Primary Care Phased Investment Programme

Overview of evaluation plan

October 2024

Context

The 2018 General Medical Services (GMS) contract set out to reduce GP and GP practice workload through the establishment of wider Primary Care multi-disciplinary teams (MDTs). Primary Care Phased Investment Programme (PCPIP) will examine the impact of these teams on workload and quality of care, and the impact that additional quality improvement support within PCPIP has had on improving implementation of Community Treatment and Care (CTAC) services and Pharmacotherapy (PT). This document provides an overview of the planned evaluation approach that includes qualitative, quantitative and health economic data.

Scope of evaluation

Purpose

PCPIP aims to:

- improve implementation of services subject to amended regulations outlined in the GMS contract - CTAC and Pharmacotherapy services,
- develop a culture of continual improvement across Primary Care settings, and
- build evidence to understand the national context for GMS contract implementation including long-term Scottish Government investment.

SG commissioned PCPIP to inform:

- the continual development of the Primary Care multi-disciplinary team as outlined in the GMS contract
- how nation-wide implementation of the MDT component of the GMS contract can be improved, and
- the creation of a standard set of national measures for ongoing monitoring and future evaluation of the impact of the MDT component of the GMS contract.

Contribution to evidence base

Considering the evaluation work that has already taken place in Scotland since 2018, the unique contribution to this evaluation will be to:

- Provide systems level data across the demonstrator sites to explore with GPs, GPNs and the wider MDT staff the impact that implementation of the GMS contract has had on their time and workload.
- Provide insights into what contributes to an effective and well-functioning general practice multi-disciplinary team, including staff wellbeing/job satisfaction.
- Explore indicative impact and stakeholder experience of the models of delivery for CTAC and PT in each of the demonstrator sites.
- Collect qualitative data from members of the wider MDT such as administrative staff who are recognised to have limited representation in previous evaluations. This is despite the

fundamental role of administrative staff in Primary Care, who may affect Primary Care as a pivotal mechanism in the implementation of the GMS contract.
- Explore service users' perceptions of CTAC and PT to further understand the issue of inequalities using Barbara Starfield's 4C framework across the demonstrator sites.
- Evaluate the contribution of HIS quality improvement (QI) support in facilitating the implementation of DS plans relating to CTAC and PT services.

Outputs

The contribution of this evaluation will be met through delivery of several outputs:

- Review of existing evidence on the impact of expanding multi-disciplinary Primary Care teams (with a focus on CTAC and PT) on service users and the wider Primary Care workforce.
- QI logic model and evaluation plan covering the collection and analysis of qualitative, quantitative, and economic data; and the QI support logic model.
- Mixed method approach (qualitative, quantitative and health economic) to collect primary data relevant to the expansion of MDT component of the GMS contract and with a strong focus on CTAC and PT.
- Six monthly interim reports.
- Final evaluation report published in December 2025.

The outputs are anticipated to provide:

- a better understanding of the context and extent of implementation of the MDT component of the GMS contract, especially in relation to CTAC and PT service,
- recent data on the barriers and facilitators to implementing the MDT component of the GMS contract which could inform the development of theory-driven implementation interventions for use nationally,
- quality improvement data indicating the capacity and capability of the demonstrator sites to develop and implement their own/local service changes,
- the impact of improvements in terms of value for money and capacity building in Primary Care
- identification of unintended consequences by expanding the MDT, such as District Nurses (DNs) moving to CTAC, GPNs/APNs moving out of Primary Care, or increased GP workload that results from the activities of the MDT (e.g. pharmacist led polypharmacy reviews resulting in more people being asked to make a GP appointment),
- a proposed set of national measures to assist the advancement of infrastructure aimed at collecting relevant and feasible routine data in Primary Care,
- recommendations to Scottish government to inform the next stage of the MDT component of the GMS implementation and long-term SG investment, and
- recommendations for future government commissioned evaluations and research.

