Healthcare Improvement Scotland

National primary care improvement event 2026

Insights from PCPIP: Building on primary care improvement

Leading quality health and care for Scotland

NHS SCOTLAND

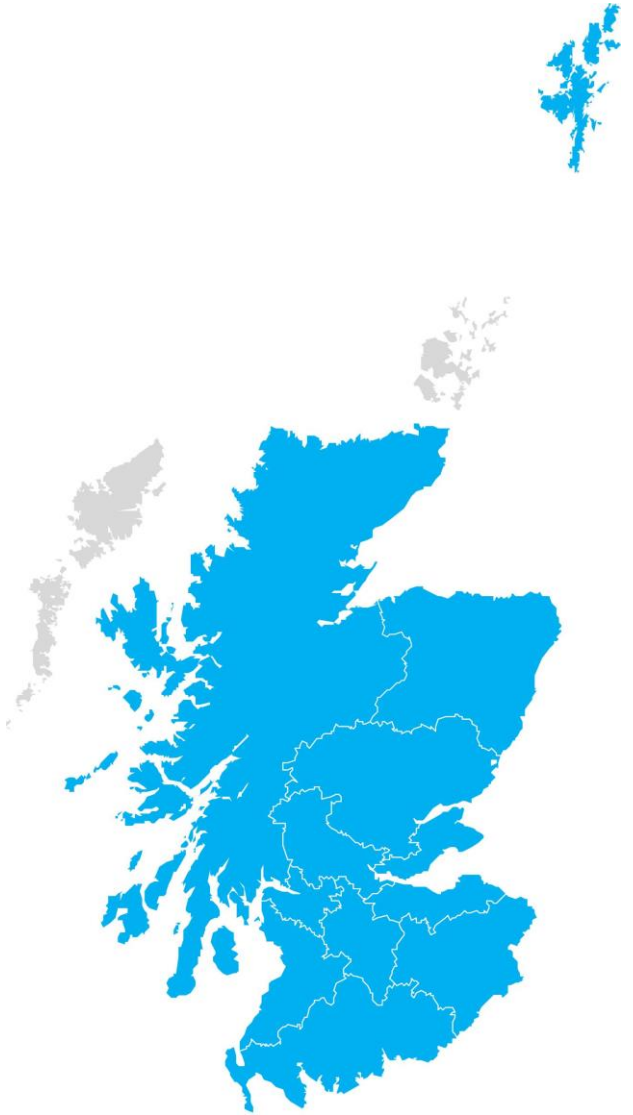
Welcome

Dr Paul Baughan
GP National Clinical Lead
Healthcare Improvement
Scotland

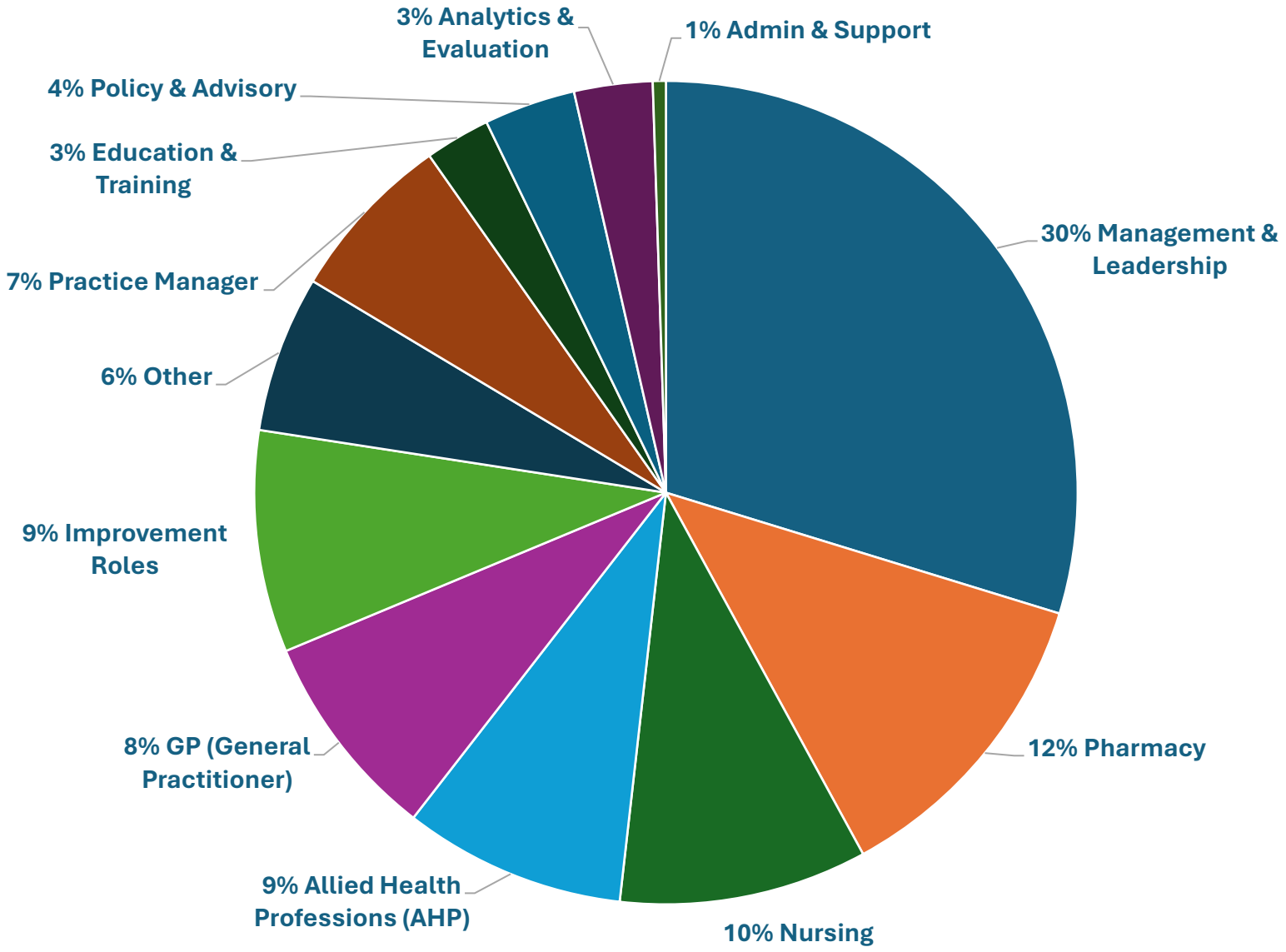
Who is here today?

