Primary Care Phased Investment Programme: Final report

Appendix 9: Full data analysis from local sampling

Data in this appendix should be viewed alongside the limitations detailed in the methodology (Appendix 6). Practice feedback is presented for certain indicators as this provides useful context for some of the trends seen. However, it is important not to place too much emphasis on the data from one individual practice, and understand the trends seen across the indicator, as well as in those providing feedback.

This appendix includes the original indicators used in the analysis, detailing their data sources, measurement methods and notes on any changes or removals because of data availability. Additionally, it provides the rationale for each indicator, explaining its relevance to the evaluation and the reasons for its selection.

Access to care

There were two areas where data was collected to understand the access to care: Encounters, long-term condition (LTC) care – diabetes and chronic obstructive pulmonary disease (COPD).

Encounters

The objective of evaluating the encounters indicator is to understand how the implementation of the wider multidisciplinary (MDT) outlined in the General Medical Services (GMS) contract affects service access and the inequalities associated with it. For this analysis, data has been categorised into two main staff groups: general practitioners (GPs) and all other MDT members.

To explore associations with deprivation, this analysis uses Health Board Scottish Index of Multiple Deprivation (SIMD) quintiles. This method ranks areas within the health board by deprivation and assigns them to quintiles based on their position within the health board, as opposed to their position nationally. As a result, an area categorised as SIMD 1 within the health board would not necessarily be categorised as SIMD 1 nationally. This best reflects the local inequalities experienced by participating practices. It is important to note that the data includes only counts of direct encounters and does not account for appointment duration or complexity.

Figure 1: Average number of direct encounters by practice

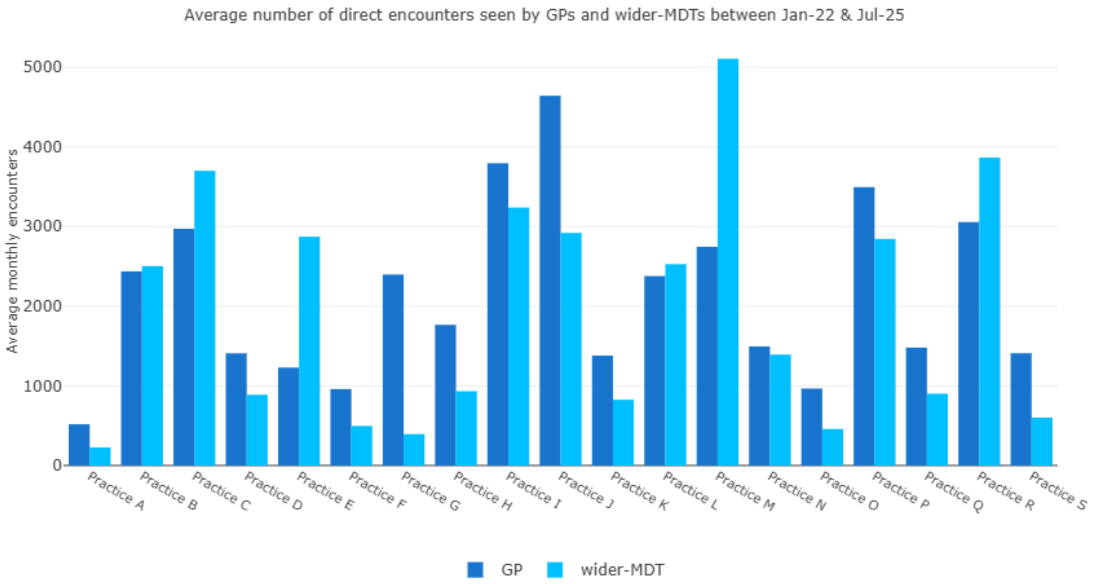


Figure 1 shows the average number of monthly direct encounters for both GPs and the wider MDT for each practice across the period January 2022-July 2025. In 58% of practices GPs had the highest proportion of direct encounters on average per month (55% or above), in 16% of practices wider MDT had the highest proportion and 26% showed a relatively even split (for example between 46% and 54% on average either way). These variations reflect differing service delivery models across the four demonstrator sites and underscore challenges in evaluating MDT implementation under Primary Care Phased Investment Programme (PCPIP). Additionally, inconsistencies in local data recording and the influence of larger practices on site-level trends limit the feasibility of grouping data by demonstrator site. For these reasons, along with those mentioned in the limitations and challenges section in the methodology, caution is advised in comparing directly between practices and instead focus on within-practice trends.

