Healthcare Improvement Scotland

Primary Care Phased Investment Programme: Final report

Appendix 4: Demonstrator site discussion flash report

Healthcare Improvement Scotland

Flash report

PCPIP: Demonstrator Site Meeting

7 October 2025

Summary

On 07 October 2025, demonstrator sites were invited to the COSLA Conference Centre to reflect on the Primary Care Phased Investment Programme (PCPIP). Through a World Café discussion, teams contributed insights to help shape the key focus areas of focus for the programme's final report.

The six areas of focus to inform the final report are:

- What are the key conditions for change and enablers required to support MDT working?
- What learning can we take from the quality improvement approach embedded in the programme, to support future implementation of the MDT and policy development?
- Which multidisciplinary team services should be prioritised for further development?
- What are the key attributes and benefits of a sustainable and effective model of multidisciplinary team 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?

Conditions for change and enablers required for MDT working

Time for planning and recruitment:

- The programme timeline was challenging with limited time for stakeholder engagement between bid development and programme launch.
- Recruitment took longer than anticipated resulting in a slower start to QI work.

Understanding roles and responsibilities:

- Greater clarity around the role of the GP within the GMS contract would be helpful.
- MDT staff reported understanding their own roles and responsibilities, but these can vary across different practices.
- Establishing clear guidance around appropriate levels of risk is essential to ensure safe care.

Stakeholder involvement:

- Securing buy-in from all stakeholders and aligning goals is essential.
- Ongoing communication with practices strengthened relationships.
- Practice managers help to create the conditions for effective MDT working between practice and board employed staff.

Training and mentorship:

- Robust training plans are required to ensure staff feel confident.
- Building confidence to make decisions can reduce the need for checks and oversight.
- The practice educator role can provide mentorship and monitor development.

Funding and infrastructure to support change:

- Funding for staff and premises was essential to being able to test changes.
- To successfully implement change, teams need to be equipped with adequate IT systems and premises.
- Investing in IT solutions such as digital prescribing would help to streamline processes and reduce inefficiencies.

Patient experience:

- A clear understanding of what patients' value from MDT working is important.
- Teams used tools from the Care Experience Improvement Model (CEIM) to focus on patient engagement.
- Future discussion around the GMS contract should focus on patient outcomes.

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Flash report: PCPIP demonstrator site meeting

MDT services to be prioritised for further development

Considerations for prioritisation

- A population needs assessment could support practices to identify the MDT required.
- A realistic medicine approach would enable teams to understand patient preferences and support patients to make informed choices.
- It could be helpful for the GMS contract to provide further guidance on responsibilities for different members of the MDT and a quality and outcomes framework.
- Findings from economic analysis about where the MDT adds value should inform further development.
- There was a lack of consensus on whether future funding should be directed to the MDT or to direct investment in GP practices.

Primary care nursing: Advanced Nurse Practitioners (ANP) General Practice Nursing (GPN) and CTAC:

- In the week of care audit Advanced Nurse Practitioner (ANP) was the most frequently chosen clinician that could have dealt with non-complex consultations.
- This is a post-appointment decision after the GP has seen the patient. It could be difficult for practice admin to decide whether the patient should be seen by a GP or ANP.
- There needs to be more consideration into how the expert nursing generalist role can be developed.
- CTAC should be considered as a potential staff pipeline into general practice nursing.

Pharmacotherapy:

- The introduction of hubs has helped to transfer some level 1 work from practices.
- Early data indicates that this is enabling practice-based pharmacotherapy teams to take on more complex level 2 and 3 responsibilities.

Other MDT roles:

- New roles such as the advanced pharmacist practitioner and practice educator roles should be explored.
- Roles such as community link workers, musculoskeletal physiotherapy etc were not evaluated in PCPIP.
- Administrative teams need to have the available IT and infrastructure to support the development of primary care services.

Learning from the QI approach

Creating the conditions for change:

- There was limited time from when bids were submitted to the programme commencing to build the conditions for change including engagement with stakeholders.
- Earlier patient engagement may have helped shaped the programme around patient needs.
- Communication with practices varied across demonstrator sites.
- Engagement with independent GP practices required.
- Building and maintaining positive and trusting relationships between HIS, demonstrator sites and Scottish Government during the programme was viewed as a key condition to support change.

QI tools:

- QI tools, including driver diagrams and process maps, helped to identify bottlenecks and plan improvement activities.
- Teams valued small scale testing using PDSA cycles.
- Sustainability- there is risk of services reverting to business as usual when QI support is withdrawn.

Understanding the system:

- Delays to recruitment led to challenges understanding the system.
- Additional time is needed to understand demand in primary care.
- Manual data collection was often required to understand demand.

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Attributes and benefits of an effective model of MDT support

Attributes of an effective MDT:
- Flexible and adapted to local context
- Supportive leadership
- Time to build trust
- Clear understanding of roles and responsibilities
- Learning and development opportunities
- Efficient digital systems

Benefits:
- Optimised patient care
- Cost efficiency
- Sustainable workforce
- Improved patient outcomes

Sustainable and effective MDT model:
- Sustainability depends on practice context.
- MDT support should be tailored to local needs.
- MDTs should adopt standardised professional approaches within their own disciplines to reduce variation and promote efficiency.
- Improved public awareness of MDT roles in primary care.

MDT working to support the reduction of health inequalities

Leadership and strategy:
- A shift from task-based contracts to person-centred outcomes is needed.
- Short-term funding and initiatives (PCPIP, DES) hinder long-term impact.
- Resource allocation should reflect need, not just list size.
- The inverse care law should be considered in strategic decision making.

Continuation of PCPIP work
- Inequality impact assessments
- Care Experience Improvement Model (CEIM) discovery conversations
- Inequalities modules on Turas

Data and systems
- Fragmented systems (e.g. VISION, EMIS, TRAK) limit holistic understanding.
- Lack of integrated data prevents flexible, needs-based responses.
- Local needs assessments are essential.
- SIMD scores alone don't capture the full picture of inequality.

Additional requirements to support monitoring and evaluation of the impact of MDT working

QI support:
- Dedicated QI support has been crucial to PCPIP progress, enabling teams to focus on delivery.
- QI support enabled teams to understand and interpret data.
- Project management played a key role in maintaining progress and focus.
- PCPIP provided teams with the opportunity to focus on QI.

Sustainable funding:
- Uncertainty remains around funding beyond PCPIP.
- Sustainable MDTs require long-term investment, including infrastructure.
- Reliance on fixed-term contracts creates workforce instability across the NHS.

PHS support:
- LIST supported teams to extract data from systems.
- LIST supported one demonstrator site to develop a pharmacotherapy dashboard.

Accurate data and measurement:
- Establish a national framework of both quantitative and qualitative measures.
- IT infrastructure to reduce gaps in the data.
- Defined outcome measures for GPs.
- Defined outcome measures for patients.
- Sharing data with other programmes such as Frailty and Hospital at Home.

Next steps

Feedback from the World Café discussions have been shared with the final report writing team and will inform the development of the PCPIP final evaluation report.

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Full report

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