NHS Board / Organisation:

- NHS Lothian **28**
- NHS Ayrshire & Arran **21**
- NHS Borders **15**
- NHS Greater Glasgow and Clyde **16**
- NHS Fife **13**
- NHS Grampian **11**
- NHS Forth Valley **9**
- NHS Tayside **10**
- NHS Lanarkshire **7**
- NHS Highland **6**
- NHS Shetland **6**
- NHS Dumfries & Galloway **4**
- Scottish Government **11**
- Other **13**



Roles of registrants: Who is here today?



Housekeeping

WiFi

Username: delegate **Password:** haymarket

Toilets
In the main foyer by registration desks.

Fire Evacuation
No fire alarm scheduled, nearest fire exits are through the doors at the back of the Lomond Hall.

Feedback
We will be using Slido throughout the day to capture real-time audience feedback.

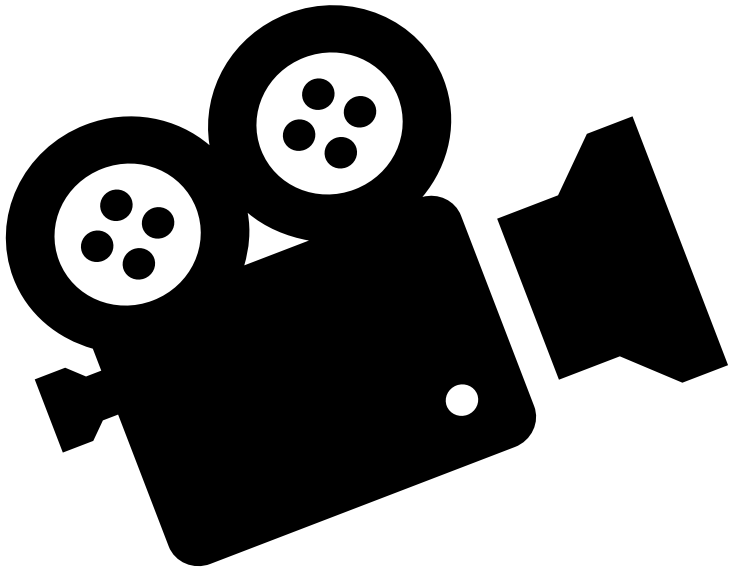
Event resources
Virtual delegate bag using QR code printed on badge. Slides will be circulated after the event.

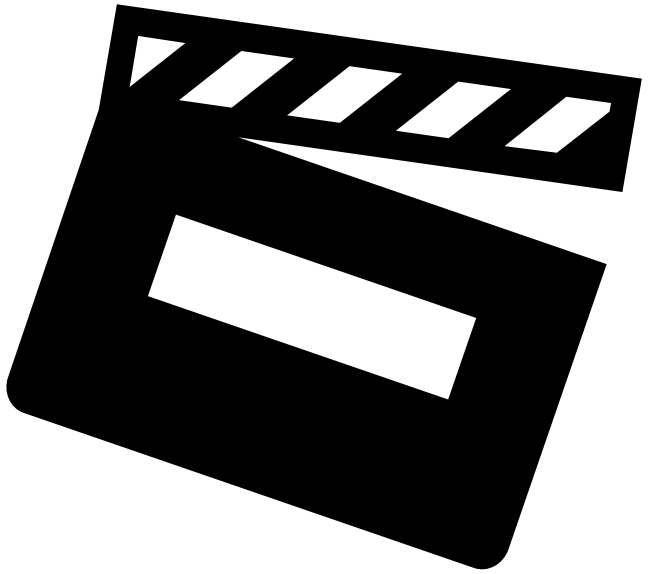
Allergies
There is a delegate here today who has a severe nut allergy – please be mindful of this.

Please ensure mobiles phones are on silent.

Credit: Microsoft stock images

Vox pops





Credit: Microsoft stock images

General practice in Scotland

Image generated using Microsoft Copilot.

Aims for today

The purpose of the national **Primary Care Improvement Event 2026** is to bring together teams from across Scotland and provide an opportunity to:

- share key lessons from the Primary Care Phased Investment Programme (PCPIP)
- discuss how learning from PCPIP can be used more widely in primary care, and
- consider priorities and next steps for improving general practice.

Credit: Microsoft stock images

Healthcare Improvement Scotland

Primary Care Phased Investment Programme (PCPIP) findings

Melissa Dowdeswell
Director of Nursing and Integrated Care

Belinda Robertson
Associate Director of Improvement Support

Leading quality health and care for Scotland

NHS SCOTLAND

Introductions

Melissa Dowdeswell
Director of Nursing and Integrated Care

Belinda Robertson
Associate Director of Improvement Support

PCPIP aims

To improve implementation of services subject to amended regulations outlined in the GMS contract [Community Treatment and Care (**CTAC**) and **Pharmacotherapy** (PT) services.

To develop a culture of continuous improvement across primary care settings.

To build evidence to understand the national context for GMS contract implementation including long-term Scottish Government investment.

Key components of PCPIP

Selection based on criteria

4 demonstrator sites:

- NHS Shetland
- Edinburgh City (9 practices)
- NHS Borders
- Ayrshire & Arran

137 teams signed up
Range of activities

Demonstrator sites

National collaborative

Learning system

Data and evaluation

Range of activities
50 learning resources

7 Data workstreams
Areas of focus

Pharmacotherapy implementation

- Pharmacotherapy hubs
- Exploring new roles
- Developing the pharmacy technician role
- Improving prescribing processes
- Establishing further level three clinics

Community treatment and care services implementation

- Improving access
- Exploring effective skill mix
- Training and development
- Understanding demand and capacity
- Service co-design using patient engagement
- Redesigning long-term condition management

PCPIP data and findings

Quantitative data

- Quality improvement (QI) data from demonstrator sites
- Week of care audit (18 practices)
- Service user views from Citizen's Panel
- Local system data
- National data

Qualitative data (326 participants)

- Interviews and focus groups
  - Service user (n=28)
  - Staff (clinical and non-clinical) (n=298)

Evaluation challenges

- Access to data.
- Lack of integrated IT systems.
- Variation in coding.
- Short programme timeframe.
- Capacity constraints.

Six areas of focus

1. Key conditions for change and enablers required to support multidisciplinary team (MDT) working.
2. Learning from the QI approach embedded in PCPIP to support future implementation of the MDT and policy development.
3. MDT services that should be prioritised.
4. Key attributes of a sustainable and effective model of MDT.
5. Support requirements for monitoring and evaluation of the impact of MDT working.
6. Requirements to ensure MDT working supports the reduction of health inequalities.

