Healthcare Improvement Scotland

Primary Care Phased Investment Programme

Final report

June 2026

Abridged report

Note: *This is an abridged version of the full report. It summarises key findings, evidence and conclusions while retaining the original structure, headings and references to appendices. Detailed methodology, full datasets, figures, tables and extended analysis are contained in the full report and associated appendices.*

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List of abbreviations and terms

A	
Acute prescribing	An acute prescription is any prescription issued without a serial or repeat mandate.
C	
CTAC	Community treatment and care
D	
Demonstrator sites	NHS Ayrshire and Arran, NHS Borders, a locality in Edinburgh City Health and Social Care Partnership and NHS Shetland successfully bid to become demonstrator sites within the Primary Care Phased Investment Programme.
G	
GMS contract (also known as GP contract)	Refers to the General Medical Services (GMS) contract (2018) between NHS boards and GP practices run by GP partners.
GP	General practice or practitioner
H	
HSCP	Health and social care partnership
Hubs	Hubs are a centralised model of providing support to GP practices.
Hybrid	An employment model which offers flexibility of both office-based and remote working.
I	
IT	Information technology
M	
MDT	Multidisciplinary team
N	
NHS	National health service
P	
PCPIP	Primary Care Phased Investment Programme
PDSA	Plan, do, study, act
Q	
QI	Quality improvement - the application of a systematic approach that uses specific techniques to improve quality.
QMS	Quality management system
R	
Repeat prescription	A repeat prescription is a prescription issued with a repeat mandate. Each issue requires authorisation.
S	
Serial prescription	A serial prescription is a prescription issued with a serial mandate of 24, 48 or 56 weeks. The frequency of issue of the prescription is decided by the GP when issuing the mandate.
W	
Workflow optimisation	Workflow optimisation, also known as document management, is a process designed to support seamless management of incoming correspondence, primarily at the point of the administration team.

Executive summary

This report presents the findings of the Primary Care Phased Investment Programme (PCPIP), commissioned by the Scottish Government to test whether additional investment, delivered alongside structured quality improvement (QI) support, could support fuller or improved implementation of multidisciplinary team (MDT) services, build a culture of continuous improvement in primary care, and generate evidence to inform future policy and investment decisions. The support for the implementation of the MDT element of the General Medical Services (GMS) contract (2018) had a particular focus on Community Treatment and Care (CTAC) and Pharmacotherapy. The findings cover programme activity from inception (April 2024) through to March 2026.

The programme was delivered through four demonstrator sites, a national improvement collaborative, a national learning system and a mixed methods evaluation drawing on qualitative and quantitative evidence. The selected four demonstrator sites were NHS Ayrshire & Arran, NHS Borders, a locality in Edinburgh City Health and Social Care Partnership (HSCP) and NHS Shetland.

Analysis of the evidence concentrated on six areas of focus agreed with Scottish Government, including conditions and enablers for implementation, learning from the QI approach, prioritisation of MDT services, attributes of sustainable MDTs, monitoring and evaluation requirements and health inequalities.

Summary of key findings

Across the four demonstrator sites, PCPIP showed that strengthening of CTAC and pharmacotherapy services is possible when additional funding is combined with QI approaches. Teams were able to improve access, strengthen role clarity and appropriately redistribute workload from general practitioners (GPs) and general practice nurses to other members of the MDT.

However, the evidence from this programme indicated that even with additional investment it has not been possible to fully implement the MDT component of the GMS contract. It is unclear what scale of further investment would be needed to deliver this given the workforce challenges across all the MDT. Across all demonstrator sites, programme progress was constrained by persistent challenges, including workforce availability, recruitment delays, limitations in digital and physical infrastructure, variability in local readiness for change, and ambiguity around what fuller or improved implementation of pharmacotherapy and CTAC services should look like.

Findings from the national improvement collaborative and learning system alongside targeted QI support for the demonstrator sites, show that PCPIP contributed to the development of QI capability and confidence. Participating teams reported improved understanding of their systems, increased confidence in using QI tools and greater opportunities for peer learning. However, short programme timescales, varying levels of engagement and limited access to reliable data made it more challenging to demonstrate impact. The key learning from the QI support provided has been highlighted in the report.

