Introstuctions

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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
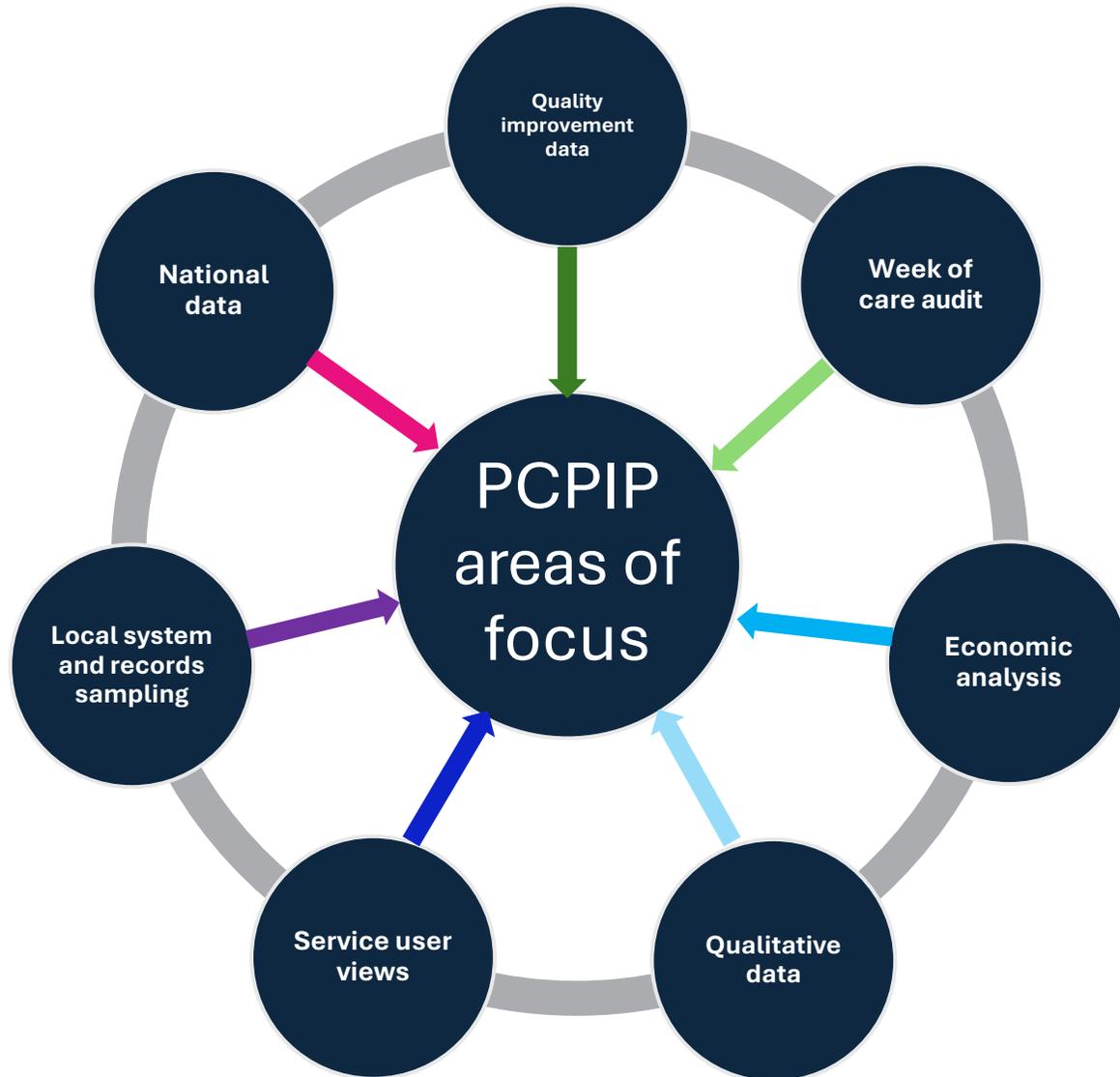
Improving access