Rate of direct encounters per 1,000 patients

To explore the within-practice trends, the data have been presented as a rate of direct encounters relative to the practice list size, within each SIMD quintile over time. In general, GP and wider MDT encounter trends were broadly consistent across SIMD quintiles, indicating no disproportionate impact – positive or negative – on any specific population group over the time period. The following analysis outlines key patterns observed across the cohort:

Figure 2 and *Figure 3* showcases variations between two large practices J (more GP encounters on average) and C (more wider MDT encounters on average) that reflect differing operational models. Both practices show relatively flat or slightly decreasing GP encounters, with modest increases in wider MDT encounters towards the end of the time period.

Figure 2: Rate of direct encounters per 1,000 patients - Practice J

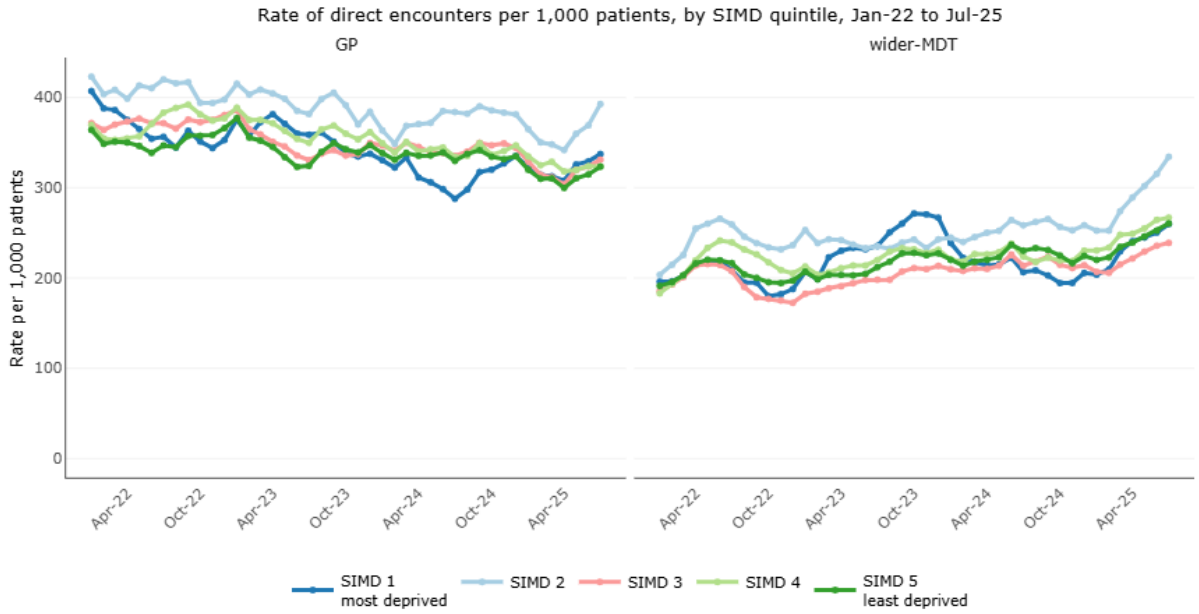
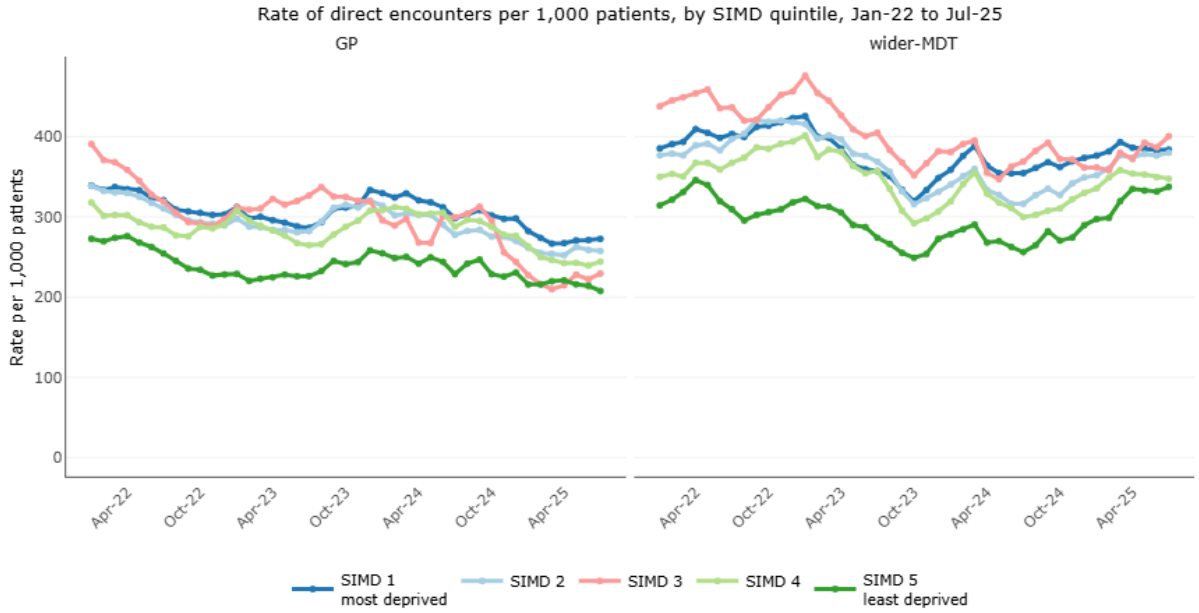
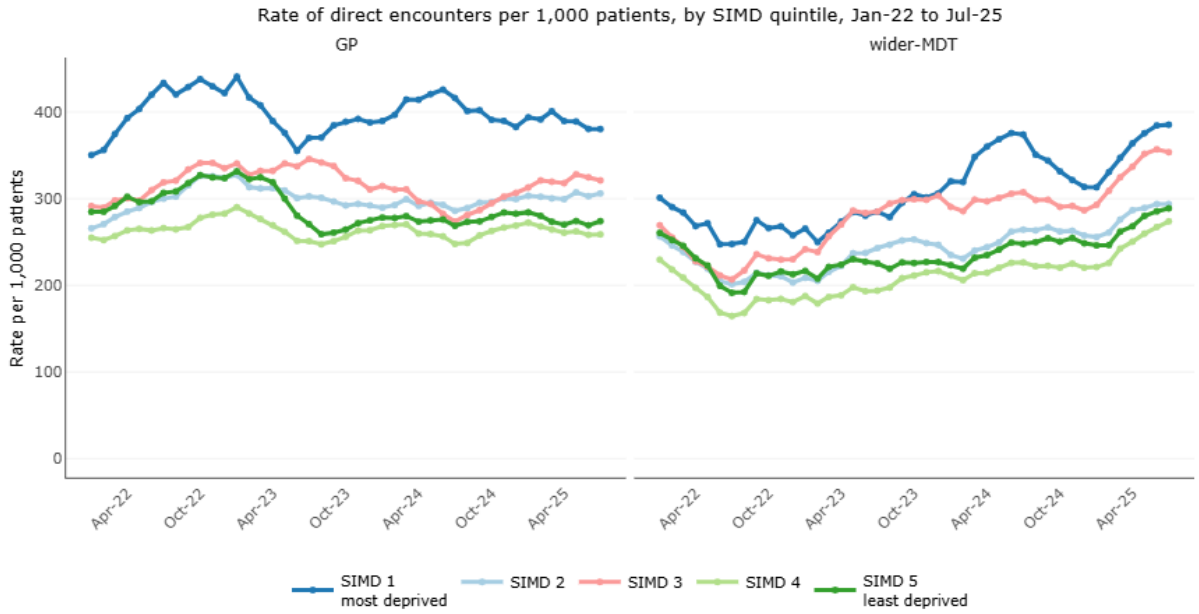