Based on evidence, a set of conditions and enablers required for effective MDT working were identified. These include clear and trusted governance arrangements, sustainable and transparent funding, robust digital and physical infrastructure, clearly defined roles, effective interdisciplinary communication, strong leadership and equitable access to training and development.

MDT working brings together professionals from different backgrounds to collaborate on shared goals, such as delivering more joined up patient care or tackling complex tasks. Each role within the MDT offers unique and essential strengths, and the biggest benefits are achieved when these roles are well integrated, clearly defined, properly supported and aligned with the needs of the local population. Overall, the findings indicated that priorities within the MDT should not be about elevating one profession above another, but about creating the right conditions for every role to contribute effectively to patient care.

Evidence showed that key attributes of sustainable MDT working were the requirement for a stable, well supported and fully integrated primary care workforce, clear shared goals, flexible delivery models based on population need, agreed recruitment and line management processes, quality assurance and monitoring and sustainable funding. Having clear career pathways and roles, a satisfied workforce and well-informed service users were also shown to be essential for MDT working to deliver holistic, high-quality care.

Findings related to monitoring, evaluation and impact on health inequalities demonstrated the limitations of current data systems. National data was insufficient to attribute short term changes directly to PCPIP activity. However, some of the data may provide a baseline to inform the future creation of a standard set of national measures for ongoing monitoring and evaluation. High-level system data, such as the national datasets analysed, have the potential to be useful for assessing trends over a longer timescale, however inconsistent coding, variable local data quality and lack of patient level outcome data constrained evaluation, particularly in relation to continuity of care and on health inequalities. Despite this, qualitative and service user evidence suggested that MDT working can support improved access and experience when services are designed with equity and continuity in mind. From an economic perspective, the data currently available are not sufficiently robust to support detailed analysis.

Summary of conclusions

These findings from PCPIP highlight the following overarching conclusions.

- The absence of a national definition of ‘full implementation’ of the GMS contract continues to present challenges. While improvements in MDT working were achieved where funding was aligned with structured QI support, leadership and learning, delivery remains constrained. Even with additional PCPIP investment, structural, workforce and infrastructure pressures limited progress.
- Local context is critical: Both the composition of MDTs, and the way in which services are organised and delivered, should be shaped by local population need, geography, workforce availability and practice maturity, rather than follow a single national template. A more flexible, needs-based approach is therefore required.
- Quality improvement is a key enabler, not a substitute for infrastructure: QI supports safer and more sustainable change but depends on stable leadership, protected time, governance and reliable data.
- Workforce sustainability must be central: While MDT roles add value, uneven workload pressures, role ambiguity and burnout risk undermine sustainability if not addressed across the whole workforce.
- Continuity of care requires active protection: Task-based models risk fragmentation unless explicitly designed to support relational, informational and management continuity.
- Current data systems limit MDT working: Inconsistent system wide coding nationally and locally, poor information technology (IT) system interconnectivity, constrained workforce integration and limited

outcome data restrict the design and delivery of services, and evaluation, particularly in relation to impact on continuity of care and health inequalities.

- Future reform should prioritise realism and learning: Sustainable progress depends on long-term investment, embedded improvement capability and expectations aligned with what can be delivered in practice.

Overall, PCPIP findings suggest that additional investment alone is insufficient to deliver the ambitions of the GMS contract. Improvement would be more likely where investment is accompanied by clear expectations, strong leadership, QI capability, reliable infrastructure and genuine engagement with primary care teams. The findings indicate that a flexible, needs based approach to MDT development, rather than a rigid interpretation of 'one size fits all full implementation', would be more realistic, sustainable and aligned with local population needs.

Recommendations

The report sets out 13 recommendations to inform future policy, investment and programme design.