1. Key conditions for change and enablers required to support MDT working

Key Conditions for Change

Structural conditions

- Clear contract and guidance
- Adequate and sustainable resource
- Physical and digital infrastructure
- Practice context variation
- Primary and secondary care interface

Relational conditions

- Stakeholder engagement and communication
- Trust – leadership and practices

Transformative conditions

- Changing mindsets and openness

Key Enablers

Clear roles and effective communication

Supportive team culture

Equitable access to training and informal learning

Robust data systems

Adequate staffing and workforce development structures

Data source: Qualitative and QI data

2. Learning from the QI approach embedded in PCPIP to support future implementation of the MDT and policy development

- QI valuable but limited by early design
- Require realistic timelines
- Clear roles & expectations across HIS, Boards, and practices
- Trust & strong relationships enable better engagement
- QI support must match local readiness

- Reliable data and analytics essential
- Peer learning strongest when locally led
- Sustainability planning from the start
- Develop and maintain QI capability
- Meaningful service-user involvement from the beginning

Data source: Qualitative and QI data

3. **MDT services** that should be **prioritised for further development**

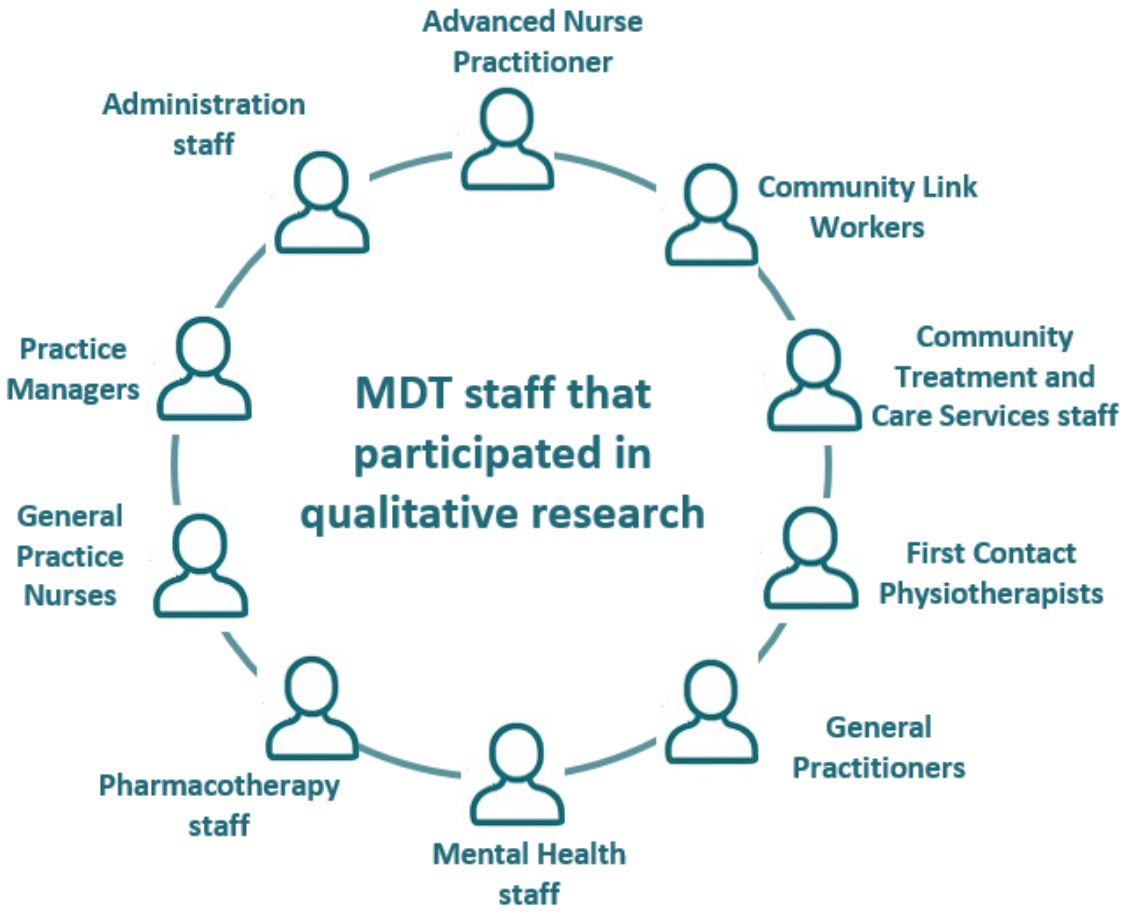
Local practice context, how the practice is set up, and population needs should be taken into consideration.

The week of care audit data showed that:

- **24%** GP consultation time and 20.1% non patient-facing activities could have been more appropriately directed to other MDT members

- **19.7%** of GPN time could have been saved if these activities had been carried out by a member of the CTAC team.

- **5,141** pharmacotherapy tasks were recorded : 58.8% of tasks were acute / repeat prescriptions or medicines reconciliation.



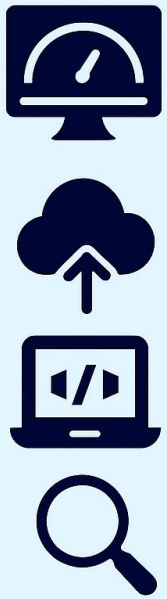
Data source: Qualitative and Week of Care Audit data

4. Key attributes of a sustainable and effective model of MDT

- MDT design aligned to local practice needs
- Stable, long-term, transparent funding
- Flexible delivery models (hub, hybrid, co-located)
- Clear roles, responsibilities and shared objectives
- Consistent quality assurance and monitoring
- Joint recruitment and line-management processes
- Workforce stability and continuity
- Workforce wellbeing and parity of pay/conditions
- Clear career pathways and development opportunities
- Holistic, person-centred MDT working with clear role understanding

Data source: Qualitative and QI data

5. Support requirements for monitoring and evaluation of the impact of MDT working



- Standardised approach for measurement
- Interoperable digital and IT systems
- Better data quality and coding consistency
- Stronger analytical capacity

- Routine service-user experience data
- Long-term, trend-based monitoring
- Better inequalities-focused data

Data source: QI, Local and National data

6. Requirements to ensure MDT working supports the reduction of health inequalities

- Better guidance for reducing inequalities
- Address wider determinants of health
- Stronger staff training to recognise inequalities
- Compassionate, standardised approaches to DNAs and ‘missingness’
- Fair distribution of MDT resources
- Effective interpreter and translation services
- Accessible hub models for people with travel, mobility, or anxiety barriers
- Greater service-user awareness of MDT roles and services
- Flexible, proactive MDT working
- Better inequalities-focused data

Data source: Qualitative, Local and QI data

Next Steps

- Finalise conclusions and recommendations.
- Publication and sharing.