Figure 3: Rate of direct encounters per 1,000 patients - Practice C



In large Practice P, GPs account for around 55% of direct monthly encounters, with stable rates across SIMD quintiles and a higher proportion in SIMD 1. Since March 2023, MDT rates have increased across all quintiles, practice feedback related this to the addition of a practice nurse supporting three advanced nurse practitioners (ANP).

Figure 4: Rate of direct encounters per 1,000 patients - Practice P



LTC indicator - COPD

COPD indicators were selected as it is a well-recorded condition and serves as a useful proxy for assessing how effectively practices are reviewing patients with long-term conditions. It is good practice for people with COPD to be reviewed at least annually and to have had a Medical Research Council (MRC) assessment of breathlessness. Data were collected for two COPD-related outcomes: COPD Review and COPD Breathlessness.

COPD review

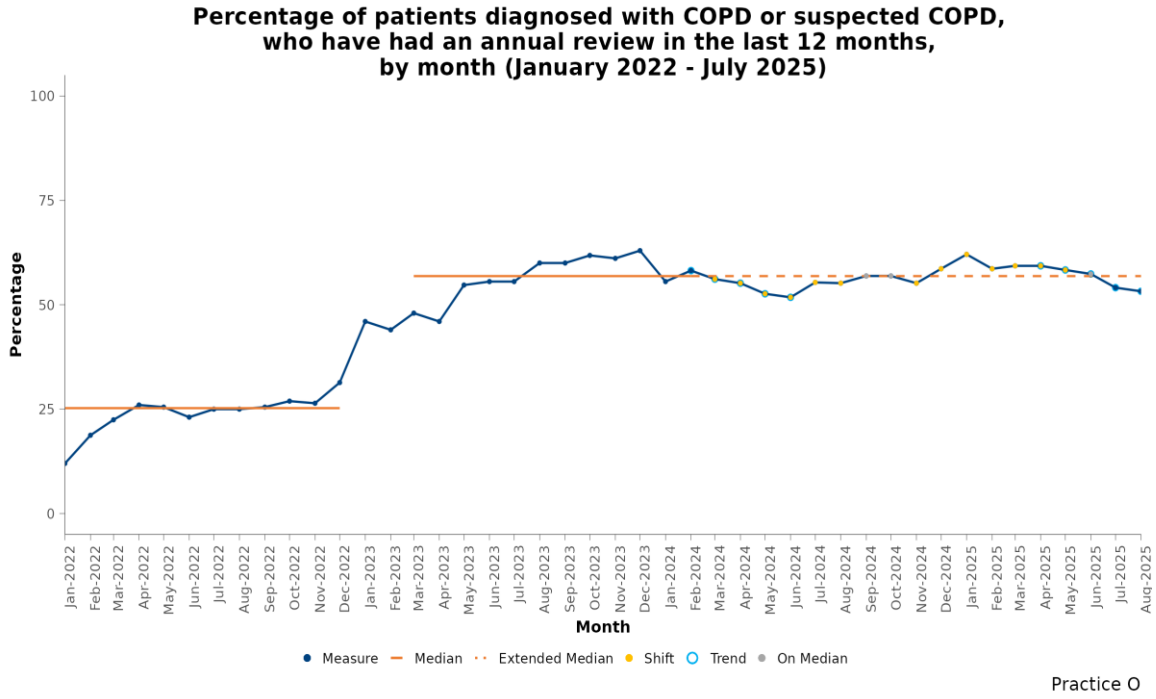
Of the 19 practices included in this analysis, the indicator for percentage of patients diagnosed with COPD or suspected COPD, who have had an annual review in the last 12 months:

- 11 practices showed an increasing trend
- 6 practices showed no discernible trend
- 2 practices showed a decreasing trend, and
- percentages across the practices ranged from under 10% to 78%.

Some examples of practice-specific feedback are detailed below.

- **Practice F:** Saw a temporary increase in this metric, which the practice linked to temporary support from a respiratory nurse for a limited period of time.
- **Practice O:** Saw a large increase in this metric which the practice attributed to community treatment and care (CTAC) and pharmacy hub support (*Figure 5*).

Figure 5: COPD annual review – Practice O



COPD breathlessness

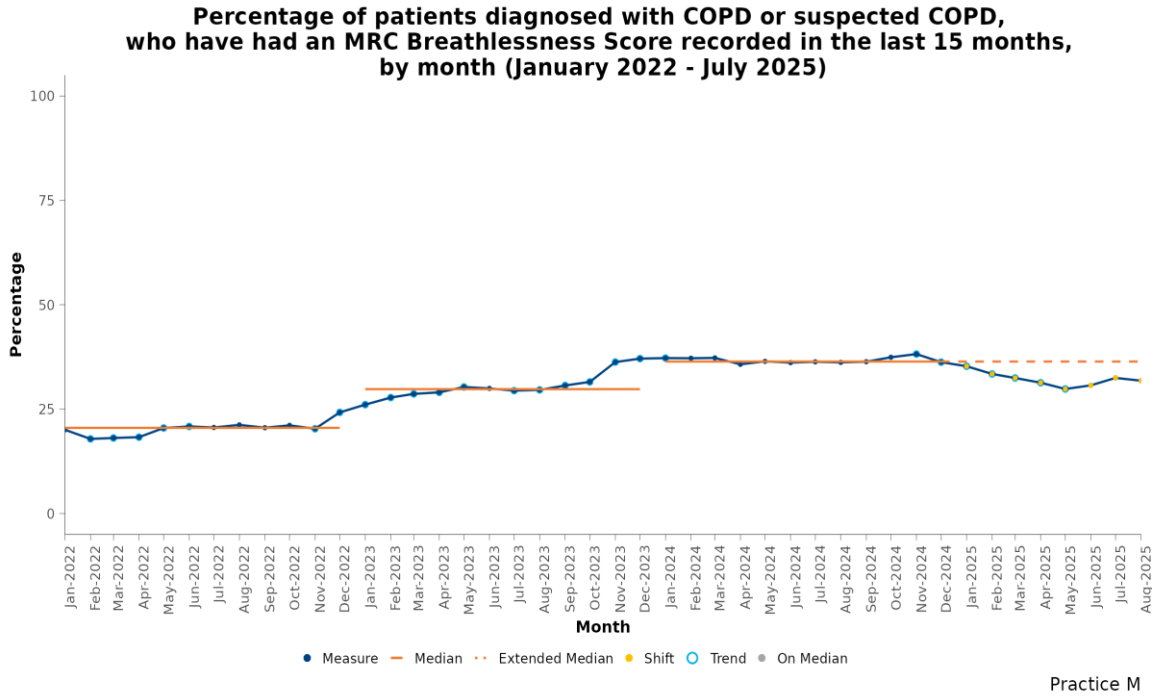
Of the 19 practices included in this analysis, this indicator measures the percentage of patients diagnosed with COPD or suspected COPD who had an MRC Breathlessness Score recorded in the last 15 months:

- 6 practices showed an increasing trend
- 9 practices showed no discernible trend
- 4 practices showed a decreasing trend, and
- recorded percentages ranged from under 10% to 64%.