Recommendation 1	**Reset national expectations to align MDT development with improving outcomes and making best use of resources.**
Recommendation 2	**Embed improvement principles and realistic timelines.**
Recommendation 3	**Apply hub/hybrid models selectively.**
Recommendation 4	**Invest in integrated IT systems and outcome-focused monitoring.**
Recommendation 5	**Establish clear governance and engage with all relevant stakeholders at the programme design stage.**
Recommendation 6	**Ensure enabling conditions for MDT effectiveness.**
Recommendation 7	**Co-design MDT configuration based on local needs.**
Recommendation 8	**Expand evaluation of MDT impacts over time.**
Recommendation 9	**Protect continuity of care.**
Recommendation 10	**Ensure workforce stability and wellbeing.**
Recommendation 11	**Adopt a Quality Management System (QMS) approach and tailor improvement support.**
Recommendation 12	**Develop a national health equity framework.**
Recommendation 13	**Strengthen public communication on MDT roles.**

Section 1: Introduction

Introduction to this report

This final report presents the findings and recommendations from PCPIP, covering the period from programme inception (April 2024) to March 2026. It synthesises evidence gathered across multiple workstreams and builds on two interim reports published in February 2025 and June 2025.

Six areas of focus were developed collaboratively with the Scottish Government to ensure the evidence generated was policy relevant. Analysis of the evidence focused on these six areas, including implementation conditions and enablers, learning from a QI approach, prioritisation of MDT services, attributes of sustainable MDTs, monitoring and evaluation requirements and health inequalities.

This abridged version aims to highlight the key points from PCPIP. More details are available in the full report.

Introduction to PCPIP

PCPIP aims

PCPIP aimed to:

- improve implementation of services subject to amended regulations in the GMS contract (CTAC and pharmacotherapy services)
- develop a culture of continual improvement in primary care settings, and
- build evidence to understand the national context for GMS contract implementation including long-term Scottish Government investment.

See *Appendix 2* for further background on the GMS contract.

Why PCPIP was commissioned

PCPIP was commissioned to explore an evidenced based approach to support fuller or improved implementation of MDT component of the GMS contract, which would inform the next steps and future Scottish Government investment. Specifically, PCPIP was commissioned to test whether additional investment, delivered alongside structured QI support, could support fuller or improved implementation of MDT services, build a culture of continuous improvement in primary care, and generate evidence to inform future policy and investment decisions.

Although MDT expansion had progressed, implementation gaps were thought to exist because of uncertainties around the scale of change required, ongoing challenges with workforce availability, and variation in how MDTs had been implemented across different areas. The programme sought to understand and address these implementation gaps as it was considered essential to realising the GMS contract's vision of improved access to care and more effective MDT working in general practice.

How PCPIP was delivered

PCPIP consisted of:

- four demonstrator sites (NHS Ayrshire & Arran, NHS Borders, a locality in Edinburgh City HSCP, NHS Shetland)
- a national improvement collaborative
- a national learning system, and
- a mixed methods evaluation (qualitative and quantitative data).

A multi-agency, multidisciplinary Programme Board was formed by Healthcare Improvement Scotland to provide advice, guidance and support to the programme. A Clinical and Care Governance Advisory Group was also formed to advise the programme on matters specific to clinical practice. In addition, an Expert Group was established to review and discuss the data aligned to the areas of focus. The demonstrator site teams also provided insights throughout the programme, and specifically at a 'world café' event, regarding the areas of focus.

See the stakeholder engagement map (*Appendix 1*), Expert Group flash reports (*Appendix 3*) and demonstrator site flash report (*Appendix 4*).

Section 2: Findings

This section summarises findings across the three PCPIP aims and six areas of focus. See *Appendix 6: Data collection and analysis methodology* for more information on the data workstreams. This Appendix explains the aim of the different data workstreams, the methodologies used for data collection and analysis and their limitations.

2.1 Findings from improving implementation of services subject to amended regulations outlined in the GMS contract (CTAC and Pharmacotherapy)

Across all demonstrator sites, additional investment combined with QI support was used to improve CTAC and pharmacotherapy services. Progress was achieved through structured QI methods such as process mapping, small-scale testing, measurement over time and iterative refinement.

Demonstrator site journeys

Each demonstrator site followed a different improvement journey reflecting local context, service maturity and workforce availability. Demonstrator sites were able to:

- improve CTAC access by opening new treatment rooms, exploring optimal skill mix, strengthening resilience planning and maintaining a clear focus on health equity, and
- enhance pharmacotherapy provision by expanding hubs, improving prescribing processes and testing new roles. This helped to ensure the right person delivered the right care, enabling practice pharmacy teams to focus on more advanced pharmacotherapy responsibilities.