Outwith scope

To ensure delivery of the final evaluation report by December 2025, it is essential to focus evaluation activities on areas most likely to contribute new evidence that will help to address the purpose of the

evaluation. To achieve this, the following areas have been identified as outwith the scope of the evaluation:

- **Non-MDT aspects of the 2018 GMS contract.** The 2018 GMS contract covers many different aspects of general practice, including a new funding formula for Primary Care, minimum earnings expectations, GP premises sustainability funding, IT infrastructure, and new arrangements relating to information sharing and data controllers.
- **Primary Care services not outlined in the GMS contract.** For example, district nursing or community pharmacy. Primary Care is much wider than GPs, GPNs and the additional roles that are part of the wider multidisciplinary team outlined in the GMS contract that are in scope of this evaluation. Although all roles across Primary Care are important, it is not possible to include their impact within the timescales or resources available for this evaluation.
- **Incorporating data from areas that are not PCPIP demonstrator sites.** It will not be possible to include emerging evidence from other areas of Scotland within the PCPIP evaluation due to time constraints on data collection and analysis. In addition, there are risks with incorporating evidence from evaluations that may have used different methodologies. This would the weaken the robustness of the evaluation methodology and comprise the validity of recommendations in the final report. A literature review of existing published evidence has been conducted which was used to inform the design of this evaluation. The findings from the literature review will be used to interpret and contextualise the findings from this evaluation. An exception will apply to the economic evaluation, which would benefit from external validation with as many experts as possible (including those based outwith the demonstrator sites).
- **Using control groups from outwith the PCPIP demonstrator sites to compare to the PCPIP demonstrator site results.** Demonstrator sites have been selected because of their different local context. This evaluation does not require a comparative design to address the evaluation aims. Instead, the design of this evaluation gives priority to a mixed methods and theory-based evaluation that considers the complexity of Primary Care settings and is focused on understanding the context of implementation. This broader perspective is considered most useful for decision-makers.

Challenges and risks

There are significant challenges to the successful implementation of this evaluation. The challenges with the highest risks include:

- **Limited availability of Primary Care quantitative data**. There are high stakeholder expectations on the inclusion of meaningful quantitative data. There is only a limited amount of quantitative data that can be automatically collected given the existing IT infrastructure of Primary Care contexts, resulting in the need for demonstrator sites to manually collect some data for this evaluation. A few GP practices within demonstrator sites have already indicated that they are not prepared to do this. Manual data collection needs to be kept at a minimum to prevent overloading a busy clinical and non-clinical Primary Care workforce leading to disengagement.
- **Understanding attribution in a complex system.** In evaluations of complex systems, linking changes on outcomes to an intervention is inherently challenging. Interpreting quantitative

data alongside the qualitative and QI data will be important to help contextualise and understand any trends and changes.

- **Access to service users and Primary Care workforce.** Co-ordinating the interviews, focus groups, and surveys will require admin support from within HIS and demonstrator sites' teams. Limited capacity in HIS and demonstrator sites may delay this data collection, reducing the time available for data collection.
- **Information governance/data sharing**. General Practice data is more challenging than traditional NHS board data to share due to the complex and varied set-up of Primary Care. It is anticipated there will be data sharing challenges that will need to be overcome to enable data sharing for the evaluation. Delays in finding solutions to emerging information governance/data sharing issues will reduce the time available for data collection.
- **Value of comparing demonstrator site data**. Comparisons of the different demonstrator site models will be part of the evaluation, however there is a risk that the difference in the context and stage of implementation between the demonstrator sites will make it difficult to identify meaningful difference between the different models.
- **Extent of measurable change within PCPIP timescales.** Changes in outcomes takes time. While it is expected that there will be changes in processes and intermediate outcomes, significant changes in key outcomes for patients and staff are unlikely to be detected until after the completion of PCPIP. However, the use of qualitative data will address this risk, in that changes in perception due to the HIS support will be explored and may evidence impact that may be otherwise unobservable from high-level quantitative indicators (e.g. retention, absence rates) over a short period of time.
- **Stakeholder expectations.** A wide range of stakeholders have interest in the PCPIP evaluation. Each stakeholder with their own area of interest. This evaluation will not meet the expectations of all interested parties while also ensuring the final report is delivered in December 2025. Requests to change the scope of the evaluation would only be possible with extensions to the final report publication date and additional funding for 2026/27 to retain the data and research roles beyond the programme's planned 2025/26.