Below is an example of practice-specific feedback though this should be viewed in the context of the overall summary above.

- **Practice M**: Steady increase from 20% in January 2022 to a peak of 37.1% in December 2023, followed by a gradual decline to 31.8% by August 2025 – staffing challenges were noted despite access to pharmacy hub from early 2022 (*Figure 6*).

Figure 6: COPD breathlessness score – Practice M



LTC indicator – Diabetes

Diabetes was selected as the LTC of interest because of its requirement for regular patient reviews and the availability of consistent data through SCI-Diabetes[1]. It helps to evaluate the impact of PCPIP funding on LTC patient management.

Data was collected on two diabetes-related outcomes within the last 15 months.

- HbA1c blood test
- Foot Screening

Diabetes HbA1c blood test recorded

Of the 19 practices included in this analysis, the indicator for the percentage of patients with a recorded HbA1c blood test in the past 15 months:

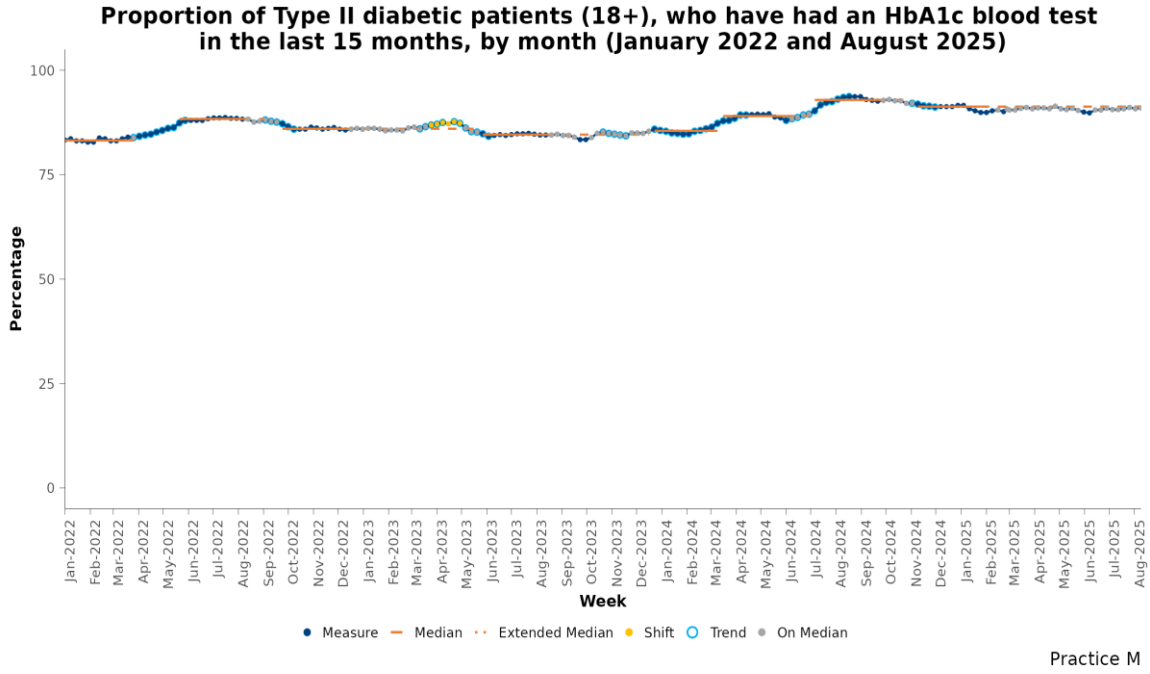
- 12 practices maintained a consistently high percentage with no discernible trend over time
- 6 practices demonstrated an upward trend in the percentage recorded, and
- 1 practice showed a decline in the percentage.

All practices began with relatively high percentages, ranging from 70% to 95%, with most between 85% and 95%. Below is an example of practice-specific feedback though this should be viewed in the context of the overall summary above.

- **Practice M:** Fluctuated, small increase from January-July 2022, decreased until October 2023, then increased again to peak in September 2024. It remained above 90%, stabilising after April/May 2025 when the practice began consistently referring patients to the CTAC service (*Figure 7*).