Common challenges included recruitment delays, limited IT and data infrastructure, premises constraints and variable local QI capacity. These factors influenced the speed and scale of improvement.
See more information on the demonstrator sites' journeys for NHS Ayrshire & Arran, NHS Borders, Edinburgh City HSCP and NHS Shetland in the full report.

Conclusions linked to recommendations

Findings show that while improvement was possible, full implementation of the CTAC and pharmacotherapy services as outlined in the GMS contract was not achievable, even with additional QI support and funding.

The findings also suggest that fully implementing the GMS contract as originally designed may not lead to the most efficient or effective MDT model, as some elements do not align with where roles add greatest value. Parts of the contract appear less relevant in the current context, and the evidence highlights the importance of local flexibility, allowing systems to prioritise MDT roles based on population needs, workforce capacity and their contribution to patient care. This directly informs **recommendation 1**, which calls for refreshed expectations and a flexible approach to MDT development.

Where QI capability and leadership were strong, teams were able to redesign pathways more quickly, respond to operational issues and build sustainable workforce pipelines. This insight directly underpins **recommendation 2**.

Across PCPIP, it became clear that local context and population need to play a critical role in informing the design and delivery of primary care improvement. The findings suggest that a blended approach may be optimal, with hub models used for high-volume administrative tasks and practice-based working prioritised for activities requiring clinical discussion, relationship building, and team-based care. These insights underpin **recommendation 3**.

The findings make clear that reliable digital infrastructure is not optional. A clear system-wide lesson is that integrated interoperable data platforms are foundational to implementing the contract at scale. Robust IT systems are essential for safe MDT working, effective QI and sustainable service delivery. This directly supports **recommendation 4**.

Table 1: Recommendations summary related to improving implementation of services subject to amended regulations outlines in the GMS contract (CTAC and Pharmacotherapy)

Recommendation	Summary	Key actions
1. Reset national expectations to align MDT development with improving outcomes and making best use of resources	Shift from rigid 'full implementation' to flexible, value-based MDT development focused on population need, workforce feasibility and person-centred outcomes.	• Co-design local priorities using population/inequality data. • Allow flexible MDT configuration. • Allocate resources based on value and need. • Use person centred outcomes as success measures.
2. Embed improvement principles and realistic timelines	Integrate QI principles and realistic planning, recruitment and evaluation timelines into programme design.	• Apply QI methods (Plan, do, study, act (PDSA), process mapping, improvement data, logic models). • Build in time for recruitment and onboarding. • Develop evaluation plans early. • Tailor QI support to readiness.
3. Apply hub/hybrid models selectively	Use hub models for technical/administrative tasks and practice-based models for clinical integration and continuity.	• Allocate reconciliation/discharge tasks to hubs. • Keep patient facing work in practices. • Apply hybrid models when needed. • Regularly review model suitability.
4. Invest in IT system integration and outcome focused monitoring	Integrated IT systems, standardised coding, and analytic capability should be prioritised. Establish a national MDT monitoring framework that is long-term, trend based, equity sensitive and focused on improvement.	• Standardise coding and role identifiers. • Improve digital interoperability across sectors. • Build analytic capacity locally/nationally. • Develop long-term outcome/continuity/equity measures.

2.2 Findings from developing a culture of continual improvement

The section describes how Healthcare Improvement Scotland supported the development of a culture of QI throughout the programme.

Demonstrator sites

As explained above Healthcare Improvement Scotland worked closely with each demonstrator site, using a QI approach, to inform the development and delivery of local improvement plans.

National improvement collaborative

Two phases of the collaborative supported primary care teams across Scotland to develop QI skills and test local improvements. Although timescales limited the ability to demonstrate sustained outcome change, participating teams reported improved understanding of their systems, increased confidence in QI tools, and valuable peer learning.

Examples of improvement work included workflow optimisation, appointment management, care navigation, call volume, acute/repeat prescribing, polypharmacy reviews, and health inequalities.

