

New commission request: GP Walk-In Centre

Meeting: Executive team

Meeting date: 24 March 2026

Agenda item: 2.4

Responsible Executive: [REDACTED]

Report Author: [REDACTED]

Purpose of paper: Decision

1. Purpose

Scottish Government (SG) have asked Healthcare Improvement Scotland to support GP walk-in service pilots to maximise their impact and evaluate the pilots to inform policy decisions on the future role of GP Walk-in Centres in primary and urgent care.

This paper outlines the proposed deliverables and costs required to deliver SG request.

2. Executive Summary

2.1 Context

General practice and primary care account for 90% of healthcare encounters. There has been a rising dissatisfaction from the public on inability to access general practice and the “8am rush for appointments”.

The First Minister announced plans to establish a new nationwide network of walk-in GP services, open seven days a week between noon and 8pm, providing easier access for people to see a clinician without the need for an appointment. 16 pilot sites have been selected and SG is providing NHS boards with £36 million in 2026/27 to pilot GP walk-in services to help improve urgent access to unscheduled primary care. The first pilot site started in February 2026. The pilot aims to:

- Reduce barriers to accessing primary care without an appointment “reduce the 8am rush”, and
- Reducing wider system pressures “reducing inappropriate attendances at ED”.

SG have requested Healthcare Improvement Scotland and Public Health Scotland work together to support the testing and evaluation of the pilot GP Walk in Centres. Public Health Scotland have submitted a response to Scottish Government outlining their role as:

- Lead on collating and reporting data on activity (management information monitoring and published figures), and
- Supply more detailed analysis to Healthcare Improvement Scotland (HIS) to support improvement and evaluation.

2.2 Strategic alignment

This request aligns with two key organisational strategic priorities:

- **Priority 1:** Enable a better understanding of the safety and quality of health and care services and the high impact opportunities for improvement.
- **Priority 4:** Deliver practical support that accelerates the delivery of sustainable improvements in the safety and quality of health and care services across Scotland.

2.3 Proposed deliverables

Following further discussion with SG and internal discussion the proposed deliverables are:

- **Evidence review:** Evidence review of walk-in centre. The review will be conducted in two stages, with an interim report in six weeks and a final report after three months. It is proposed this is delivered by Research and Information Services in Evidence and Digital.
- **Implementation support:** Provide local pilot sites Quality Improvement support (DCAQ, coaching, measurement support, knowledge sharing and project/implementation tools) to fully implement their planned GP Walk-in centre model and optimise the delivery of their model. It is proposed this is delivered by Shifting the balance of care team in Nursing and System Improvement throughout 2026/27 and the first three months of 2027/28 to wrap-up the programme. (Please note it will take longer for all walk in centres to be established for a year)
- **Learning system:** Rapidly capture learning, draw insights and share between Walk-in centres to increase the pace of implementation. This includes peer to peer learning opportunities, documenting characteristics of services, developing guiding principles and sharing key insights from the evidence review with services. This is closely aligned with implementation support and it is proposed this is delivered by Shifting the balance of care team in Nursing and System Improvement until end of Q1 in 2027/28.
- **Evaluation:** Undertake a developmental evaluation based on monitoring and rapid review for this emerging model of care. A more detailed evaluation would prove difficult given the emerging nature of the model and short timescales for services to become established. This approach would use the interim evidence review and engagement with stakeholders to develop an evaluation framework within the first three months. The next 12 months would be used to gather and analyse data. This deliverable would work closely with PHS and Implementation Support to access data. It is proposed this is delivered by a range of teams across Evidence and Digital.

The following deliverables are proposed to be outwith scope:

- **Clinical governance of services.** Local NHS board clinical governance process would

apply.

- **Direct HIS data collection.** HIS will work with NHS boards and other national bodies for data. HIS will not directly collect data **except manual data for improvement**.
- **Governance of funding to NHS boards.** The funding will be provided by SG and the reporting and management of spending is outwith HIS remit.
- **Performance management of NHS boards.** HIS can provide improvement support but do not directly performance manage NHS boards. HIS can share intelligence with SG on observed progress and can escalate delivery risks to SG which can be used by SG as part of their NHS board performance management processes.
- **Quality assurance of services.** HIS does not have the remit to inspect or provide quality assurance of primary care services. Local NHS board quality assurance mechanisms would apply.
- **Workforce development and modelling.** NHS Education for Scotland are better placed at supporting workforce development than HIS.

2.4 Outcome, impact and progress monitoring

The desired outcomes align with the HIS strategy and the SG's Operational Improvement Plan.

