

Health equity improvement sprint evaluation

Background

Health inequalities are unfair and avoidable differences in health between groups of people, caused by social, economic and environmental factors. Achieving health equity requires removing barriers and allocating resources based on individual needs. The Scottish Government has identified inclusive and equitable access to general practice as a key principle in primary care.

The Scottish Government's 2022 [primary care health inequalities report](#) recommended targeted investment in the care of patients who experience inequalities. This resulted in the creation of the [inclusion health action in general practice \(IHAGP\) fund](#). The fund is currently being invested in practice improvements in some ['deep end' general practitioner \(GP\) practices](#). Deep end GP practices serve the most disadvantaged communities in Scotland.

In practice, equity is often overlooked in favour of other quality measures. If equity-focused values are not included in quality improvement (QI), [research](#) has shown it risks initiatives by either maintaining or widening health inequity. The improvement sprints aimed to address this challenge by directly focusing on issues relating to health equity.

Approach

Improvement sprint

In 2024, the primary care team at Healthcare Improvement Scotland (HIS) agreed to test a sprint approach to support improvements in health equity in a primary care setting. This QI method had been used in previous HIS programmes.

Sprints deliver structured improvement support over a short period (for example four or eight weeks). Teams receive support to identify areas for change and improve an aspect of their service. The eight-week sprint ran from May to July 2025.

Teams received a range of support with their improvements including:

- an improvement coach to provide support with data collection and testing of changes,
- an online introductory session to explain the QI approach,
- drop-in sessions for coaching and peer support, and
- a final session to present progress and advice for next steps.

Clinical colleagues with expertise in health equity, including an NHS Education for Scotland (NES) health inequalities fellow, provided training and resources for coaches. This ensured the coaches understood the issues around health equity in general practice.

Participating teams

Seven teams were recruited from relevant networks, such as IHAGP. Teams were provided with a range of health equity topics to focus on, including:

- barriers to access or registration,
- continuity of care,
- [missingness from general practice appointments](#) (also known as multiple missed appointments),
- missingness from preventive care, particularly in cardiovascular risk,
- trauma-informed practice,
- relational care, and
- unavailable appointments.

Coaches worked with teams to agree their improvement focus (*Table 1*). The [cardiovascular disease designated enhanced service \(CVD DES\)](#) was launched around the same time as the sprint. This provided an opportunity for teams to focus on this within the missingness topic, and four of the seven teams chose this area.

Table 1: Improvement focus of participating teams

Practice	Improvement focus
Practice 1	Cardiovascular disease prevention (CVD DES)
Practice 2	Cardiovascular disease prevention (CVD DES)
Practice 3	Continuity of care
Practice 4	Cardiovascular disease prevention (CVD DES)
Practice 5	Missed GP appointments
Practice 6	Cervical screening
Practice 7	Cardiovascular disease prevention (CVD DES)

Learning

Examples of impact and learning from sprint

High engagement with tangible progress

- Practices tested changes such as new CVD DES communication approaches, updated missed appointment letters, and increased CVD DES reviews (from 10 to 80).
- Whole team involvement, including administrative staff and practice manager, helped sustain momentum despite pressures.

Coaching and faculty support were key enablers

- Introductory calls and one-to-one coaching were rated as the most useful components.
- Clinical HIS faculty expertise strengthened teams' understanding of health inequalities and supported focused testing.

Peer learning enhanced improvement

- Online sessions enabled quick, accessible sharing of ideas between practices.
- Learning spread beyond sprint teams through GP clusters, a Scottish Government IHAGP webinar, and a NES webinar on CVD prevention and inequalities.

Time and capacity were major challenges

- Teams reported eight weeks was too short, particularly without protected time.
- Summer leave, illness and childcare pressures disrupted continuity.
- Some teams struggled with complex clinical searches needed for data-driven QI.

Next steps

- Provide more lead-in and protected time to support planning and meaningful testing.
- Consider seasonal timing to reduce disruption from staff absence.
- Expand recruitment to include more practices across Scotland.
- Strengthen support for data and searching skills within teams.
- Maintain ongoing relationships with sprint teams to follow progress and share learning.
- Adjust the sprint structure (eg fewer sessions, more time between them) to support deeper testing.
- Continue building HIS internal learning on applying an inequalities lens to QI.

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