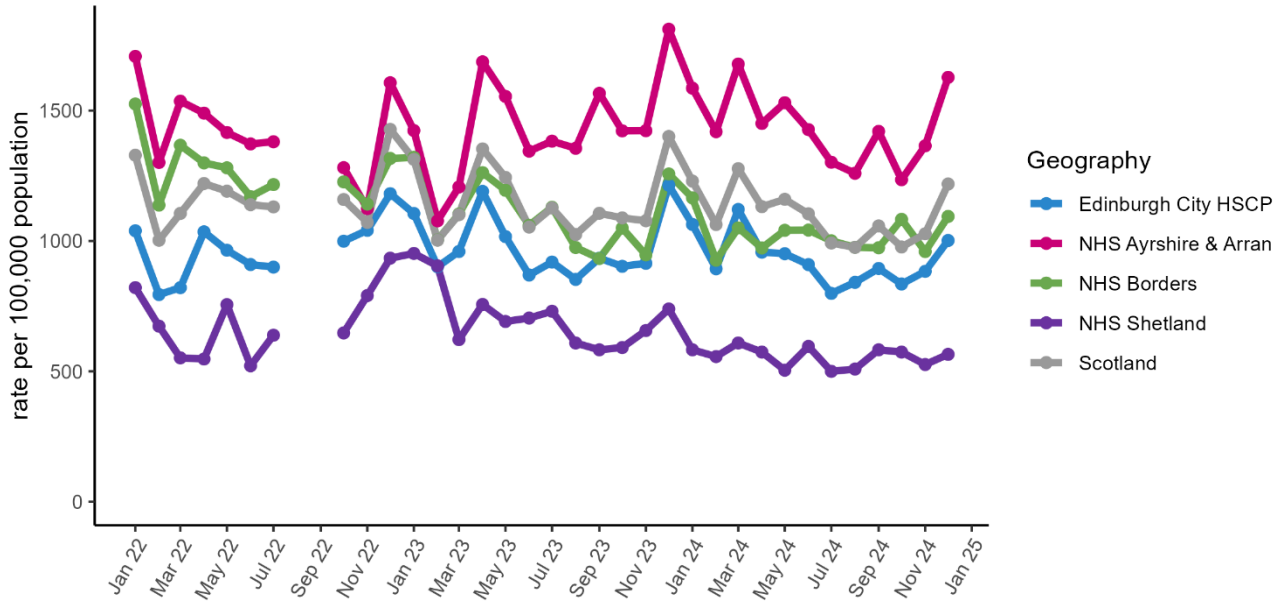


Figure 39: Continuous unscheduled care pathways including at least one OOH pathway as a rate per 100,000 population.