Learning system

The PCPIP learning system activities included online webinars and workshops, in-person national events and the development and dissemination of written resources and session recordings to share learning. Feedback indicated that these activities supported reflection and knowledge exchange, though formal evaluation was limited by capacity and data constraints.

Conclusions linked to recommendations

Combining the national improvement collaborative with the PCPIP learning system, alongside targeted QI support for the demonstrator sites, enabled teams to embed a culture of learning both within and beyond the demonstrator sites.

Their combined impact highlighted the importance of leadership, protected time for improvement work, reliable data and ongoing workforce development These findings underpin **recommendation 2**.

Table 2: Recommendations summary related to developing a culture of continual improvement

Recommendation	Summary	Key actions
2. Embed improvement principles and realistic timelines	Integrate QI principles and realistic planning, recruitment and evaluation timelines into programme design.	• Apply QI methods (Plan, do, study, act (PDSA), process mapping, improvement data, logic models). • Build in time for recruitment and onboarding. • Develop evaluation plans early. • Tailor QI support to readiness.

2.3 Findings from the evidence gathered to inform implementation of the GMS Contract

This section summarises findings across six areas of focus.

Area of focus 1 – Key conditions for change and enablers required to support MDT working

Data sources: Qualitative data, QI data

Qualitative evidence identified structural, relational and transformative conditions necessary for effective MDT working. Key enablers included clear roles, supportive team cultures, informal learning opportunities, equitable training access, robust data systems and effective communication.

Overall, effective MDT working relies on supportive structures, constructive relationships and strong interdisciplinary communication. Clear guidance, sustainable resourcing, appropriate infrastructure, equitable training opportunities and defined roles provide the foundation. Meaningful engagement, trust and a collaborative culture strengthen these foundations. These insights directly inform **recommendation 5 and 6.**

Findings underlined that improving MDT working requires more than local problem solving, it depends on establishing systemwide digital foundations that enable reliable data sharing, consistent coding and clear role identification. Only with interoperable IT systems and supportive infrastructure can MDTs function effectively and overcome the relational and structural tensions identified in the programme. These findings directly inform **recommendation 4**.

Table 3: Recommendations summary related to the evidence gathered to inform implementation of the GMS contract

Recommendation	Summary	Key actions
5. Establish clear governance and engage with all relevant stakeholders at the programme design stage	Define roles and responsibilities between Scottish Government, Healthcare Improvement Scotland, NHS boards, HSCPs and GP practices, with early formal engagement where practices lead or provide data.	• Create governance maps and role clarity. • Agree everyone's responsibilities early. • Clarify data expectations and resourcing. • Include GPs in programme governance of improvement work related to the GMS contract.
6. Ensure enabling conditions for MDT effectiveness	Ensure MDT models have the required structural, relational and cultural conditions to function effectively.	• Provide clear role descriptions and guidance. • Establish supervision/line management clarity. • Protect MDT time for learning/case discussion.

Recommendation	Summary	Key actions
		• Invest in digital and physical infrastructure.
4. Invest in IT system integration and outcome focused monitoring	Integrated IT systems, standardised coding, and analytic capability should be prioritised. Establish a national MDT monitoring framework that is long-term, trend based, equity sensitive and focused on improvement.	• Standardise coding and role identifiers. • Improve digital interoperability across sectors. • Build analytic capacity locally/nationally. • Develop long-term outcome/continuity/equity measures.

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

Data sources: Qualitative data, QI data

Findings highlighted the importance of co-design, realistic timelines, clarity of roles, early relationship building, tailored QI support, conducting QI skills and needs assessments, supporting data collection and interpretation, supporting learning, sustainability planning, small-scale testing and measurement over time. These insights directly inform **recommendation 2.**

Table 4: Recommendations summary related to learning from the QI approach embedded in PCPIP to support future implementation of the MDT and policy development

Recommendation	Summary	Key actions
2. Embed improvement principles and realistic timelines	Integrate QI principles and realistic planning, recruitment and evaluation timelines into programme design.	• Apply QI methods (Plan, do, study, act (PDSA), process mapping, improvement data, logic models). • Build in time for recruitment and onboarding. • Develop evaluation plans early. • Tailor QI support to readiness.