Desired outcomes:

- improved access to primary care services
- improved Emergency Department and GP Out Of Hours performance due to reduced demand, and
- Scottish Government use evaluation to inform future policy on GP Walk-in Centres.

Monitoring change in system (Implementation support only):

- Outcome, process and balance measures focused on activity and service delivery,
- Board progress tracker, and
- Case studies of services and service profiles.

Internal key performance indicators:

- Percentage of NHS boards actively engaged in implementation support and learning system over previous three months.
- Percentage of participating GP Walk-in centre pilot sites that have opened to patients.
- Percentage of participating GP Walk-in centre with evidence of *modest improvement in number of appropriate patients accessing service.
- Percentage of evaluation milestones complete.

* see appendix for information on IHI Progress on Improvement scale for KPI

2.5 Resources

Additional capacity will be required to deliver the proposed deliverables.

Please note:

- 2026/27 pay costs are based on mid-point scales for 2025/26 with a 3.5% uplift. The 2027/28 pay cost are for the first three months of 2027/28 with an additional 3.5% uplift.
- Non-pays are for events, travel and accommodation.
- * are for posts start in June 2026. ** are for more specialist posts that take longer to recruit for starting in July 2026.
- Posts to support the Evaluation are indicative and may vary following completion of evaluation framework.

Proposed deliverable	Role	AFC Band	WTE	2026/27 Cost	2027/28 Costs (Q1 only)
Evidence Review (E&D)	(Delivered with existing resources)	-	0	£ 0	£ 0
Implementation support and Learning System (NIC)	Improvement Advisor	7	2*	£ 123,951	£ 38,487
	Improvement and Implementation Facilitator	6	1*	£ 50,871	£ 15,796
	Knowledge and Information Skills Specialist	6	1*	£ 50,871	£ 15,796
	Project Officer	5	1*	£ 41,484	£ 12,881
	Non pays	N/A	N/A	£ 12,000	£ 5,000
Evaluation (E&D)	Health Services Researcher	7	3**	£ 167,333	£ 57,730
	Data Measurement Advisor	7	1**	£ 55,778	£ 19,243
	Health Economist	7	1**	£ 55,778	£ 19,243
	Programme manager	7	1*	£ 61,975	£ 19,243
	Project Officer	5	1*	£ 41,484	£ 12,881
	Admin Officer	4	1*	£ 35,350	£ 10,976
	Non pays	N/A	N/A	£ 6,500	£ 2,000
Clinical leadership (All deliverables)	Advance Nurse Practitioner Clinical Lead	8a	0.2**	£ 17,685	£ 4,576
	GP Clinical Lead	N/A	0.2	£ 73, 307	£ 11,206

Totals			13.4	£759,946	£245,057
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The sub totals are:

- Evidence review (E&D): £0
- Implementation support and Learning System (NIC): £279,177 in 2026/27 and £87,959 in 2027/28.
- Evaluation (E&D): £424,198 in 2026/27 and £141,317 in 2027/28.
- Clinical leadership (All deliverables): £56,571 in 2026/27 and £15,782 in 2027/28.

2.6 Equality impact assessment

HIS will complete an EQIA as part of implementation support and will be informed by the Evidence review.

2.7 Key risks

- There is a risk services will not be able to engage with implementation support due to operational pressures and requirement to meet closely monitored performance targets. This may result in slower implementation, failure to fully realise the benefit of GP Walk-in Centres within the programme timeframe and reputational damage to HIS.
- There is a risk political priorities will change after the 2026 Scottish Parliament election. This may result in poor engagement from NHS boards and the need to renegotiate deliverables with Scottish Government.
- There is a risk Scottish Government expectations for the evaluation are higher than what can realistically be delivered for a new emerging model of care over short timescale. This may result in relational damage between Healthcare Improvement Scotland and Scottish Government.
- There is a risk the rapid implementation of GP Walk-in Centres in some NHS boards before measures or baseline data has been established will make it very challenging to identify if an improvement has taken place. This may result in failure to fully realise the benefit of GP Walk-in Centres within the programme timeframe.
- There is a risk the evaluation will result in a conclusions against political vision for GP Walk-in Centres. This may result in relational damage between Healthcare Improvement Scotland and Scottish Government.
- There is a risk staff cannot be deployed or quickly recruited internally to deliver the planned deliverables within given timescale. This may result in failure to deliver all deliverables before end of financial year and reputational damage to HIS.

3. Recommendation

The Executive Team are asked to review the proposal and agree to proceed with accepting a new additional allocation for GP Walk-in Centres.