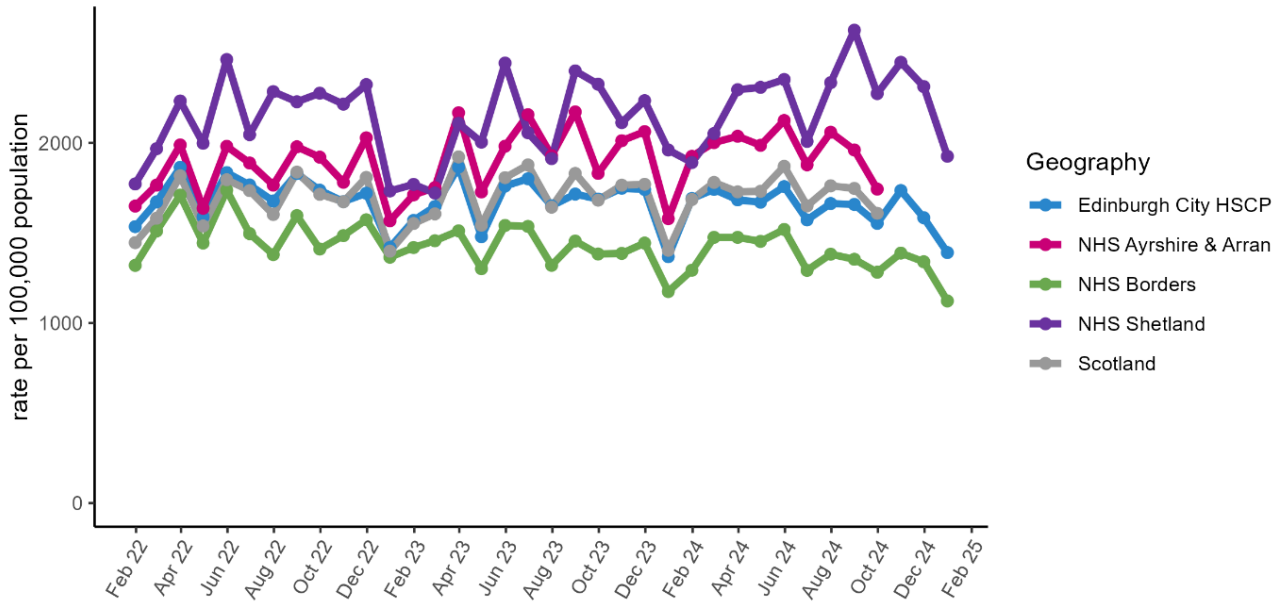


Note: OOH data is incomplete for August and September 2022 as a result of a system outage and should be treated with caution.

GP referrals to elective care

GP practice referrals to elective care serve as a key indicator of impact (*Figure 40*) as improved care management through multidisciplinary working may change referral trends, especially with improved management of LTCs.

Figure 40: Additions to the waiting list via GP referral for new outpatients as a rate per 100,000 population.



Note: NHS Ayrshire & Arran data is unavailable beyond October 2024 and as such the Scotland rate is unavailable too.

Challenges and limitations

- Not all activity is recorded in the clinical systems and information on the complexity or duration of the activity is currently unavailable. Therefore, the activity reported does not represent all the work happening within general practice. Improvements in the recording of activity on GP clinical systems may also affect some trends when looking at activity over time.
- The data is based only on the practices in the selected geographical regions that provided information.

Rates per 1,000 registered patients presented in this document have been adjusted to take account of the variation in the number of working days in each month.

Future plans

Healthcare Improvement Scotland is establishing an expert group that includes both clinical and non-clinical experts with a strong background in primary care. This group will review data collected to discuss findings and develop recommendations.

The final report will bring together data across all data sources to address the agreed areas of focus (Figure 41).

- What learning can we take from the QI approach embedded in PCPIP, to support future implementation of the MDT and policy development?
- What are the key conditions for change and enablers required to support MDT working?
- Which MDT services should be prioritised for further development?
- What are the key attributes of a sustainable and effective model of MDT support?
- What is additionally required to support monitoring and evaluation of the impact of MDT working?
- What is required to ensure MDT working supports the reduction of health inequalities?