Healthcare Improvement Scotland

PCPIP quality improvement (QI) journey and panel: learning from demonstrator sites

April Masson
Portfolio Lead, Primary Care

Leading quality health and care for Scotland

NHS SCOTLAND

PCPIP Panel

April Masson
Healthcare Improvement Scotland

Dr Deepa Shah
NHS Shetland

Cathy Wilson
NHS Borders

Karin Mathie
NHS Ayrshire and Arran

Hazel Garvin
NHS Lothian

PCPIP QI Journey

Healthcare Improvement Scotland

Health equity: building on PCPIP

Dr Peter Cawston
GP Advisor Health Inequalities Clinical Faculty

Dr Marianne McCallum
GP Advisor Health Inequalities Clinical Faculty

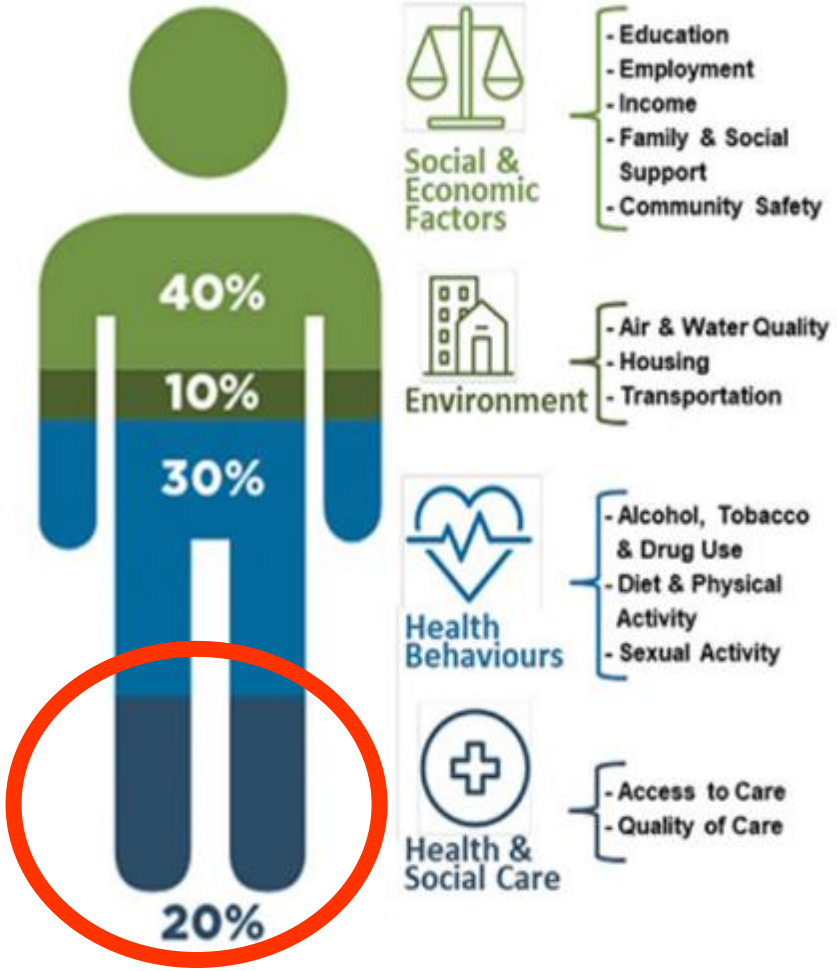
Leading quality health and care for Scotland

NHS SCOTLAND

Outline

- How do we see the system?
- How might we stop 'magic' thinking?
- Recognise resource.
- Recognise relationships.
- Practical suggestions.

The role of healthcare



Chapter 3: Health inequalities: Turning the Tide - Realistic Medicine - Doing the right thing: Chief Medical Officer annual report 2022 to 2023 - gov.scot

The starting point matters

- **Primary Care GMS contract – 2018:**

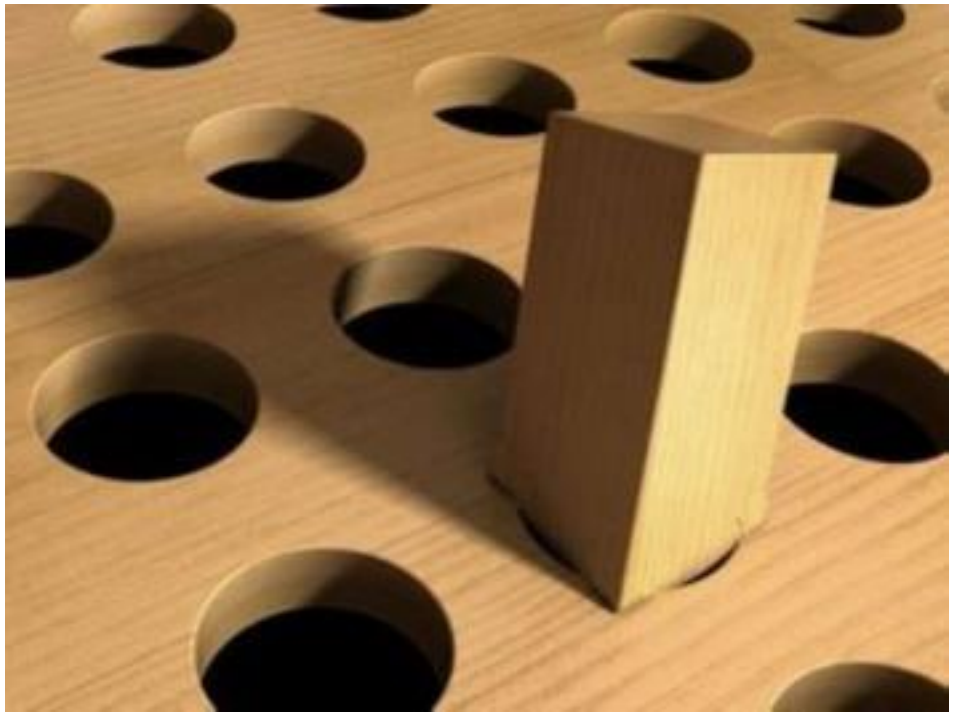
  ‘A strong and thriving general practice is critical to sustaining high quality universal healthcare and realising Scotland’s ambition to improve our population’s health and reduce health inequalities.’

https://www.gov.scot/publications/gms-contract-scotland/pages/3/

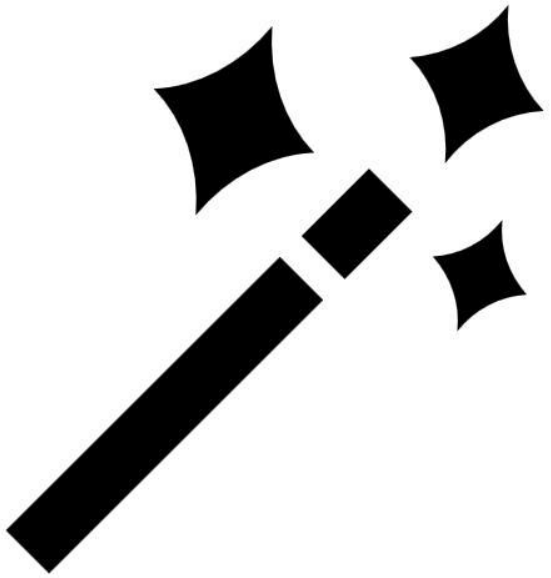
Recognise the system

'Health Systems are designed by healthy people for healthy people'