Evidence collection

Objectives

The evaluation has four primary objectives - to understand the:

- impact implementation of the wider MDT as described in the GMS contract has had on service users,
- impact implementation of the wider MDT as described in the GMS contract has had on the Primary Care workforce,
- impact implementation of the wider MDT as described in the GMS contract has had on the wider system, and

- what elements contribute to successful implementation of the wider MDT as described in the GMS contract.

To provide additional insight into the role of the quality improvement support delivered through PCPIP, the evaluation will also explore the impact QI support has had on:

- building a culture of continuous improvement and building QI capacity in the demonstrator sites, and
- implementing the demonstrator site delivery plans for CTAC and PT.

Data collection

Data collection will take place from September 2024 to October 2025. The winter of 2025 will be required to complete analysis of data and prepare the final report. Different approaches will be taken to collect data depending on the nature and availability of the data.

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Qualitative data will primarily be collected through interviews and focus groups.

- Interviews will focus on the Primary Care workforce, services users and local leadership in demonstrator sites and quality improvement staff in HIS.
- Focus groups will focus on the Primary Care workforce and services users in demonstrator sites.
- Qualitative data will be used to provide an in-depth understanding of impact outcomes related to experience, behaviour, attitudes, and processes related to MDT component of the GMS implementation.
- Qualitative data also plays an important role in attribution and will be triangulated with the quantitative data in order to contextualise and understand any change over time identified in the data.
- Qualitative data collection and analysis will be led by the HIS Health Services Researchers. For more details on the qualitative data collection and analysis, see appendix one.

Quantitative data will be collected through existing national datasets, surveys, and from local sampling/locally collected quality improvement data. A full set of the measures that were considered are list in Appendix 2. Each measure was assessment based on its relevancy to the evaluation and the feasibility to consistently collect data. Quantitative data can be grouped into two categories, system-level data and local-level data.

- System-level data will include existing national datasets will be used to provide high-level indicators of changes in practice or outcomes over time. However, given this evaluation setting is an adaptive and complex system, identifying any causal relationship between system-level measures and the implementation of the MDT component of the GMS will be challenging.
- System-level data also includes brief surveys based on established surveys such as HACE (the biannual Health and Care Experience survey), with previous HACE data offering a baseline to

detect any changes over time or context to discuss the findings from this evaluation. The questionnaires will consist only of the items directly relevant to the system-level indicators.

- Local-level data will consist of local sampling will focus on a small sample of practices and other members of the wider MDT in each demonstrator site to provide additional insight into the quantitative data. Consistent data collection across the demonstrator sites will support comparisons in models of care.
- The quantitative data will be key to informing recommendations on future system-wide measures.
- Quantitative data collection and analysis with be led by the HIS Improvement Advisor with support from HIS Data Measurement and Business Intelligence team. Partnership working with PHS will support the use of national datasets. HIS Senior Improvement Advisors and PHS LIST analysts will be key when working with demonstrator sites for local data sampling. Surveys will be managed by HIS PCPIP project support in partnerships with demonstrator sites.

Economic data will be collected through sampling a small number of Primary Care teams in each demonstrator site for a cost-consequence analysis.

- This will identify the value expected for each demonstrator site model in terms of the costs and outcomes they deliver.
- The Primary Care case load will also be identified to create vignettes to explore the types of work delivered across GPs, GPNs and the wider MDT component of the GMS. This will be further developed, where possible, with staff reporting approximately how much time they take to complete tasks, and consideration of their preferences for providing care. Together these data could help us understand the potential capacity and limits thereof, within the system, but we note even at this stage that it may not be possible to summarise this quantitatively and will depend on the feasibility and acceptability of data collection.
- Economic analysis will be led by the Senior Health Economist from HIS Scottish Health Technologies Group.