It is recommended that the Executive Team accept the following Level of Assurance:

Moderate: reasonable assurance that controls upon which the organisation relies to manage the risk(s) are in the main suitably designed and effectively applied. There remains a moderate amount of residual risk.

4. Appendices and links to additional information

Use of IHI measure of modest improvement as a KPI.

We use modest improvement for KPI as it shows the programme participants are moving towards impact. By using modest it gives us an early warning signal in the event participating services are not progressing as expected allowing action to mitigate. This KPI value will change each month from the mid to late stages of a programme. If we wait for significant or outstanding the KPI will remain 0% for most of the year and will only change at the end of the year, or in the following year. This would make a less effective KPI to gauge if a programme is on track for delivery.

The KPI on modest improvement (rating 3) is used in combination with the measure on rating 2 (moving from talking about make changes to making changes) to show the programme is on track to deliver. Together they show an improvement programme is progressing towards its anticipated impact.

The two KPIs do not replace impact data reporting which normally becomes available at the later stages of a programme or in the post-programme wrap-up stage. These KPIs are used to monitor programme performance towards impact during the life cycle of the programme.

This scale is well understood and used across NHS Scotland to measure improvement, first introduced when SPSP launched and used by NES in Improvement teaching programmes. It has been widely used across QI-based programmes delivered by HIS for many years

[Progress on Improvement Project](#)

Details of PHS proposal on data collection



Support for GP walk
in centres - proposal C

GP Walk in centres - PHS resources

2026/27

March 2026

1. Background

This paper sets out the potential work required by Public Health Scotland (PHS) to support the GP-led walk-in service pilot during 2026/27.

The Scottish Government has announced plans to establish a nationwide network of walk-in GP centres aimed at enhancing access to healthcare services. This initiative is part of a broader strategy to alleviate the pressure on traditional GP practices and address the common issue of the "8am rush" for appointments. The aim is to deliver over 1 million additional appointments. One centre has now opened with fifteen more to follow in the coming weeks and months.

2. Proposed PHS approach

We propose that the PHS work would form two parts. PHS would:

1. Lead on collating and reporting data on activity (management information monitoring and published figures)
2. Supply more detailed analysis to Healthcare Improvement Scotland (HIS) to support their work on the national evaluation

The following indicative plan and costs are based on early discussions with SG and HIS. Assumptions, dependencies and risks are noted and further detail is required to scope out the full extent of the work.

2.1 Activity

The majority of pilot walk-in sites will capture data via the ADASTRA system that is usually used by primary care out of hours (PC OOH) services. One site is expected to capture data in the GP IT Vision system.

The following information can be collected from ADASTRA, assuming the data feed is set up to do so. Data from Vision can be collected if walk-in patients are identified separately, practice approval given and Albasoft delivery commitment.

Data required	Comments
ADASTRA - mirroring PC OOH dataset	
Count of completed consultations	Avoid using 'cases' (inconsistent recording)
Date & time of consultation	To enable analysis of patterns of attendance and linked pathways of subsequent contacts with unscheduled care services
CHI number & patient postcode	To enable demographic & geographical analysis, counts of individuals and multiple attendances and linkages
Read codes	To enable analysis of diagnosis/reason for attendance (high-level groupings); codes are limited compared to GP In Hours recording
Vision	
Count of consultations	With practice approval for patient identifiable data - otherwise aggregate counts only
Date of consultation	
CHI number, DOB & patient postcode	If permission, to enable demographic & geographical analysis.
Read codes	Coding may differ from ADASTRA - diagnosis, reason for attending, intervention, DM&D codes for prescriptions available High-level groupings based on types used for GP In Hours reporting

2.2 Impact / Outcomes

At this stage, it is difficult to estimate what the wider data measurement plan would look like, further scoping and clarification on the main questions/key measures to be supported

by the data is required. However, there is an expectation that there would be a need to understand the impact on current GP services (possibly utilising GP In hrs activity data) as well as other services such as A&E, NHS24, SAS, FNC etc.

Potential data	Comments
For ADAstra sites only	To be confirmed if Vision site can do
Recorded PC OOH outcome (e.g. referred to A&E, advised to see own GP, self-care advice etc)	There may be scope to add more options, but note that local changes can result in unmapped centralised codes and difficulties doing national analysis, so this ideally needs to be managed centrally
Potential for individual case linkage to the Unscheduled Care Datamart to track subsequent contact/s with unscheduled care services within defined timeframes	Subject to Information Governance (IG) approval of linkage. For example, this could show what proportion of people using the walk-in attend A&E, have a Primary Care Out of Hours consultation, call NHS 24 or Scottish Ambulance Service, or are admitted to hospital as an emergency within 24 hours of their walk-in consultation.
Potential for higher level analysis of patterns of unscheduled care service use by populations in areas with walk-ins (pre and post comparisons - by age group)	For example, this could look at population rates of contact with NHS 24, SAS, A&E, PC OOH for defined periods pre and post the walk-in clinic being available.
Potential for higher level analysis of GP in hours activity for practices in these areas (pre and post comparisons – by age group)	Not possible at individual level, but could do by practice with new IG approval or at HSCP level with current IG approvals.