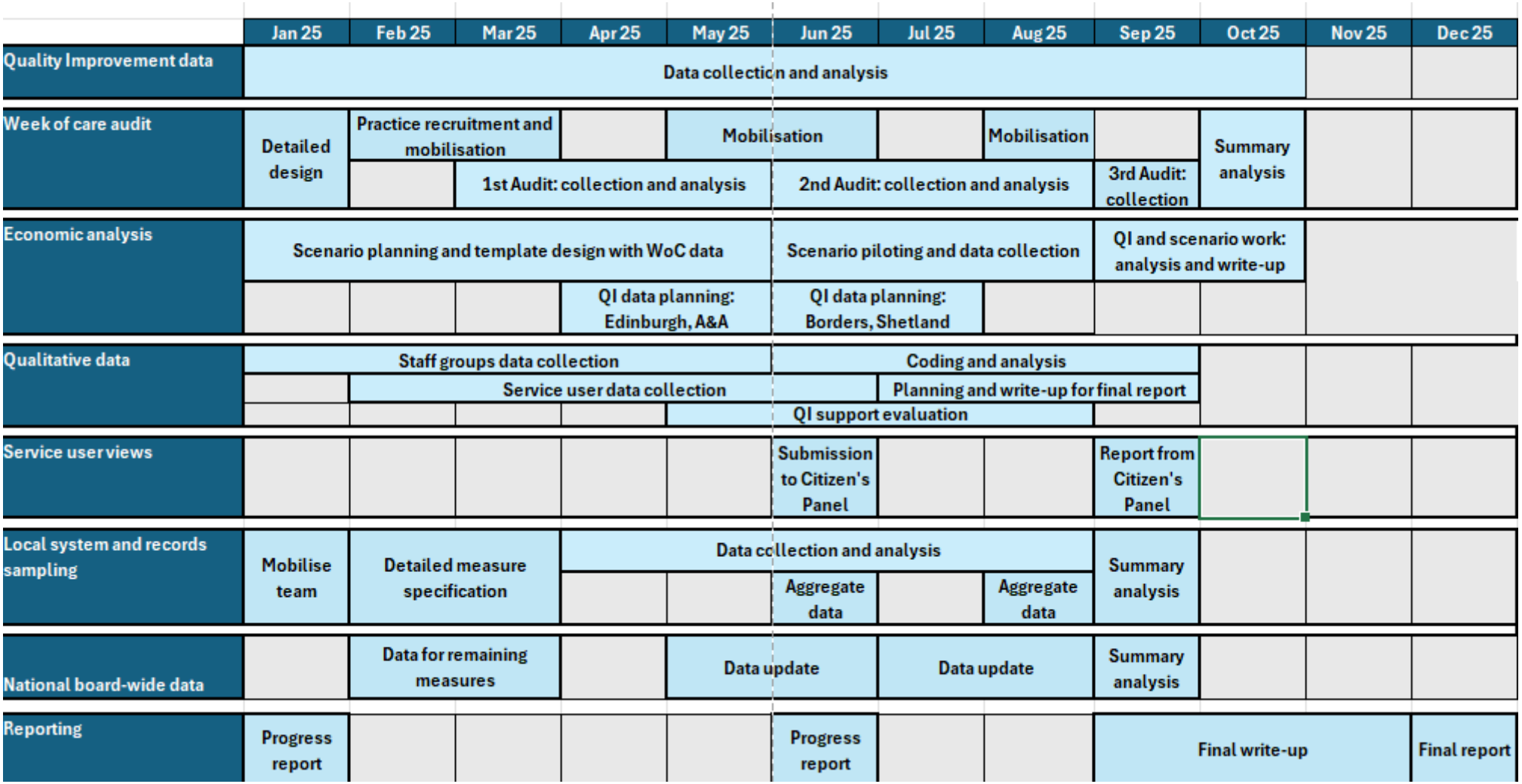
Figure 41: Data for PCPIP final report

More information

For more information, please contact Healthcare Improvement Scotland's primary care team by emailing his.pcpteam@nhs.scot.

Appendices

Appendix 1: PCPIP evaluation timeline



Appendix 2: Week of care data collection tools

GP: CONSULTATIONS

Log of **clinical consultations** for GPs–any clinical interaction involving decision and recording in patient notes (includes F2F, telephone, e-consult, home visits)

	Please note the MAIN reason for consultation (*MARK ONE ONLY PLEASE*)									**If you were NOT the most appropriate person to take the consultation, who was most appropriate? (*ONE ONLY PLEASE*)**								
Patient #	Complex clinical care	Non-complex clinical care	Mental health	MSK*	Medicine-related	Other	Time spent	Were you most appropriate person?		ANP	GPN	CTAC	Practice pharm.	Community pharm.	MSK physio or APP	Mental health (MH) nurse	Community link worker	Other
	co-morbidity, undifferentiated symptoms, frailty				medication was ***main*** appt reason		Approx no. of mins	**Yes**	**No**				inc. PT or PSW	inc. Pharmacy First	1st contact MSK or APP	community MH service (1st contact)	non-clinical practitioners	
(Ex.1)	**x**						**10**	**x**										
(Ex.2)			**x**				**15**		**x**							**x**		
1																		
2																		
3																		
4																		
5																		
6																		
7																		

**Musculoskeletal*

GP NON-CONSULT

Log of non-patient-facing GP activity - Where more than one is done in a bundle, enter approx. number of patients, and the total time to do that bundle

	Please document GP workload outside of consultations, by noting the approx. number of patients (*ONE ACTIVITY TYPE PER ROW)*										If you were NOT the most appropriate person to have completed this activity, who was the most appropriate? (*ONE ONLY PLEASE*)									
Activity	**Acute Rx**	**Repeat Rx**	**Other pharma**	**Docman results and letters**	**Patient-related Admin**	**Advice to other MDT**	**Other**	**Time spent**	**Were you most appropriate person?**		**Admin**	**ANP**	**GPN**	**CTAC**	**Practice pharm.**	**Community pharm.**	**MSK physio or APP**	**Mental health nurse**	**Community link worker**	**Other**
									Yes	**No**										
			eg. med rec, med review		eg. emails, dictation, referrals	formal or informal		Approx no. of mins							inc. pharm tech or support worker	inc. Pharmacy First	1st contact MSK or APP	community MH service (1st contact)	non-clinical practitioners	
(Ex.1)				**10**				**20**	**x**											
(Ex.2)			**5**					**45**		**x**					x					
1																				
2																				
3																				
4																				
5																				
6																				
7																				

PRACTICE NURSE

Count of Practice Nurse activity - where more than one activity is done in a bundle (ie. emails and results), enter approx. number of patients this refers to, and the total time to do that bundle. For appointments, the number will be 1. Put each activity type on a separate row.