[1] SCI-Diabetes is NHS Scotland's diabetes patient management system.

Figure 7: Diabetes blood test recorded – Practice M



Diabetes Foot Screening

Of the 19 practices included in this analysis, the indicator for the percentage of patients having a foot screening assessment recorded in the last 15 months:

- 10 practices showed an increasing trend, and
- 9 practices showed no apparent change, with some fluctuations.

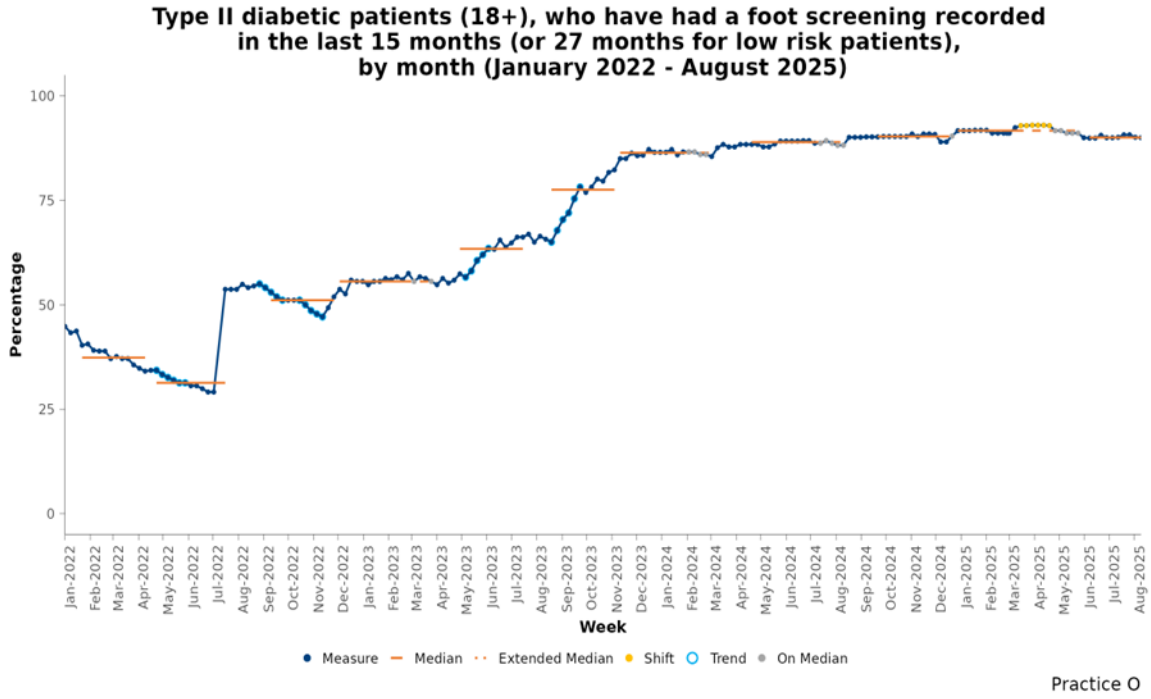
The examples below illustrate specific trends in selected practices, though these should be viewed in the context of the overall summary above.

- **Practice O:** Increased from <50% to ~90% since December 2022; feedback from the practice was that CTAC hub support freed up nurse capacity, which enabled practice nurses and ANPs to focus more on LTC reviews. No specific diabetes-related quality improvement activity was undertaken during this period (*Figure 8*).
- **Practice N:** Steady increase from January 2022-August 2025, attributed to enhancements in the patient recall system and patient acceptance of CTAC.
- **Practice K:** Decreased between January 2023-August 2024, then a slight increase; data recording issue identified to be addressed through staff education as well as a change to the patient recall process.

Please note: The indicator definition was updated in June 2022, following a recommendation from the Scottish Foot Action Group. As a result, people with diabetes and low-risk feet were not considered to have met the foot screening requirement until after 27 months (24 months with 3 months grace period).[2] This resulted in a step change in percentages for some practices at that time.

[2] Foot screening for individuals with Diabetes is changing | Information Site

Figure 8: Diabetes foot screening – Practice O



Continuity of care

Continuity of care is associated with numerous positive outcomes for doctors, patients and health systems and was an underpinning principle of the GMS contract changes in 2018. Data for the demonstrator sites was sourced from Albasoft and used the same methodology for an Adjusted (St Leonard's Index of Continuity of Care) SLICC measure as in the NSS GP Activity Project's 'In Practice Dashboard.' A 'Usual Provider of Care' (UPC) is assigned to each patient and identifies the most commonly seen clinician for each patient over the preceding 2 years.