Other data will be collected as part of the broader PCPIP programme that can help to provide contextual information to the evaluation. This includes:

- Demonstrator sites Delivery Plans that will be routinely submitted to Scottish Government during the programme to show progress towards fuller implementation of the contract.
- Local measurement plans developed by demonstrator sites to support the use of quality improvement to implement their delivery plans.
- Case studies developed by HIS improvement support that will outlining the models implemented by each demonstrator site.

Impact implementation of the MDT component of the GMS contract has had on service users

Qualitative data will be collected through interviews and focus groups of service users. Ethical consideration for a service evaluation limits the selection of service users to people who have used different MDT services rather than service user characteristics. Qualitative data collection will focus on

understanding care experience and issue of inequalities using Barbara Starfield's 4C framework across the demonstrator sites which were used as guiding principles in the GMS (2018) contract:

- **Contact:** Ability of services users to access care delivered by primary care MDT and has it changed since the introduction of different MDT services.
- **Comprehensiveness:** Primary care MDT meets the service-users health needs.
- **Coordination:** Services-users' perceptions on how "joined-up" their care has been within the primary care MDT.
- **Continuity:** Service-users' thoughts and experience of receiving care from different clinicians that are part of the MDT and the person-centred nature of their care.

Quantitative data will be collected through existing national data sets, local sampling, and a service-user survey. Some of these measures are not expected to change significantly over the short lifetime of the project but are intended to establish a baseline. Table 1 below outlines the measures for assessing the impact on service users.

Data source	Measure(s)	Notes
National Therapeutic Indicators (National data published by PHS)	Anticholinergics Mental Health Triple Whammy Poor Asthma Control Type 2 Diabetes and ASCVD management Wound care	Overall indicators of quality of care which would improve through effective MDT working and more time for GPs to be Medical Expert Generalist. See below for additional information on the clinical rationale for selecting these measures. Some of these measures are not expected to change significantly over the lifetime of the project but are intended to establish a baseline. Risk indicators change too slow for PCPIP. Risk change in MDT working may not show impact on these measures within the timescale of the PCPIP.
Scottish Therapeutics Utility	Number of acute prescriptions issued. Number of repeatable acute prescriptions. Percentage of all dispensed prescriptions that are serials prescriptions.	Indicates improved medicine management through improved working between GP and Pharmacotherapy. Acute requests are managed as acutes and number of repeatable acute requests minimised by switching

Data source	Measure(s)	Notes
		to the repeat prescribing process with appropriate monitoring. Increasing the percentage of repeats that are switched to MCR may are expected to improve care experience, medicine management in the GP setting and reduce workload /increase capacity.
Service user survey	Existing HACE questions that relate to the system-level measures on experience and awareness.	Overall indicator of service user experience. Previous HACE survey would be used as a baseline. This will supplement the quantitative data provided by the service-user interviews.
Local sampling of service-user access to MDT services by SIMD	Comparison of service-users who have access services delivered by MDT by SIMD, with the SIMD of local population.	This is to identify gap between service use and local population to determine if there is an inequality in service access. All attempts will be made to extract data from each service in the MDT however there may be local limitation on data availability for individual MDT services.
Local sampling of clinic attendance	Percentage of long-term condition reviews attended	Overall indicator for improved management of long-term conditions which should improve patient outcomes and quality of life.
Local sampling of appointment systems	Time to third GP and GPN appointments	Overall indicator of access issues. Need to consider context around local appointment systems, such as proportion of pre-booked vs on the day appointments.
Local sampling of patient records	Proportion of consultations with the person's regular care provider out of all consultations (UPC index)	Overall indicator of continuity of care.