Area of focus 3 – MDT services that should be prioritised for further development

Data sources: Qualitative data, week of care audit, economic analysis[1]

Multidisciplinary working brings together professionals from different backgrounds to collaborate on shared goals, such as delivering more joined up patient care or tackling complex tasks. Each role within the MDT offers unique and essential strengths, and the biggest benefits are achieved when these roles are well integrated, clearly defined, properly supported and aligned with the needs of the local population. Overall, the findings indicate that priorities within the MDT should not be about elevating one profession above another, but about creating the right conditions for every role to contribute effectively to patient care. These findings support **recommendations 3, 7** and **8**.

Table 5: Recommendations summary related to MDT services that should be prioritised for further development

Recommendation	Summary	Key actions
3. Apply hub/hybrid models selectively	Use hub models for technical/administrative tasks and practice-based models for clinical integration and continuity.	• Allocate reconciliation/discharge tasks to hubs. • Keep patient facing work in practices. • Apply hybrid models when needed. • Regularly review model suitability.
7. Co-design MDT configuration based on local need	Develop MDT configuration collaboratively to reflect local population needs and ensure services are prioritised accordingly.	• Use local data and community input. • Co-design with all MDT roles and GPs. • Match skill mix to population needs. • Review configuration regularly.
8. Expand evaluation of MDT impacts over time	Conduct ongoing evaluation of MDT impacts on service users, workforce and system outcomes.	• Commission longitudinal and mixed method studies. • Include staff and service user experience data. • Evaluate continuity, equity and systemic impact. • Share learning nationally.

[1] *The primary source for the economic analysis was the week of care audit data and is therefore limited in its strength. For more information see (Appendix 6: Data collection and analysis methodology)*

Area of focus 4 – Key attributes of a sustainable and effective model of MDT support

Data sources: Qualitative data, QI data, service user views

Key attributes included stable funding, flexible delivery models, shared objectives, workforce stability, career pathways, holistic care and informed service users. Overly task-based models risked fragmentation and reduced continuity.

Evidence showed that key attributes of sustainable MDT working were the need for a stable, well supported primary care workforce, clear shared goals, flexible delivery models, agreed recruitment and line management processes, quality assurance and monitoring and sustainable funding. Having clear career pathways and roles, and a satisfied workforce and well-informed service user were also essential for MDT working to deliver holistic, high-quality care. This informs **recommendations 9** and **10**.

Table 6: Recommendations summary related to key attributes of a sustainable and effective model of MDT support

Recommendation	Summary	Key actions
9. Protect continuity of care	Ensure MDT development enables joined up care and better continuity.	• Assess continuity impacts in service design. • Design models of care that support relational, informational and management continuity.
10. Ensure workforce stability and wellbeing	Ensure MDT development protects staff stability and wellbeing through balanced workloads and meaningful roles.	• Provide supervision and reflection time. • Monitor workload, complexity of workload and burnout risk. • Optimise staff's skills and experience.

Area of focus 5 – Support requirements for monitoring and evaluation of the impact of MDT working

Data sources: Qualitative data, service user views, QI data, local system and record sampling, national data

Findings related to monitoring, evaluation and impact on health inequalities demonstrated the limitations of current data systems. National data was insufficient to attribute short term changes directly to PCPIP activity. However, some of the measures were intended to establish a baseline and inform the creation of a standard set of national measures for ongoing monitoring and future evaluation. High-level system data, such as the national datasets analysed, have the potential to be useful for assessing trends over a longer timescale. Inconsistent coding, variable data quality and lack of patient level outcome data constrained evaluation. Findings emphasised the need for consistent measurement, improved data quality and long-term monitoring focused on patient outcomes and learning rather than performance. This supports **recommendations 11** and **4.**

Table 7: Recommendations summary related to support requirement for monitoring and evaluation of the impact of MDT working

Recommendation	Summary	Key actions
11. Adopt a QMS approach and tailor improvement support	Use a Quality Management System to integrate planning, assurance, control and improvement. Tailor QI support to local capacity.	• Align programme processes with QMS. • Assess skills and capacity early. • Provide targeted coaching and support. • Focus on learning, not performance assessment.
4. Invest in integrated IT systems and national MDT monitoring	Integrated IT systems, standardised coding, and analytic capability should be prioritised. Establish a national MDT monitoring framework that is long-term, trend based, equity sensitive and focused on improvement.	• Standardise coding and role identifiers. • Improve digital interoperability across sectors. • Build analytic capacity locally/nationally. • Develop long-term outcome/continuity/equity measures.