Dr Adam Burley Clinical Psychologist



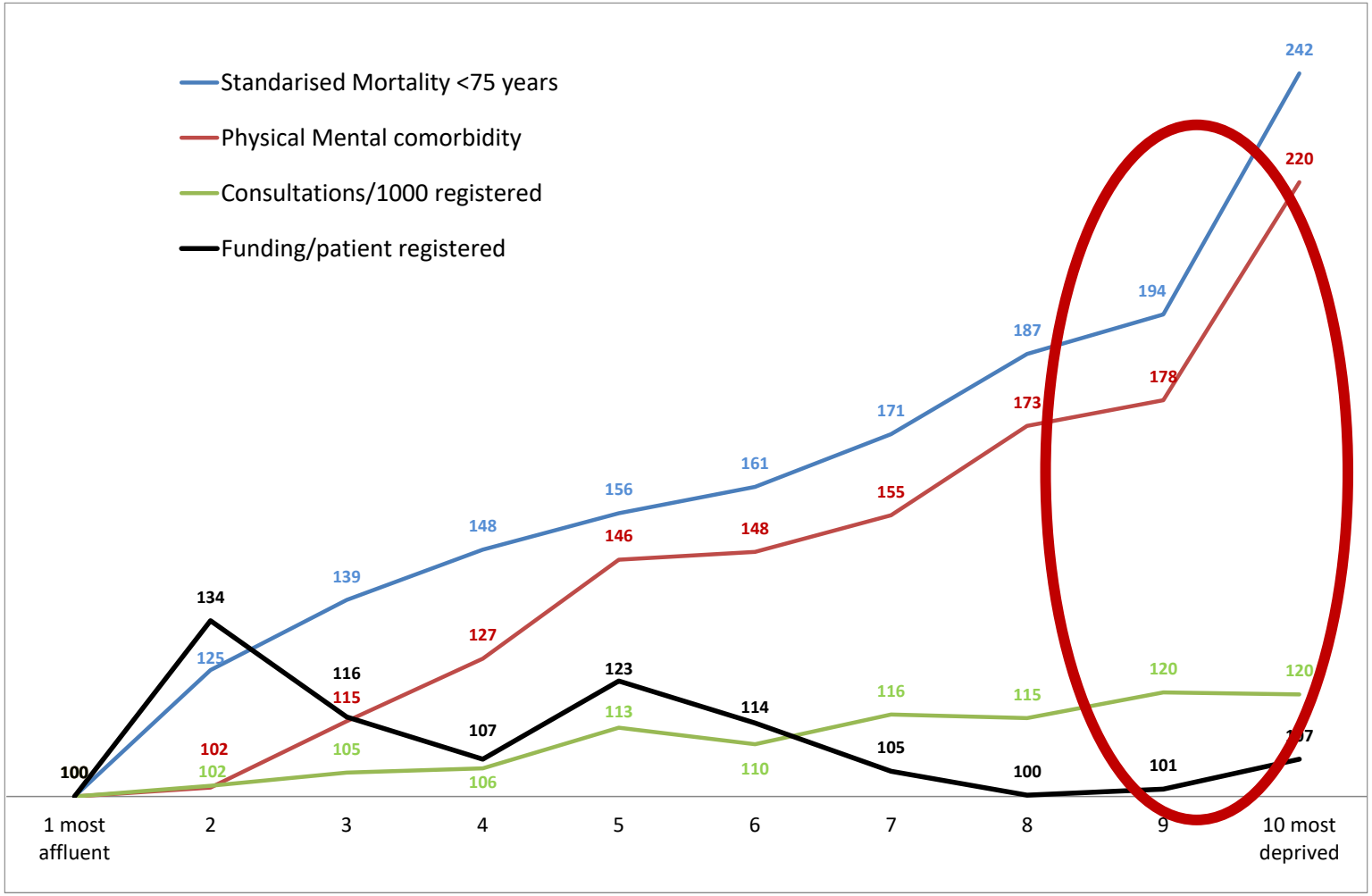
How do we stop magic thinking ?



- Health inequalities in the **centre** from the **start**.
- How do we look at the system?
- Measure what matters, not what is easy.
- System design from community not just practitioner perspective.

Credit: Microsoft stock images

The inverse care law



McLean G, Guthrie B, Mercer SW, Watt GC. General practice funding underpins the persistence of the inverse care law: cross-sectional study in Scotland. Br J Gen Pract. 2015 Dec;65(641):e799-805. doi: 10.339

Missingness

GP no-shows 'more likely to die early'

Research says people with long-term health conditions are most likely to miss GP appointments.

‘High levels of non-attendance at services should be treated as a signal of a service that is difficult for people to use’

NHS Service Delivery and Organisation. Vulnerable groups and access to health care. Department of Health, 2006

‘We now know that this is a group of patients who have **complex health needs and are also more likely to die prematurely.**

If anything, this is a marker of people who need more input rather than being punished with fines.’

https://www.gla.ac.uk/schools/healthwellbeing/research/generalpractice/research/serialmissedappts/