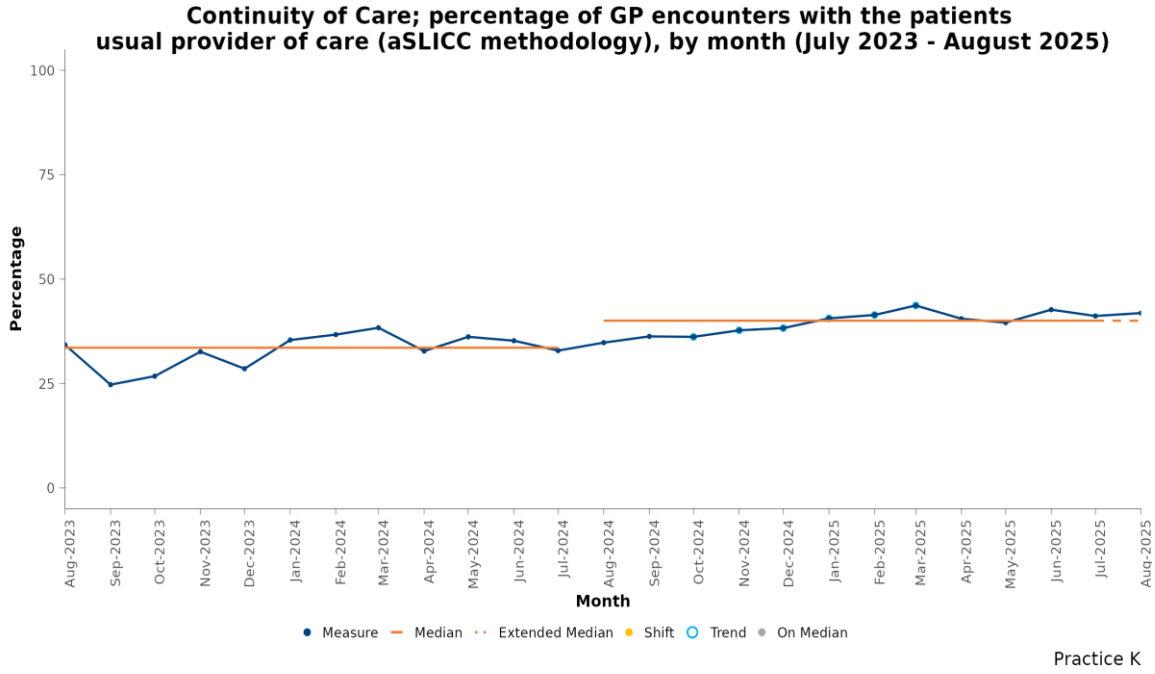
Of the 19 practices included in this analysis, the indicator for the percentage of direct encounters per month which were with the patients' UPC:

- 10 practices had no discernible trend
- 7 practices showed an increasing trend, and
- 2 practices were seen to have a decreasing trend.

Specific examples of the trends for some selected practices are provided below, though these should be viewed in the context of the overall summary above.

- **Practice K:** Saw an increase in the metric, with the median increasing from 34% to 40% (*Figure 9*).

Figure 9: Continuity of care – Practice K



Improved medicines management - Serial Prescriptions

Data includes the number of patients receiving medication prescribed by GPs, flagged as 'serial prescriptions' and dispensed in Scotland. A serial prescription is a long-term prescription that allows a community pharmacy to dispense medicines at regular intervals (e.g. every 8 weeks) for up to 56 weeks, without the patient needing to request each supply. It supports safer, more efficient medication management for people with stable long-term conditions. An increase in serial prescriptions indicates that the practice has allocated capacity for medication reviews and is transitioning patients from acute or repeat prescriptions to serial prescribing.