There are over 60 National Therapeutic Indicators (NTI) available from PHS. No single NTI will perfectly demonstrate the impact of the wider MDT component of the GMS contract, and there is a time delay of up to three months to receive these indicators. However, the following five NTIs could be used to demonstrate improvements in care from well-functioning CTAC and PT services. The rationale for choosing these is provided below:

- **Anticholinergics** – Medicines with anticholinergic activity can result in medicine related harm, especially in older adults. It is well recognised that medicines with a high anticholinergic burden can cause temporary short-term impairment in cognition, including attention and reaction time. There may also be an association with falls, and increased mortality and cardiovascular events. Investment in pharmacotherapy should result in a greater proportion of people having polypharmacy reviews, and a reduction in the prescribing of medicines with a high anticholinergic burden in vulnerable populations. A lower percentage represents good care.

- **Mental Health Triple Whammy** - People in receipt of 3 or more of benzodiazepine/z-drug, opioid (including Tramadol), gabapentinoid, antidepressant, antipsychotics: The combination of three or more of these medicines increases the risks of medicine-related harm. The 'benzo-burden' is important – this is the total benzodiazepine-type drug load prescribed per day – because benzodiazepines, z-hypnotics and gabapentinoids have similar synergistic effects: sedation, respiratory depression, etc. These may interact with an individual's conditions to cause more adverse effects and avoidable medicine-related harm. Investment in pharmacotherapy should result in a greater proportion of people having polypharmacy reviews, and a reduction in the number of people prescribed three or medicines included in NTI mental health triple whammy.

- **Poor Asthma Control** – Scottish Governments Respiratory Conditions Quality Prescribing Strategy Improvement Guide 2024 to 2027 makes the clinical recommendation to review patients that are taking three or more reliever inhalers (short acting beta agonists) annually. However, the clinical and patient consensus was to prioritise those prescribed six or more annually. Reducing SABA use in people with asthma is an effective measure of effective asthma reviews and resultant better asthma control as people are using either regular inhaled corticosteroids (ICS) preventer therapy or ICS/LABA prn in mild asthma. Investment in CTAC and pharmacotherapy should enable practice nurses, pharmacists, and GPs to support more people with their asthma. Good asthma management at practice level should be associated with a smaller percentage of people prescribed 6 or more short acting beta agonists a year.

- **Type 2 Diabetes and atherosclerotic cardiovascular disease (ASCVD) management** -People with diabetes and established atherosclerotic cardiovascular disease, heart failure and/or renal disease are known to benefit from SGLT-2i or GLP-1RA regardless of HbA1c. These medicines have positive evidence for cardiovascular and renal outcomes and additional indications for use (atherosclerotic cardiovascular disease (ASCVD), chronic heart failure (CHF), chronic kidney disease (CKD)), independent of glycaemic control. Due to these co-morbidities, there may be individuals with Type 2 Diabetes who may benefit from these medicines, especially if glycaemic control not at target. With investment in CTAC and pharmacotherapy, there should be more time available for practice nurses, pharmacists, and GPs to support people with their

diabetes. Good care should result in a higher proportion of suitable people being prescribed these medicines.

- **Wound care** - A Health Technology Assessment (HTA) for the use antimicrobial wound dressings (AWDs) in the healing of chronic wounds, found the clinical and cost effectiveness evidence for antimicrobial wound dressings was either insufficient to draw conclusions on the use of AWDs, or showed no difference in healing outcomes compared with non-AWDs. Therefore, the routine use of AWDs to heal chronic wounds in NHS Scotland is not recommended. With investment in CTAC services and standardised protocols for wound care, it would be expected that the use of antimicrobial wound products would decrease, however there are other considerations such as time to vascular assessment, time to heal and patient outcome. A lower percentage represents good care.