Area of focus 6 – Requirements to ensure MDT working supports the reduction of health inequalities

Data sources: Qualitative data, QI data, local systems and record sampling

MDT working has potential to reduce health inequalities when supported by targeted outreach, equitable resource allocation, effective interpretation services and community-based roles. However, inconsistent data and limited patient level information constrained evaluation and the conclusions that can be drawn. This underpins **recommendations 4, 12 and 13**.

Table 8: Recommendations summary related to requirements to ensure MDT working supports the reduction of health inequalities

Recommendation	Summary	How to (Key Actions)
4. Invest in integrated IT systems and national MDT monitoring	Prioritise integrated IT systems, consistent coding, analytic capability and a national outcome focused monitoring framework.	• Standardise coding and role identifiers. • Improve digital interoperability across sectors. • Build analytic capacity locally/nationally. • Develop long-term outcome/continuity/equity measures.
12. Develop a national health equity framework	Create and implement a national framework to support equitable access and outcomes, with MDT staff skilled in addressing inequalities.	• Produce a national equity improvement framework. • Provide staff training on equity. • Use equity sensitive indicators. • Support local equity action plans.
13. Strengthen public communication on MDT roles	Improve national communication explaining MDT roles, complemented by local messaging targeted to those most in need.	• Develop clear national materials on MDT roles. • Support NHS boards/practices with local resources. • Target key groups with tailored messages. • Use multiple communication channels.

Section 3: Conclusion

The PCPIP findings suggest that targeted investment combined with QI support can deliver meaningful improvements in MDT working in primary care. Across all demonstrator sites, CTAC and pharmacotherapy services were strengthened, access improved and aspects of workload were safely redistributed when teams were supported to redesign services using structured QI approaches.

However, the findings also demonstrate that full implementation of the MDT element of the GMS contract, as originally written, remains challenging, even with additional short-term investment. Persistent constraints including the absence of a national definition of full implementation, workforce availability, recruitment challenges, variable local readiness and limitations in physical and digital infrastructure significantly shaped what could be delivered. The findings indicate that a flexible, needs based approach to MDT development, rather than a rigid interpretation of 'one size fits all full implementation', would be more realistic, sustainable and aligned with local population needs.

A consistent message across the programme is that local context matters. MDT models that were flexible, responsive to population need and supported by trusted relationships between practices and health boards were more effective and sustainable. Where clarity of roles, leadership stability and supportive infrastructure were present, improvement progressed more quickly; where these conditions were absent, progress was slower and more fragile.

PCPIP also showed that QI capability was a critical enabler of change, but it could not compensate for underlying structural weaknesses. While the national improvement collaborative and learning system helped build confidence and skills in QI, their impact was constrained by short timescales, variable engagement and limited access to reliable data. Sustainable improvement requires QI to be embedded alongside clear governance, protected time and long-term commitment.

Workforce findings highlighted both opportunity and risk. While many MDT roles added value and were highly regarded, several staff groups experienced increasing workload pressure, role ambiguity and reduced job satisfaction. Task based approaches, if poorly designed, risk fragmenting care and undermining continuity, particularly for people with complex or long-term conditions. Future MDT development must therefore take a whole workforce and continuity focused approach.

Finally, inconsistent coding, variable data quality and limited patient level outcome data constrained the ability to assess impact, particularly in relation to continuity of care and health inequalities. Addressing these gaps is essential if MDT working is to be monitored, evaluated and improved over time.

Overall, PCPIP findings suggest that contract implementation would be more effective when expectations are realistic, improvement is embedded and investment is sustained. The recommendations that follow are intended to support a flexible, improvement led approach to MDT development that is grounded in local context, addressing population needs and focused on delivering person centred, equitable care.