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
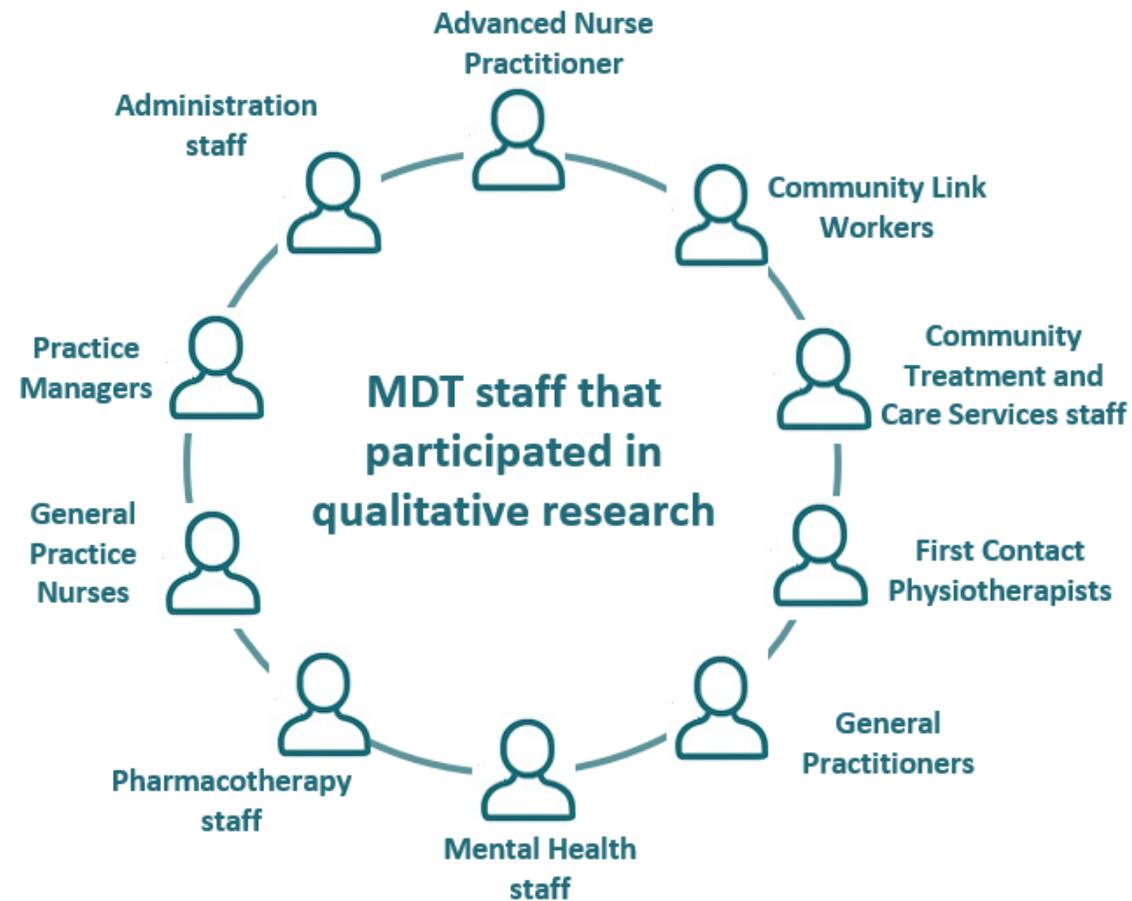
Meaningful service-user involvement from the beginning

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.

MDT staff that participated in qualitative research

- Advanced Nurse Practitioner
- Administration staff
- Community Link Workers
- Practice Managers
- Community Treatment and Care Services staff
- General Practice Nurses
- First Contact Physiotherapists
- Pharmacotherapy staff
- General Practitioners
- Mental Health staff

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
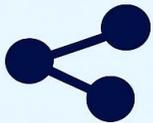
Long-term, trend-based monitoring

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.