Proportionate universalism

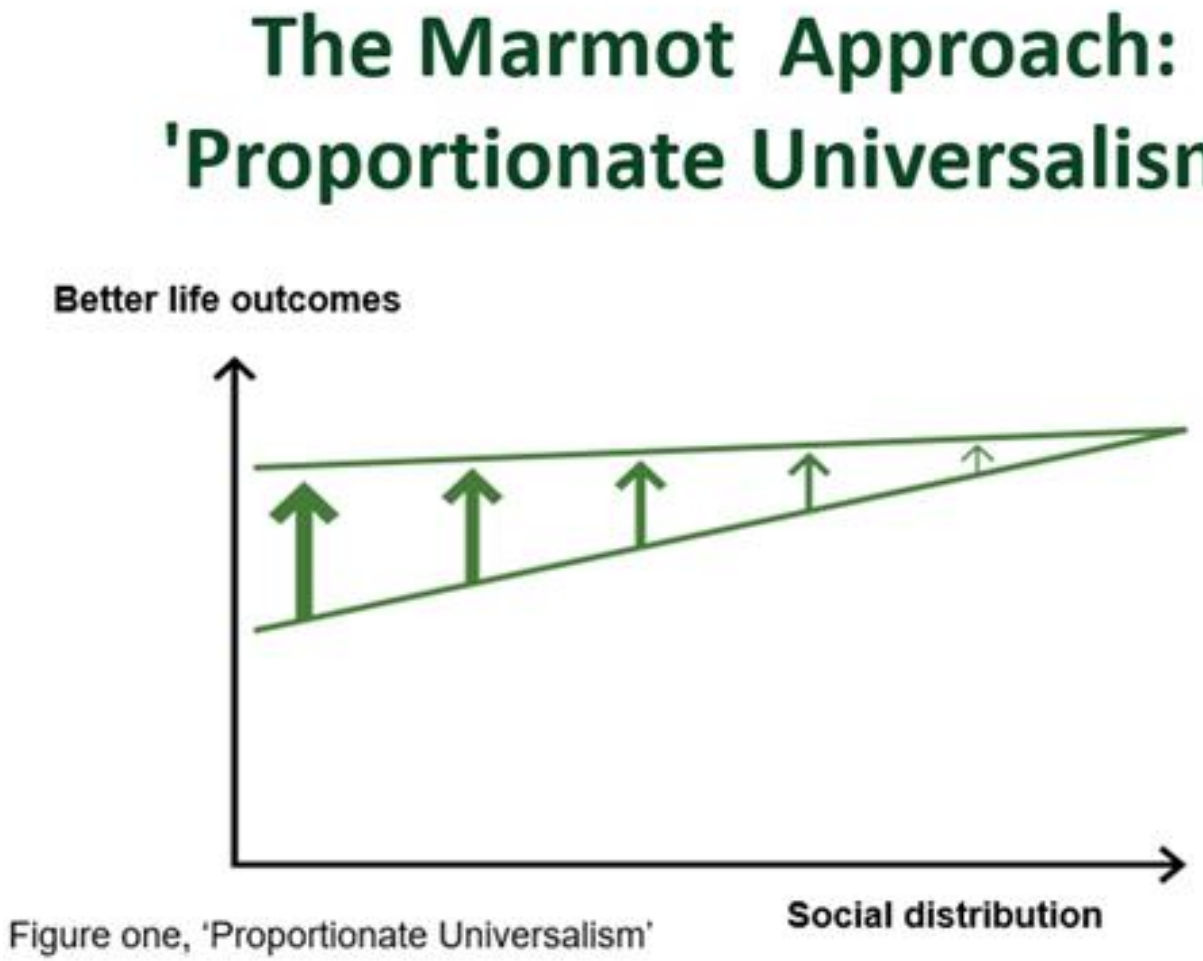
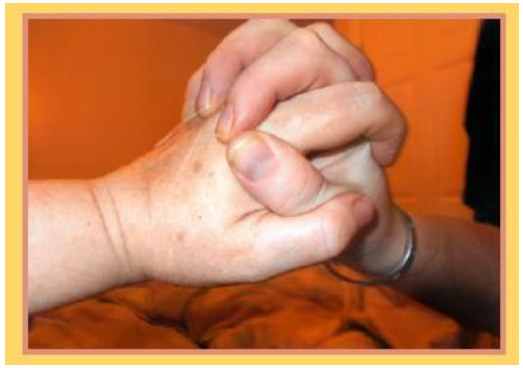


Figure one, 'Proportionate Universalism'

https://solutionsplatform.co.uk/improving-education-skills-and-employment-in-coventry-a-marmot-city-approach/

Three words



Relationships

Relationships

Relationships

Relational care/ continuity of care

- Reduces mortality (1)
- Reduces hospitalisation (2,3)
- Increases patient trust (4)
- Improves uptake of preventive care (5) and adherence to medical advice (6)
- Increases quality of care (7) and satisfaction (8)
- Improves job satisfaction & reduces workload (9)
- And much more!

1.Baker R, Freeman GK, Haggerty JL, Bankart MJ, Nockels KH. Primary medical care continuity and patient mortality: a systematic review. British Journal of General Practice. 2020;70(698):e600-e11.
2. Hansen AH, Halvorsen PA, Aaraas IJ, Førde OH. Continuity of GP care is related to reduced specialist healthcare use: a cross-sectional survey. British Journal of General Practice. 2013
3. Barker I, Steventon A, Deeny S. Continuity of care in general practice is associated with fewer ambulatory care sensitive hospital admissions: a cross-sectional study of routinely collected, person-level data. Clinical Medicine. 2017;17(3, Supplement):s16
4.Murphy M, Salisbury C. Relational continuity and patients' perception of GP trust and respect: a qualitative study. British Journal of General Practice. 2020;70(698):e676-e83.
5. O'Malley AS, Mandelblatt J, Gold K, Cagney KA, Kerner J. Continuity of Care and the Use of Breast and Cervical Cancer Screening Services in a Multiethnic Community. Arch Intern Med. 1997;157(13):1462–1470.
6. Warren JR, Falster MO, Tran B, Jorm L (2015) Association of Continuity of Primary Care and Statin Adherence. PLoS ONE 10(10): e0140008
7. João Delgado, Philip H Evans, Denis Pereira Gray, Kate Sidaway-Lee, Louise Allan, Linda Clare, Clive Ballard, Jane Masoli, Jose M Valderas, David Melzer. Continuity of GP care for patients with dementia: impact on prescribing and the health of patients British Journal of General Practice 2022; 72 (715): e91-e98.
8. Rhodes Adler, Athanasia Vasiliadis, Nina Bickell, The relationship between continuity and patient satisfaction: a systematic review, Family Practice, Volume 27, Issue 2, April 2010, Pages 171–178,
9. Kajaria-Montag, Harshita and Freeman, Michael and Scholtes, Stefan, Continuity of Care Increases Physician Productivity in Primary Care (June 05, 2023). Available at SSRN: https://ssrn.com/abstract=3868231 or http://dx.doi.org/10.2139/ssrn.3868231

Continuity of care

‘Continuity of care is especially vital for managing chronic conditions, mental health issues, and complex healthcare needs, particularly among vulnerable groups such as trauma survivors, the elderly, and marginalized communities.’

What can General Practice do to Strengthen Continuity of GP Care for those who Need it Most?