Summary of recommendations

Table 9: Summary of recommendations

Recommendation	Summary	Key actions
1. Reset national expectations to align MDT development with improving outcomes and making best use of resources	Shift from rigid 'full implementation' to flexible, value-based MDT development focused on population need, workforce feasibility and person-centred outcomes.	• Co-design local priorities using population/inequality data. • Allow flexible MDT configuration. • Allocate resources based on value and need. • Use person centred outcomes as success measures.
2. Embed improvement principles and realistic timelines	Integrate QI principles and realistic planning, recruitment and evaluation timelines into programme design.	• Apply QI methods (Plan, do, study, act (PDSA), process mapping, improvement data, logic models). • Build in time for recruitment and onboarding. • Develop evaluation plans early. • Tailor QI support to readiness.
3. Apply hub/hybrid models selectively	Use hub models for technical/administrative tasks and practice-based models for clinical integration and continuity.	• Allocate reconciliation/discharge tasks to hubs. • Keep patient facing work in practices. • Apply hybrid models when needed. • Regularly review model suitability.
4. Invest in IT system integration and outcome focused monitoring	Integrated IT systems, standardised coding, and analytic capability should be prioritised. Establish a national MDT monitoring framework that is long-term, trend based, equity sensitive and focused on improvement.	• Standardise coding and role identifiers. • Improve digital interoperability across sectors. • Build analytic capacity locally/nationally. • Develop long-term outcome/continuity/equity measures.
5. Establish clear governance and engage with all relevant stakeholders at the programme design stage	Define roles and responsibilities between Scottish Government, Healthcare Improvement Scotland, NHS boards, HSCPs and GP practices, with early formal engagement where practices lead or provide data.	• Create governance maps and role clarity • Agree everyone's responsibilities early. • Clarify data expectations and resourcing. • Include GPs in programme governance of improvement work related to the GMS contract.
6. Ensure enabling conditions for MDT effectiveness	Ensure MDT models have the required structural, relational and cultural conditions to function effectively.	• Provide clear role descriptions and guidance. • Establish supervision/line management clarity. • Protect MDT time for learning/case discussion.

Recommendation	Summary	Key actions
		• Invest in digital and physical infrastructure.
7. Co-design MDT configuration based on local need	Develop MDT configuration collaboratively to reflect local population needs and ensure services are prioritised accordingly.	• Use local data and community input. • Co-design with all MDT roles and GPs. • Match skill mix to population needs. • Review configuration regularly.
8. Expand evaluation of MDT impacts over time	Conduct ongoing evaluation of MDT impacts on service users, workforce and system outcomes.	• Commission longitudinal and mixed method studies. • Include staff and service user experience data. • Evaluate continuity, equity and systemic impact. • Share learning nationally.
9. Protect continuity of care	Ensure MDT development enables joined up care and better continuity.	• Assess continuity impacts in service design. • Design models of care that support relational, informational and management continuity.
10. Ensure workforce stability and wellbeing	Ensure MDT development protects staff stability and wellbeing through balanced workloads and meaningful roles.	• Provide supervision and reflection time. • Monitor workload, complexity of workload and burnout risk. • Optimise staff's skills and experience.
11. Adopt a QMS approach and tailor improvement support	Use a Quality Management System to integrate planning, assurance, control and improvement. Tailor QI support to local capacity.	• Align programme processes with QMS. • Assess skills and capacity early. • Provide targeted coaching and support. • Focus on learning, not performance assessment.
12. Develop a national health equity framework	Create and implement a national framework to support equitable access and outcomes, with MDT staff skilled in addressing inequalities.	• Produce a national equity improvement framework. • Provide staff training on inequalities. • Use equity sensitive indicators. • Support local equity action plans.
13. Strengthen public communication on MDT roles	Improve national communication explaining MDT roles, complemented by local messaging targeted to those most in need.	• Develop clear national materials on MDT roles. • Support NHS boards/practices with local resources. • Target key groups with tailored messages • Use multiple communication channels.

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Healthcare Improvement Scotland

Edinburgh Office
Gyle Square
1 South Gyle Crescent
Edinburgh
EH12 9EB

Glasgow Office
Delta House
50 West Nile Street
Glasgow
G1 2NP

0141 225 6999

www.healthcareimprovementscotland.scot