2.3 Cost analysis

PHS do not have access to this information from routine national sources so will not be providing costs data. Alternative methods to be considered by HIS.

2.4 Patient and Staff experience

PHS will not be involved, to be taken forward by HIS or via the HACE survey.

2.5 Outputs

PHS will provide high-level activity management information to SG and HIS for monitoring purposes on a monthly basis (subject to data flows being in place). Publication schedule of activity monitoring reporting to be agreed, but we expect this to be high-level numbers of consultations by area each month.

More detailed analyses (such as demographic breakdowns, comparisons of attendance rate pre and post implementation, linked analysis) mentioned above will not be reported by PHS - these will be passed to HIS as management information to feed in to their national evaluation.

2.6 Other requirements

- The commissioning relationship between SG and Advanced (the supplier of ADAstra) needs to be confirmed and governance and oversight agreed. PHS is happy to engage with Advanced to confirm requirements for the data flows once this is confirmed.
- Additional PHS resource required to engage with Advanced, coordinate IG approvals for data flows and linkage.
- Similarly, Albasoft/NSS should be approached to agree their involvement and additional resource from PHS will be needed to coordinate with them to extract data.
- At source of data collection, mechanisms should be in place to robustly and consistently separate the data from regular PC OOH (e.g. via site identifiers, or consultation type) and GP In Hours recording (e.g. separate Read code for Vision practice).
- Appropriate processes need to be set up to register and record patients who turn up to walk-in centres. The ADAstra system usually handles scheduled out of hours appointments from NHS 24 or Flow Navigation Centres; it is not yet clear how walk-ins will be registered. Patients are usually required to be registered with a GP before information on the patient can be recorded in the GP IT system; it is unclear how this will work for walk-in centres using Vision.

3. Assumptions/dependencies

- A weekly flow of ADAstra data for the pilot walk-in centres will be established to PHS; this be consistent with data available to boards for their local evaluation
- The ADAstra data flow for pilot walk-in centres will not have a detrimental impact on the quality and consistency of primary care out of hours data supplied to PHS and boards
- A flow (frequency TBC) of data for the one site using Vision will be established; this will be consistent with data available to the board for their local evaluation

- Walk-in activity captured on Vision will be distinguishable from and will not compromise the quality of GP In Hours recording at this site.
- It is assumed that PHS will receive back-dated data to cover the full period of operation of walk-in centres (where data flows are being set up after launch).
- It is assumed that all walk-in centres have given permission for their activity data to be supplied to PHS and that information governance will be agreed and put in place ahead of any extraction and processing of data from the Vision system.
- SG will cover any system supplier costs associated with establishing these data flows.
- HIS will lead the national evaluation and require only agreed analysis from PHS.
- PHS involvement in programme meetings will be limited to those directly related to monitoring and reporting, and to supporting the HIS national evaluation.

4. Unknowns

- Local variation in how services are set up and delivered e.g. differing MDT input, or differing local coding and data items created in local ADAstra versions.
- Unclear whether ADAstra can record consultations with all MDT team (e.g. nurses and physios) as well as GPs.
- Unclear if ADAstra could capture people attending but not having a consultation; this could be people turned away as they are ineligible to attend, or people who register but then leave before being seen.

5. Risks

- There is a risk that robust weekly flows from ADAstra will not be established in a timely way.
- There is a potential risk to current PC OOH flows i.e. walk-in activity needs to be clearly distinguishable from PC OOH.
- There is a risk that GP In hours activity data from Vision will be unreliable due to data quality and IT issues. Therefore any measurement of additional appointments will be inaccurate or even not possible.
- There is a risk that due to approval, resource and other priorities, that Albasoft will not be able to extract the data from Vision in a timely manner.

- There is a risk that due to small numbers in small areas, and complex systems and behaviours, impact analysis may be limited.

6. Out of Scope

- The extent of the existing 8am rush is currently not captured centrally and therefore PHS will not be able to measure any change to this as a result of the walk-in centres.

Assessment of this would be part of the broader HIS evaluation work.

- Patient level data from in hours will not be possible at a national level unless mandated or agreed with SGPC for this specific purpose.