	Please note the count of the MAIN activity or main reason for appointment (*ONE ACTIVITY TYPE PER ROW*)												
Activity	**Expert Nursing Generalist**	**GPN admin**	**LTC monitor and measure**	**Bloods (except LTC)**	**Biometrics (except LTC)**	**Wound care and minor injury**	**Ear care**	**Injections**	**Doppler and Hosiery**	**Other**	**Time spent**	**Could CTAC have done this activity?** (if trained or staffed)	
	LTC management, LARC, men's and women's health, self-management, goal setting, care planning	CPD, emails, patient admin, results, supervision	LTC bloods and biometrics, diabetic foot review. ***NOT*** *LTC management*	routine or high-risk meds bloods. ***NOT*** *LTC bloods*	BP, specimen, height and weight ***NOT*** *LTC biometrics*	assess, remove suture or staple, dressing, minor injury	assess, irrigation, micro suction	Sustanon, B12 etc, vaccination	Assess and manage, hosiery measure	ECG, health promotion, chaperone	Approx no. of mins	**Yes**	**No**
(Ex.1)						**1**					**35**	**X**	
(Ex.2)		**5**									**10**		**x**
1													
2													
3													
4													
5													
6													
7													
8													

Pharmacotherapy Team

Date: _____
Initials: _____
Practice: _____
Role (circle as appropriate): Pharmacist / PT / PSW
Employed by (circle as appropriate): Practice / NHS board
Based in (circle as appropriate): Practice / Hub

Count of pharmacotherapy activity

Mark ONE TASK per patient which best fits the interaction										
	Med rec of OPL and IDLs	Acutes and repeats requested	Serial prescriptions	Out of stock	High-risk medicines monitoring	Medication queries	Polypharmacy reviews	Other clinical med reviews	Clinical check	Other
	letters from clinics inc. Docman, email requests, IDLs	meds requests actioned by pharmacy	serial Rx requests or assoc. tasks	request for other meds because of stock issues	meds requiring monitoring eg. DMARDs	from practice staff, community pharmacy, patients	7-step polypharmacy review inc. phone, f2f, video consults	clinical med reviews (*exclude polypharmacy*)	clinical check of anyone else's work	inc. prescribing improvement projects, non-clinical med review
Manual count using tally marks										
TOTAL (tot up and write number)										

Appendix 3: Local systems and record sampling – measures overview

Concept	Data sources	Measures
Access to care	Local sampling of practice systems for direct patient encounters by GPs and wider MDT staff	Service users who have accessed practice and board-delivered MDT services by SIMD (Scottish Index of Multiple Deprivation) Comparison of service user SIMD profile by MDT service with local population by SIMD to identify gaps
	Local sampling of practice EMIS/Vision systems for patients with COPD (chronic obstructive pulmonary disease). SCI diabetes will be used for sampling of patients with Type II Diabetes	Percentage of LTC reviews attended
Continuity of care	Local sampling of practice systems based on the St Leonard's Continuity of Care (SLICC) method	Proportion of consultations with the person's regular care provider out of all consultations
Improved medicines management	Extraction using the national database Prescribing Information System, STU and local sampling of pharmacotherapy services	Percentage of all dispensed prescriptions that are serial prescriptions Proportion of repeat prescriptions by reviewing repeats not requested or no longer required
Impact on MDT on workforce	Sources being explored: potential to use practice annual returns or request from practices directly	Staff turnover rate Vacancy rate Absence rate

Appendix 4: National board-wide data collection – measures overview

Concept	Data sources	Measures
Changes in primary care activity	National data from Primary Care Activity Dashboard	Number of service user contacts for GPs and GPNs
Impact of MDTs on improving patient outcomes	NTIs (National Data Published by PHS)	- Anticholinergics - Mental Health triple whammy - Poor asthma control - Type 2 diabetes and ASCVD management - Wound care
Use of unscheduled care	National elective care data publications	Number of GP referrals to elective care specialists Number of A&E attendees who are not admitted to hospital Potentially avoidable admissions Use of unscheduled care pathways (pathways including at least one NHS 24 step or at least one OOH step).

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or email his.contactpublicinvolvement@nhs.scot

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