Team relationships

- Shared learning (trauma / missingness informed) (1)
- Coordination of complex care (2)
- Management & informational continuity (3)
- Shared problem solving (3)
- Clear lines of responsibility & accountability (4)
- Wellbeing and retention (4)
- Patient satisfaction and safety (5)

Credit: Microsoft stock images

1. Noël PH, Lanham HJ, Palmer RF, Leykum LK, Parchman ML. The importance of relational coordination and reciprocal learning for chronic illness care within primary care teams. Health Care Manage Rev. 2013 Jan-Mar;38(1):20-8
2. Rundall TG, Wu FM, Lewis VA, Schoenherr KE, Shortell SM. Contributions of relational coordination to care management in accountable care organizations: Views of managerial and clinical leaders. Health Care Manage Rev. 2016 Apr-Jun;41(2):88-100.
3. Haggerty JL, Reid RJ, Freeman GK, Starfield BH, Adair CE, McKendry R. Continuity of care: a multidisciplinary review. BMJ. 2003 Nov 22;327(7425):1219-21. doi: 10.1136/bmj.327.7425.1219.
4. Abrams R, Jones B, Campbell J, de Lusignan S, Peckham S, Gage H. The effect of general practice team composition and climate on staff and patient experiences: a systematic review. BJGP Open. 2024 Apr 25;8(1)
5. Weaver SJ, Dy SM, Rosen MA Team-training in healthcare: a narrative synthesis of the literature BMJ Quality & Safety 2014;23:359-372.

Community relationships

Health equity focused quality improvement

- From health inequality to health equity.
- From non-engagement to missingness.
- From ‘too big to solve’ to quality improvement.

Inclusion health action in general practice programme (IHAGP)

Scottish Government
Riaghaltas na h-Alba
gov.scot

NHS
Greater Glasgow and Clyde

GPs at the Deep End

IHAGP Early Evaluation findings, Spring 2024

Inclusion health action in general practice programme (IHAGP)

Enhancing workforce knowledge and skills (24 practices)

200+ staff participated in training, including GPs, nurses, practice managers, pharmacists, healthcare assistants and non-clinical roles

A wide variety of training undertaken:

- Signposting
- Drugs and alcohol
- Trauma
- Health inequalities
- Suicide prevention
- Long-term disease monitoring and management
- Data management and medical coding
- Conflict negotiation
- Gender-based violence

‘Every so often people present agitated or distressed at the reception desk. So, they've had suicide awareness training and communication skills training’

Outreach and longer appointments (52 practices)

7,000 longer appointments and outreach appointments delivered, including home visits

Targeted at patients with high levels of need or, identified as high risk.

For example people who need translation services, people who miss appointments, people with multiple co-morbidities

‘We've got people claiming Universal Credit or Personal Independence Payment who haven't actually spoken to a doctor in a year… so I've been actively seeking these people out in my outreach clinics because I think that they are really good candidates for this.’

Accessible Social Research - The Lines Between (2024)

Primary Care collaborative quality improvement sprint 2025

Health equity QI focussed sprint topics:

- identifying and removing barriers to access to GP registration
- practice policies around missed appointments
- services for people with communication and language needs
- health equity focused team training and self-assessment (various topics)
- missing from early cancer detection
- developing trauma informed practice
- improving continuity and relational care, and
- understanding barriers to booking appointments.

Primary Care collaborative quality improvement sprint 2025

- Seven general practice (GP) practices worked with Healthcare Improvement Scotland on an 8-week quality improvement health equity focused sprint.
- Four of the practices used the CVD DES as an opportunity to engage patients who do not routinely access primary care.
- Practices used a whole team quality improvement approach.

Health equity sprint and cardiovascular disease (CVD) direct enhanced service (DES)

Examples of change ideas tested:

- flexible communication strategies to invite patients, including admin, nurse and GP phone call
- improving communication to ensure patients recognise messages as legitimate
- phoning patients to understand reasons behind missed appointments and understand barriers to engagement
- targeting patients using existing clinics – eg shared care addictions clinic
- designing searches to target patients with mental health conditions
- scales placed at reception – patients invited to weigh themselves, and
- engaging with a local community group to raise CVD awareness.

Key learning points

- Build meaningful community and staff engagement to understand visible and invisible barriers in systems
- Enhance workforce knowledge & skills in health equity
- Be proactive in coding, outreach, tailoring care to needs, removing barriers and safety netting
- Relationships are key – good consultations, continuity, co-ordination and communication

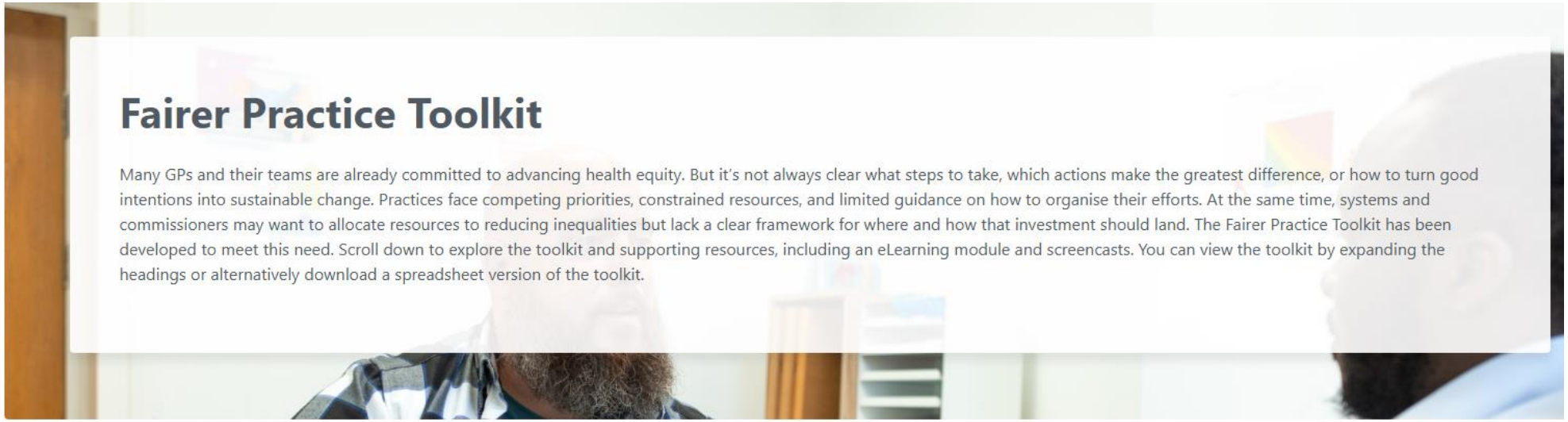
Health equity: building on PCPIP

- How will we (re) build relational continuity of care from where we are today?
- How will we ensure that primary care workforce investment maximises return for relational care, complex care coordination and access for all?
- How will we redefine ‘access’ to encompass missingness, relational care and barriers to care?