- PHS cannot supply costs data as we do not have a robust national source of this information.

- PHS will not be involved in staff or patient surveys for the HIS national evaluation.

- The Local Intelligence Support Team (LIST) from PHS may be involved in supporting some local evaluation work in some areas, but this is not part of the scope of the national work outlined in this proposal.

7. Resources

With the support of existing systems and teams for data collection/analysis, we estimate that the following additional resource is required to deliver the work set out in this proposal:

2026/27	wte	Cost
Information Consultant (8b)	0.4	£48,465
Principal Information Analyst (7)	0.6	£55,574
Senior Analyst (6)	1.5	£120,840
Data Management (5)	0.15	£10,099
IG?	?	?
Total		£234,978

Not including NSS/Albasoft or Advanced costs

GP Walk in Services

Scottish Government Lead: [REDACTED] **Head of GP Contract policy/** [REDACTED] **Deputy Director of Primary Care**

HIS Lead Director: [REDACTED], **Executive Lead Primary and Community Care Portfolio and** [REDACTED]

Proposal prepared by: [REDACTED]
[REDACTED]

Date SBAR submitted: N/A

Date business case submitted: March 2026

1. Background

1.1. The First Minister announced plans to establish a new nationwide network of walk-in GP services, open seven days a week between noon and 8pm, providing easier access for people to see a clinician without the need for an appointment. 16 pilot sites have been selected by SG with funding to NHS boards up to £36 million in 2026/27 to pilot GP walk-in services. These aim to help improve urgent access to unscheduled primary care. The first pilot site started in February 2026, with an additional two in March and a further two in April. The pilots aim to:

- Reduce barriers to accessing primary care without an appointment “reduce the 8am rush”, and
- Reducing wider system pressures “reducing inappropriate attendances at ED”.

SG have asked Healthcare Improvement Scotland to support GP walk-in service pilots to provide improvement and implementation support to maximise their impact and to evaluate the pilots to inform policy decisions on the future role of GP Walk-in Centres in primary and urgent care.

1.1. Walk in services are new and will straddle existing general practice delivery and Out of Hours provision.

1.2. The desired outcomes align with the HIS strategy and the SG’s Operational Improvement Plan.

Desired outcomes:

- improved access to primary care services for all and especially for people who do not routinely access general practice services
- improved Emergency Department and GP Out Of Hours performance due to reduced demand, and
- Scottish Government use evaluation to inform future policy on GP Walk-in Services.

It is unclear at this time whether health inequity will be reduced through the introduction of these services.

1.3. The Primary Care Phased Investment Programme is soon to publish its final report and recommendations which will be used to inform the development of the SG business case on the next iteration of the General Medical Services 2018 (GMS) contract. The Primary Care Improvement Portfolio will continue to provide national improvement support building on implementation progress since the introduction of the new GP contract and will provide support to the elements of core general practice that were agreed between SG and BMA as part of the additional £531m of funding for primary care. It is anticipated by SG that GP Walk in Services will provide improved access to care.

2. Proposed HIS deliverables

2.1. Following further discussions with SG and internal discussions the proposed deliverables are detailed in two sections, the **Evidence Review and Evaluation** and the **Improvement and Implementation Support and Learning System**.

Evidence Review and Evaluation

An Evidence Review and Evaluation will be undertaken by the Evidence and Digital Directorate using the approach outlined below.

Evidence review

An evidence review will be delivered in two stages, starting with a high-level scoping review to establish the overall evidence base, followed by a series of more detailed analytical reviews focused on priority issues.

a) High level scoping evidence review

An initial high level scoping evidence review will provide an overview of the existing evidence on GP walk-in services to address (i) their effectiveness as an intervention (what works and who for) and (ii) steps for effective implementation (how it works).

The research questions will be:

- Do GP walk-in services improve access to care, for whom, and at what overall cost?
- What approaches, mechanisms, and contextual factors influence the effectiveness of GP walk-in services in achieving policy, service, and patient objectives?

The scoping review will identify lessons learned from services in England and other countries and will assess how this learning can inform the design and delivery of future GP walk-in services in NHS Scotland.

The scoping review will be delivered by the end of June 2026. The review will provide a foundation for identifying priority areas for more detailed analysis.

b) In-depth evidence reviews

The scoping review will be followed by a series of more in-depth evidence reviews, undertaken at approximately 2–3 month intervals. These will focus on specific issues, including those highlighted as priorities through the scoping review.

Based on initial discussions, these in-depth reviews are expected to include:

- **Personal and clinical outcomes**
Which clinical outcomes, and patient-reported outcome and experience measures, are most relevant for assessing the impact of GP walk-in services?
- **Equity and inclusion**
How can GP walk-in services best support improved equity and inclusion in meeting urgent care needs?