Impact implementation of the MDT component of the GMS contract has had on the Primary Care workforce

Qualitative data will be collected through interviews and focus groups with:

- GPs (including locums),
- General Practice Nurses,
- Pharmacotherapy staff (including Pharmacists and, Pharmacy Technicians and support workers,
- Advanced Nurse Practitioners,
- CTAC staff (including nurses, healthcare support workers, and phlebotomists)
- Practice managers, and
- Administration staff.

These disciplines have been prioritised given the focus on CTAC and Pharmacotherapy services in the PCPIP programme. However, as per the GP contract, additional professional services (such as musculoskeletal physiotherapists, advanced nurse practitioners, community mental health services, community link workers and occupational therapists in some areas) will be included in the qualitative data collection depending on capacity and representation in previous and ongoing research.

The focus of the qualitative data will be on exploring the following:

- release of GP time to act as expert medical generalist,
- release of GPN to act as expert nurse generalist,
- impact on delivering patient care,
- integration of the MDT team, and
- staff wellbeing.

Quantitative data will be collected through existing national data sets, local sampling, and a workforce survey. Table 2 below outlines the measures for assessing the impact on Primary Care workforce.

Data source	Measure(s)	Notes
National data from Primary Care Activity Dashboard (PHS has access to data)	Number of service-user contacts for GPs, GPNs and members of the wider MDT.	This applies to each service in the MDT with data in the activity dashboard. It will show global change in activity but requires day of care audit and qualitative data to fully interpret the data. Data currently segmented to HSCP level which will be a challenge for obtaining data for the Edinburgh City Demonstrator site and needs further exploration. Joint working with NSS may be required to ensure all practices have set-up local dashboards. If an MDT service data is not available in the dashboard we will explore other data sources in local systems.
Local sampling of a week of care audit	Time spent by GPs and GPNs that could have been delivered by another member of the wider MDT. Time spent by GPs and GPNs on appropriate cases. Count of types of activity delivered by MDT members outwith GPs and GPN.	Applies to each service in the MDT. Week of care audit would need to be repeated by the same sample group every quarter. Results will be segmented by different members of the MDT. Appropriate cases refers to GPs and GPNs undertaking activity in line with definition of expert medical generalist and expert nurse generalist. Narrative will be developed on the nature of primary care as multiple interventions happening within a consultation resulting in the right person and the right time undertaking the care. Relevant guidance will also be developed with demonstrator sites and clinical leads on a clear, shared understanding of common

Data source	Measure(s)	Notes
		definitions and ensure consistent recording of data, including what is meant by appropriate cases.
Local sampling of system pressures	Count of days at each Operational Pressures Escalation Levels (OPEL)	An overall indicator of system pressure in primary care. It would focus on the OPEL of a sample of GPs.
Local sampling of HR reports	Turnover rate Number of vacancies Absence rate	Applies to each service in the MDT. Summary level data for teams will be recorded in different IT systems. Ideally this data would represent the whole demonstrator site area but if this is not practical, such as in NHS Ayrshire and Arran with 53 practices spread over three HSPC, a representative sample of the workforce could be used.
Local sampling of staff estimates of time taken to complete specific sample of tasks	Time spent by staff member given context described in each "vignette" and preferences for time taken.	Applies to each service in the MDT. Indicator of efficiency (health economics) and capacity limitations.
Workforce survey	Focus on questions related to feeling valued, supported, and fulfilled, as well as awareness of other roles in MDT.	Applies to each service in the MDT. Survey would be demonstrator-site wide across the GPs, GPNs and the other roles in the MDT (including practice admin).

Impact that implementation of the MDT component of the GMS contract has on the wider system

Qualitative data will be collected through interviews and focus groups with the same workforce groups listed in the "Impact implementation of the MDT component of the GMS has had on Primary Care workforce" section above, with additional interviews with local system leaders. The focus of the qualitative data will be:

- Safety of Care
- Efficiencies of system

Quantitative data will be collected through existing national data sets and local sampling. Table 3 below outlines the measures for assessing the impact on the wider system.