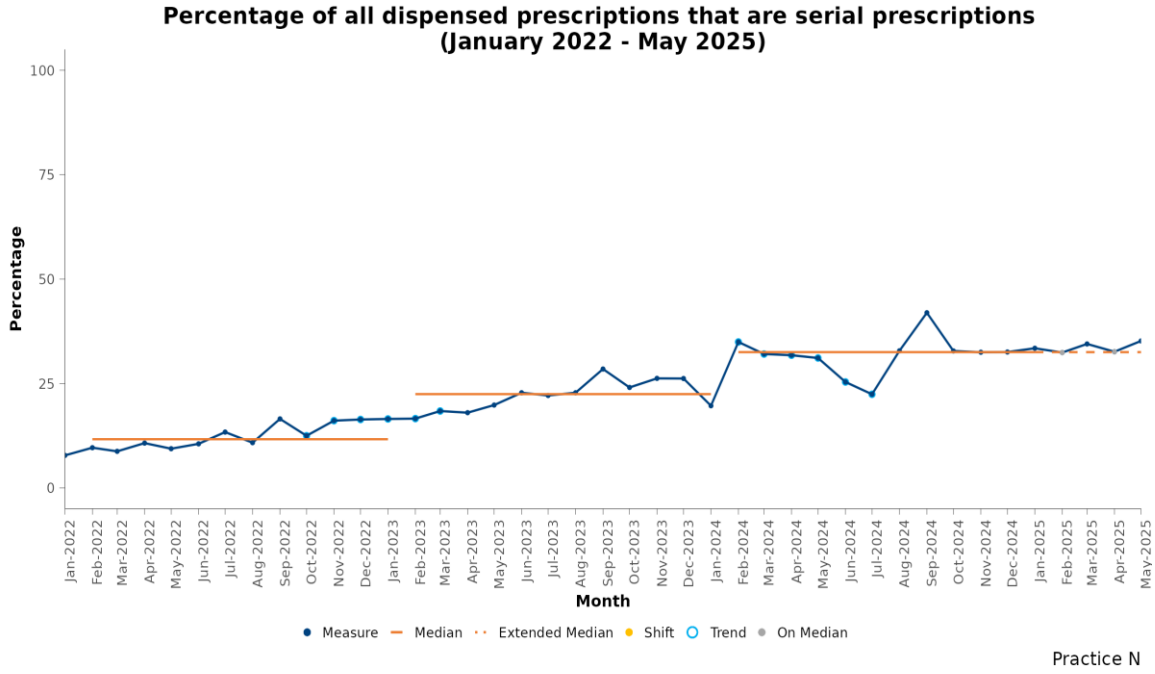
Of the 19 practices included in this analysis of the percentage of all prescriptions that are serial prescriptions (by month between January 2022-May 2025):

- most practices began with <10% serial prescriptions; one started at 20%
- 9 practices had consistently low rates (0–5%), with no discernible trend
- 6 practices showed increases (5–10 percentage points), all remaining below 15%
- 2 practices had larger increases (20–30 percentage points)
- 1 practice showed a downward trend (within a 5–10% range), and
- 1 practice does not prescribe serial prescriptions, so it was excluded from this analysis.

Examples of practices are shown below; however, these should be viewed in the context of the above summary, in which the majority showed no clear change over time and consistently had low rates of serial prescriptions.

- **Practice N:** Increased from 10% in January 2022 up to 30% by April 2024; the increasing trend began before PCPIP (*Figure 10*).
- **Practice K:** Showed an upward trend from December 2022-January 2024, then stabilised around 4%, the practice attributed the improvement to PCPIP pharmacotherapy support, though the expectation was for a higher increase.

Figure 10: Serial prescriptions – Practice N



Impact of MDT on workforce

The introduction of MDT working was expected to make the workload more manageable and enhance working conditions. This impact may be reflected in workforce measures, including:

- sickness absence rate,
- vacancy rate, and
- turnover rate.

Public Health Scottland (PHS) in collaboration with Public Services Delivery Scotland (formerly NHS Education for Scotland (NES)) investigated these workforce indicators with analyses prepared and presented to the expert groups. However, when focusing on a small subset of practices, issues with the consistency of the data submissions to the workforce survey (not all practices participated or participated each year) have a greater impact. These issues and the consequent small numbers involved due to measuring relatively rare events lead to this data not being suitable for inclusion here.

Insight from data

The data presented in this section show changing trends which could be attributed to local PCPIP implementation in some instances. Increasing trends were observed in some practices, and where feedback was available, some actions related to PCPIP were identified that could have contributed to the trend. However, the number of practices across all indicators which saw either no change or an opposing trend makes it difficult to definitively attribute PCPIP as the cause, though this is likely to be the case in some practices. This, in part, highlights the variable nature of PCPIP implementation, as well as the challenges of using routinely and incidentally collected data to measure such changes, and underlines the importance of embedding appropriate monitoring and quality improvement approaches with interventions.

In addition to providing analysis to understand PCPIP implementation, the work to produce this analysis required a high number of bespoke analyses and conversations. Nonetheless, these serve as an initial set of indicators for general practice more broadly.

A key theme for general practice in Scotland is the availability and quality of data. Significant effort and resources were required to gather the data included in this section, and such efforts would not be easily replicated on a national scale. Were such data more readily available, variation in local coding practice would limit the validity of comparisons between practices and so limit the potential for scaling nationally to promote learning between different areas. Comparisons between practices were limited in this analysis because of these variations. A key area for improvement to enhance the sharing of data and intelligence within general practice is improving data availability. Within that, data quality, and any national efforts towards the important aim of improving data availability and accessibility (such as the Primary Care Data and Intelligence Platform) would need to have methods of improving the quality of such locally collected data.

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