- **Adoption and spread**

What approaches to implementation and scale-up have been effective elsewhere, what challenges have been encountered, and how have these been addressed?

Together, these analytical reviews will build a progressively deeper and more actionable evidence base to support policy decisions, service design, and ongoing improvement.

C) Evaluation Framework:

Scottish Government has requested a full monitoring and evaluation framework, led by Healthcare Improvement Scotland and PHS. Walk-in service pilots are expected to test and evaluate multiple elements including service feasibility, patient access and experience, service impact on system utilisation and cost/resource and reducing healthcare inequalities.

We understand that NHS boards are expecting a national evaluation and monitoring framework to be available to collect and share KPIs and other evidence on activity, outcomes, and costs for the pilot site and related services.

The development of a reliable and robust evaluation framework development requires clarification of theory of change and evaluation aim, objectives and questions. Given the early stages of the planned GP walk in services programme, the framework should provide feedback for learning and should include both process and impact aspects. This requires a mixed methods approach i.e. collection of both quantitative and qualitative data. The evaluation framework will also guide the collection of resource impact data.

The high-level evidence review and early engagement with stakeholders will be used to develop an evaluation framework. This will then allow a more precise understanding of resources required. Following the development of the framework, the next 12 months would be used to support collation and analysis of data. HIS would only be able to directly support data collection if appropriate approvals and information governance arrangements are put in place. This requires input from Scottish Government and PHS to allow access to data.

The timeline of a high-level outline of evaluation framework deliverables is set out in Table 1. Optional activity associated with qualitative data collection is marked in *blue italics*. In addition to the three proposed review points, a monthly HIS-SG leadership communication schedule should be developed, complementing PHS monthly reporting timelines.

Table 1: Proposed Timeline for Evaluation Framework Deliverables

Timeline	Deliverable	Considerations
Phase 1		
0-6 weeks Scope Design the evaluation and monitoring framework, including agreement of aim, objectives and guiding evaluation questions.	Draft framework A draft evaluation and monitoring framework ready for sharing with SG and NHS board stakeholders for comment and review. Evaluation question(s) may consider patient access, experience or outcomes, or healthcare inequalities.	Should incorporate aims of Scottish Government, findings from evidence review, developing theory of change.

6 weeks – 3 months Finalise and agree Incorporate outline data collection and analysis plans in partnership with PHS and NHS boards.	Final version of framework A final evaluation and monitoring framework will be ready for use by SG and NHS board stakeholders. <i>Planning for qualitative data collection- to be confirmed in scoping phase whether required.</i>	Should incorporate monitoring and evaluation indicators, and responsibilities for data collection, management, analysis and synthesis and reporting planning. Should ascertain with PHS whether data from other parts of the locality can be used as counterfactual.
Review point 1 (after 3 months) HIS, PHS, SG – including agreement of evaluation resources		
Phase 2		
3 months – 12 months Deliver and Coordinate Implement framework in partnership with HIS implementation support and NHS boards. Align monthly reporting of monitoring data from PHS with HIS interim reporting. <i>HIS could support rapid interviewing with key stakeholders to ascertain threats and opportunities to the pilot to share real-time learning via the implementation support work/learning system- to be confirmed in scoping phase whether required.</i>	Specialist advice, analysis and support Monitoring data collection led by NHS boards and PHS; reporting to SG led by PHS. <i>HIS could also provide advice/ direct support with qualitative data collection – to be confirmed in scoping phase whether required.</i>	HIS framework should act as an enabler for NHS Boards; framework and data collection should be as streamlined as possible with existing service activity. <i>If it does not already exist, developing a patient feedback questionnaire which provides insight into selecting the walk-in service may be helpful – to be confirmed in scoping phase whether required.</i> <i>Programme and administrative support would enable researchers to rapidly operate within the 16 sites.</i>
Review point 2 (after 6 months) HIS, PHS, SG – including review of risks, opportunities		
6 and 9 months Liaise regularly with HIS implementation support colleagues regarding context.	Interim (formative) reports Progress report on evaluation data to establish framework use to date and any limitations.	Aims to support transparent reporting to SG and guide refinement of parameters of final report.
Review point 3 (after 12 months) HIS, PHS, SG – including review of interim reports		
12 -15 months Final Reporting	Final (summative) report Report on monitoring and evaluation data, identifying key learning about early development and testing of the framework and potential emerging impact.	It is not possible to produce this deliverable to a high standard without completion of Phase 1.