Data source	Measure(s)	Notes
National unscheduled care data publications (National data published by PHS)	Number of people who attend A&E that are not admitted to hospital Potentially Avoidable Admissions NHS24 and GP Out of Hours service activity	Overall indicator of success of GMS. Improved management of care through GMS would reduce attendance and admissions for people with long term conditions. Risk there are too many other variables that impact on results. Risk that it may take some time to see an improvement
National elective care data publications (National data published by PHS)	Number of referrals to elective care specialties	Overall indicator of success of GMS. Improved management of care through GMS may change referral trends, especially with improved management of long-term conditions. Results would be segmented by specialty. Risk any changes will be masked in the data by changes caused by the COVID pandemic. Risk there are too many other variables that impact on results.
Scottish Therapeutics Utility	Change in costs due to de-prescribing and medicines optimisation.	Applies to pharmacotherapy services working with GPs. Improved management of care through GMS would reduce number of service users with repeated acutes.
Local sampling of costs	Costs borne by Primary Care practices and multi-disciplinary teams in organisation of services and provision of care to provide chosen outcomes under	Applies to each service in the MDT. Indicator of resource use (health economics).

Data source	Measure(s)	Notes
	consideration by the demonstrator sites.	
STU Scottish Therapeutics Utility and Local sampling of pharmacotherapy services	Proportion of repeat prescriptions by reviewing repeats not requested or no longer required	Applies to pharmacotherapy services working with GPs. Indicator of Primary Care MDT which works together to provide proactive and responsive care to meet population health needs. It is resilient and presents value for money and is joined up with the rest of the healthcare system. Nonclinical medication review, multidisciplinary medication review and polypharmacy review will result in medicine optimisation with the aim of improving patient outcomes. Indicator of resource use (health economics).

Economic data will be collected through sampling a small number of Primary Care teams in each demonstrator site for a cost-consequence analysis. Costs and consequences of interventions delivered by each demonstrator site will be summarised to evaluate cost-effectiveness in terms of direction and magnitude of change. If multiple demonstrator sites have collected the same outcomes (in addition to cost), it may be possible to combine the demonstrator site economic evaluation for each of these consistent outcomes into a cost-effectiveness assessment. This will provide an example of the value of investing in improvement for that particular outcome.

Efficiency in terms of capacity within the system will also be considered through local sampling of staff regarding time taken to complete standardised examples of caseload "vignettes" and preferences for time taken to complete tasks. If it is not considered feasible or acceptable by staff to undertake this using quantitative methods, a narrative summary of the factors influencing capacity (based on the preliminary qualitative work to inform the health economics) will be provided instead. Although involving sites outwith the demonstrator sites is not possible for the evaluation, we will seek to validate our data on caseload examples and any quantitative data on capacity gains, using as many experts as possible within the timeframe.

What elements contribute to successful implementation of the MDT component of the GMS contract

This will primarily be qualitative data collected through interviews and focus groups with all workforce groups and service users. The focus of the qualitative data is based on learning from previous work and will explore:

- MDT working (including workforce planning, development, and supervision),
- infrastructure (including physical and digital),
- strategic leadership and partnership management,
- culture for improvement,
- QI support, and
- service user engagement.

The role of the quality improvement support delivered through PCPIP

This will primarily be qualitative data collected through interviews and focus groups with key representatives of the demonstrator sites. The focus on the qualitative data will be:

- Culture for improvement
- QI support

Locally collected quality improvement data will provide quantitative data. Data and measurement plans will be co-designed with each demonstrator site to provide data to understand their system, then ongoing process, balance and outcome measures appropriate to their individual context.

Data processing and sharing

Data analysis

The significant quantity of data that will be collected in this evaluation will be analysed as it is collected. Data collection will start in September 2024 and end no later than October 2025 to ensure there is sufficient time to complete the data analysis and development of recommendations to publish the final report by December 2025.

Reporting

Six monthly interim reports will be published to share findings to date and there will be regular engagement with the Primary Care Evaluation Network to share learning as it emerges. Interim reports will be limited to data collected and results. They will not include the in-depth discussion or recommendations that are expected for the final report.