Further resources

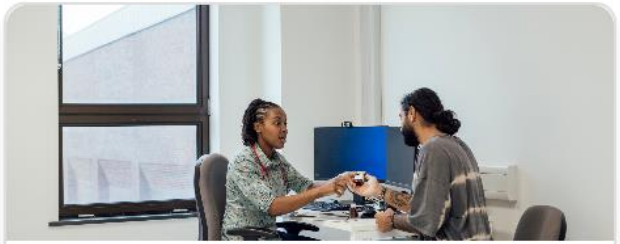
- IHAGP early evaluation report
- IHAGP case studies
- Deep end resources
- Safe surgeries toolkit
- RGCP inequalities hub
- Health equity evidence centre
- Fairhealth courses
- Trauma informed organisational roadmap

Royal college of general practitioners (RCGP) GP Fairer practice toolkit



Understanding the Fairer Practice Toolkit (Module)

w.php?id=1188#



An overview of the Fairer Practice Toolkit (Screencast)

Understanding the Fairer Practice Themes (Screencast)

Royal college of general practitioners (RCGP) GP Fairer practice toolkit

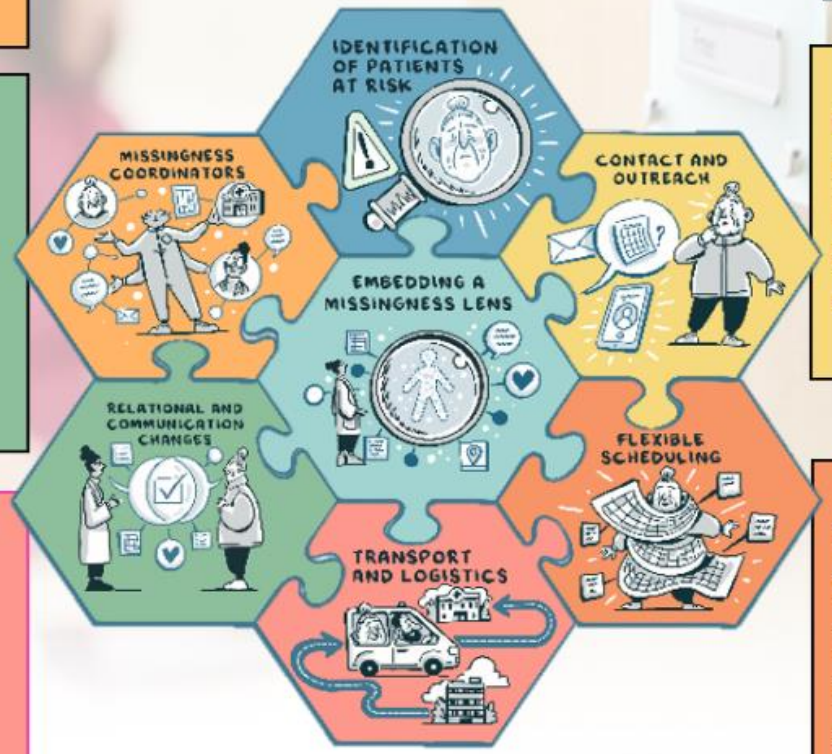
Intervention to address missingness

Coordination: Open-ended, flexible, relational; bridging work; address SDOH and patient priorities, advocacy and promoting system change.

Resourcing a change in perspectives, practices, systems; staff development and support; build in localised perspectives; means for monitoring and accountability

Identifying and tracking local patterns and trends.
Exploring barriers while building relationships.
Building a picture – individual + collective.

Person-centred, trauma-informed practices.
Choice/continuity of staff; addressing comms needs and power dynamics; advocacy work.



Contact before/after appts – reminders; orientation; explore immediate barriers; offers of support or care; check-ins; points of contact for patients.

A stepped, needs-led approach:
Tickets/reimbursement > taxis > accompaniment > outreach/inreach.

Prioritising for tailored forms of access: choice of how, when, who, where; longer appts/opening hours; allowances/accommodations.

Williamson, Andrea et al (2025) Developing Interventions to Address Missingness in Healthcare. Project Report. University of Glasgow.

Meaningful Community Engagement

SEE ME – I am a person with feelings. LISTEN – my opinion matters

BE HONEST - even if you don't know because I would appreciate that.

HELP ME UNDERSTAND - please don't tell me what to do, offer me advice and where appropriate alternative solutions.

REMEMBER I AM AN EXPERT in your professional hands - 50:50 partnership, each valuing the other's expertise.

CONSIDER PEER SUPPORT - it is our experience that people build confidence in people far more effectively than medication.

Meaningful community engagement: a Deep End perspective. Nic Dickson, Leanne McBride, Colette Mason, Fraser Devine, Marianne McCallum
British Journal of General Practice 2025; 75 (752): 126-127.

Healthcare Improvement Scotland

Transition to plenary session

Leading quality health and care for Scotland

NHS SCOTLAND

Afternoon plenary

Professor Graham Ellis

Deputy Chief Medical Officer

Scottish Government

Healthcare Improvement Scotland

Scottish Government update

Professor Graham Ellis
Deputy Chief Medical Officer

Leading quality health and care for Scotland

NHS SCOTLAND

Healthcare Improvement Scotland

Future plans for HIS primary care

April Masson
Portfolio Lead, Primary Care

Leading quality health and care for Scotland

NHS SCOTLAND

What did we do in the past?

Supporting learning
- Webinars
- Improving Together interactive (website)
- Toolkits and usable resources (ACP, SP, AP, PASC)
- Case studies
- Learning cycles
- Contributing to National Groups
- Funding for Safety Fellowship
- National events

Sprints
- Workflow
- Appointments
- Care Navigation
- Call Volume
- Pharmacotherapy
- Inequalities

Collaboratives
- SPSP PC
- SPSP Pharmacy
- SPSP Pressure Ulcers in Care Homes
- SPSP Dentistry
- Practice Admin Staff Collab (PASC)
- PCPIP collaborative

Responsive support
- PC Improvement Faculty
- Assist with local needs (eg. Workshop to CQLs)

Networks
- Acute Prescribing Network
- GP Cluster Improvement Network
- CTAC Network

Service implementation
- PCPIP
- Near me

Shaping our priorities together

- Using SLIDO to share your feedback and insights
- What are the priorities in the system?
- What will make the biggest difference?

Healthcare Improvement Scotland

Closing remarks

Paul Baughan
GP Clinical Lead, Healthcare Improvement Scotland

Leading quality health and care for Scotland

NHS SCOTLAND

Closing remarks

Image generated using Microsoft Copilot.

Event evaluation

Please give us **feedback** on how you found today's event with the QR code shown here.

Event **Evaluation** Form

Thank you

- Resources from today's event will be circulated by email.
- Please leave your delegate lanyards.
- If you have any questions, please contact us at his.pcpteam@nhs.scot

Event **Evaluation** Form