Implementation Support and Learning System

The Nursing and Integrated Care Directorate would provide quality improvement and implementation support to the selected walk in centre pilots. This will commence immediately and will be provided throughout the duration of the programme until end June 2027.

Deliverable 1: Implementation support and optimisation of GP walk-in services.

Provide local pilot sites:

- Quality Improvement and Implementation support including DCAQ, coaching, measurement support,
- Knowledge sharing and project/implementation tools, to fully implement their planned GP Walk-in Service model
- Optimise the delivery of local model.

It is proposed this is delivered by Shifting the Balance of care team, utilising the experience of the national roll out of H@H and SPoC for Cancer, with some support and subject matter knowledge from Primary Care Improvement Portfolio. Additional senior strategic support will be provided by the Associate Director of Improvement, the Portfolio Lead and a Senior Improvement Advisor, all of whom are already in post. It is anticipated that this work will progress throughout 2026/27 and the first three months of 2027/28 to wrap-up the programme. (Please note this is as it will take longer for all walk in services to be established for a year)

Deliverable 2: Learning System

Rapidly capture learning, draw insights and share between Walk-in services to increase the pace of implementation. This includes:

- Peer to peer learning opportunities
- Documenting characteristics of services and sharing key insights
- Developing guiding principles

These outputs will be developed through direct alignment with the proposed improvement and implementation support and will be co-produced with pilot sites using qualitative and quantitative data and evidence gathered as the programme progresses.

2.1. This work will report to the General Practice Programme Board, the Primary and Community Care Wellbeing Steering Group and through DG health and Social Care Board. The initial pilot sites will be funded for one year with programme funding initially until end June 2027 to allow for completion of reporting and delivery of outputs.

2.2. The following deliverables are proposed to be outwith scope:

- **Clinical governance of services.** Local NHS board clinical governance process would apply.
- **Direct HIS data collection.** HIS will work with NHS boards, PHS and other national bodies for data. HIS will not directly collect data **except manual data for improvement.**
- **Governance of funding to NHS boards.** The funding will be provided by SG and the reporting and management of spending is outwith HIS remit.
- **Performance management of NHS boards.** HIS can provide improvement and implementation support but do not directly performance manage NHS boards. HIS can share intelligence with SG on observed progress and can escalate delivery risks to SG which can be used by SG as part of their NHS board performance management processes.
- **Availability of data.** Walk in services are a complex intervention being piloted within a complex system.

Service models are emerging and there are short timescales for these to become established. The project duration is rapid and this may lead to limited data availability including a lack of baseline data or services not being willing or able to share data.

- **Challenges recruiting staff.** Specialist role recruitment in HIS may take longer; clinical recruitment delays will lead to delays in service set-up and associated data collection.
- **Quality assurance of services.** HIS does not have the remit to inspect or provide quality assurance of primary care services. Local NHS board quality assurance mechanisms would apply.
- **Workforce development and modelling.** NHS Education for Scotland (now part of Public Services Delivery Scotland) are better placed at supporting workforce development than HIS.

3. Costs and resources

Additional capacity will be required to deliver the proposed deliverables.

Please note:

- 2026/27 pay costs are based on mid-point scales for 2025/26 with a 3.5% uplift. The 2027/28 pay cost are for the first three months of 2027/28 with an additional 3.5% uplift.
- Non-pays are for events, travel and accommodation.
- * are for posts start in June 2026. ** are for more specialist posts that take longer to recruit for starting in July 2026.
- Posts to support the Evaluation are indicative and may vary following completion of evaluation framework. For example, if HIS is required to directly support the collection of qualitative data across the sites, greater Health Services Researcher and administrative capacity would be required.
- Evidence Review costs: Given the urgency of need, the Evidence and Digital Directorate will conduct the first 4-6 weeks of the initial scoping review within existing resource. However, costs will need to be covered for the remaining time commitment – estimated at 9 months of Health Service Researcher effort in total – 8 months in 26/27; 1 month in 27/28, and 2 months of Knowledge and Information Skills specialist input to conduct expert searches and produce decision-ready summaries of the evidence reviews. Initially this may be sourced on a consultancy basis for 3 months for speed in progressing the work, followed by recruitment to a 6-month post.