Recommendations

HIS will form a small expert group of clinical and non-clinical experts with a strong background in Primary Care to review findings of the interim reports and the final evaluation to develop recommendations.

Appendix 1: Detailed evaluation documentation

Further documentation	Link
Qualitative evaluation proposal	Link
Quantitative measure specification	Under development
Health economic analysis proposal	Link

Appendix 2: Potential evaluation measures

Table 1: The measures listed in table 1 below were identified as being highly relevant and aligned to the objectives of the evaluation. However, exploration into the feasibility of collecting this data demonstrated it would be difficult to collect and analyse the data. It would have required significant manual data collection and analysis. This evaluation is attempting to limit manual data collection to reduce burden on clinical staff and has focus the manual data collection on the week of care audit rather than these measures.

Impact on service-users	Impact on workforce	Impact on wider system
Average wait for an appointment	Number of appointments/time spent by GP on more complex cases	Demand not met
Call demand (Number of calls, number of dropped calls and average wait time	Percentage of staff reporting a positive experience within primary care	IDL – Better interface working processes and understanding - process map duplication
	Number of re-directed appointments	Increase provision and number of longer appointments available
	Number of patients seen by multiple professions	Percentage of patients reporting access to healthcare professional within 3 days

Table 2: The measures listed in table 2 below were identified as being relevant and aligned to the objectives of the evaluation. However other measures were prioritised that would require similar or less effort to collect and analyse while providing similar or more contribution towards the evaluation and the creation of recommendations.

Impact on service-users	Impact on workforce	Impact on wider system
Increase in positive stories on Care Opinion	Attrition rates	Cost of saving of polypharmacy review
Life expectancy	Length of service	Number of appointments offered
Long term conditions management measures	Number of adverse events	Number of people aware of services available e.g. ear care

Impact on service-users	Impact on workforce	Impact on wider system
(process of care, effective care, shared decision making)		
No. of GP practices gathering patient feedback (PROMS, PREMS)	Number of complaints and compliments	Number of people that have planned surgery on time and not derailed/postponed due to poor LTC management
Number of complaints	Number of staff attending Personal Learning sessions	Reduction of cancelled or redirected appointments done by provider
Number of e-consults	Number of staff reported adequate time to reflect	Pathway analysis (Primary Care, Secondary Care, Number of touchpoints)
Number of polypharmacy reviews	Number of times patient 'tells their story'	Service-user awareness of primary care offer verse other services
Number of times patient interactions within a certain time period	PDP completion	Urgent vs Routine demand
Prevalence rates (long term measure)	Percentage uptake of external courses	
Reduction in high resource social care		

Table 3: The measures listed in the table 3 below were identified as being potential measure for the evaluation. However other measures were prioritised that were more closely aligned to the objectives of the evaluation.

Impact on service-users	Impact on workforce	Impact on wider system
Acuity in general practice	Board/Self-reported by practice	
Atlas of variation	Number of SAER	
Days in prescribing patterns	Number of grievances	
No of people economically active (capacity of work)		

Impact on service-users	Impact on workforce	Impact on wider system
Number of positive media stories vs negative media stories		
Practice triage queue		
Travel times (Scottish household survey)		

Appendix 3: Glossary of Terms

CTAC – Community Treatment and Care

DS – Demonstrator Site

GP – General Practitioner

GNP – General Nurse Practitioner

HACE – Hospital and Care Experience

HIS – Healthcare Improvement Scotland

MDT – Multidisciplinary Team; a Board-employed member of the wider multidisciplinary team working alongside GPs, GPNs and practice teams as set out in the 2018 GP contract.

PHS – Public Health Scotland

PT - Pharmacotherapy

QI – Quality Improvement

Expert medical generalist – a medical professional with expertise in whole person medicine, which requires and approach to the delivery of healthcare that routinely applies a broad and holistic perspective to service user's problems.

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