Proposed deliverable	Role	AFC Band	WTE	2026/27 Cost	2027/28 Costs (Q1 only)
Evidence Review (E&D)	Health Service Researcher	7	0.67	£ 48,978	£ 6,122
	Knowledge and Information Skills Specialist	6	0.17	£10,050	£ 0
Implementation support and	Improvement Advisor	7	2*	£ 123,951	£ 38,487

Learning System (NIC)	Improvement and Implementation Facilitator	6	1*	£ 50,871	£ 15,796
	Knowledge and Information Skills Specialist	6	1*	£ 50,871	£ 15,796
	Senior Project Officer	6	1*	£ 50,871	£ 15,796
	Project Officer	5	1*	£ 41,484	£ 12,881
	Non pays	N/A	N/A	£ 12,000	£ 5,000
Evaluation (E&D) Note: Range of HSR/SR and PM, AO costs as these will depend on decision at Review point 1 as to whether HIS supports qualitative data collection	Director/AD oversight	N/A	0.05	In post	In post
	Lead for Evidence and Evaluation work	8b	0.5	In post	In post
	Lead researcher	8a	0.5	In post	In post
	Health Services Researcher/Social Researcher	7	2**	£ 123,951	£ 38,487
	Data Measurement Advisor	7	0.5**	£ 30,987	£ 9,621
	Health Economist	7	1**	£ 55,778	£ 19,243
	Programme manager	7	1.0*	£ 61,975	£ 19,243
	Knowledge and Information Skills Specialist	6	1*	£ 50,871	£ 15,796
	Admin Officer	4	0.5*	£ 17,675	£ 5,488
	Non pays	N/A	N/A	£ 6,500	£ 2,000
Clinical leadership (All deliverables)	Advance Nurse Practitioner Clinical Lead	8a	0.2**	£ 17,685	£ 4,576
	GP Clinical Lead	N/A	0.2	£ 73, 307	£ 11,206
Totals			13.4	£827,805	£235,538

The sub totals are:

- Evidence review (E&D): £59,028 in 2026-27, £6,122 in 2027-28.
- Implementation support and Learning System (NIC): £330,048 in 2026/27 and £103,756 in 2027/28.

- Evaluation (E&D): £347,737 in 2026/27 and £109,878 in 2027/28.
- Clinical leadership (All deliverables): £90,992 in 2026/27 and £15,782 in 2027/28.

3.1 IT, digital, cybersecurity, information security and information governance requirements

There are requirements for the following:

- **IT/home working:** IT kit will be required for new starts.
- **Information Governance:** A Data Protection Information Agreement (DPIA) may be required, setting out how information shared by people who work in services and people with lived and living experience will be used.

4. Governance and project management

4.1. Governance structures/arrangements

HIS will deliver GP Walk in Services improvement and implementation support and evaluation, and we will demonstrate our accountability to both HIS and Scottish Government (SG) on the process of deliverables, financial spend and risk management. This will be conducted through monthly meetings with SG and a rhythm yet to be agreed with Ministers of progress meetings and/or reports to the General Practice Programme Board and the SG GP Walk in Services Advisory Board (to be established by SG). Internal monthly corporate reporting will also be undertaken.

The HIS governance structure will include the following:

- **Quality and Performance Committee (QPC)**
 - Purpose and authority: This is the programmes central oversight committee as prescribed by HIS board, we will report to this board as directed and seek contribution and guidance as required.
- **General Practice Programme Board (GPPB) or GP Walk in Services Advisory Board**
 - Purpose and authority: joint HIS and SG to monitor financial expenditure, strategy, delivery, project outcome quality control, and risk management.
- **Delivery Groups (Internal HIS Delivery Team)**
 - Purpose and authority: Day-to-day delivery and tracking of organisational activities through the programme plan. Opportunity to identify risks, discuss financial spend requests, share learning and insights across the workstream, and input into Clinical Care and Governance reports.
- **HIS Primary and Community Care Portfolio**
 - Purpose and authority: Oversight of all relevant cross organisational working, progress towards delivery and tracking of organisational activities. Opportunity to discuss or escalate risks, discuss financial management, share learning and insights across the organisation, and input into Governance board reports.
- **Pilot sites reference group**
 - Purpose and authority: Strategically connect with relevant work areas for learning and intelligence sharing. There is no decision-making authority for scope, strategy, delivery, budget, or risk management. The groups provide the opportunity to engage with the system to reduce duplication or burden.

Governance deliverables:

- Quarterly progress report to include improvement data
- Monthly internal HIS reporting submissions through the Primary and Community Care Portfolio
- Reporting to QPC as required by Board
- Reporting to other relevant HIS portfolios as set out in new process for portfolio management.

4.2. Clinical and care governance

The programme delivery team includes additional sessions from the HIS GP Strategic Clinical Lead to help support our clinical and care engagement and oversight. Additional general practice nursing support will be provided by Director of Nursing and Integrated Care Directorate who is an ANP alongside the Associate Director of Nursing. Pharmacy engagement and oversight will be supported as required by the HIS Chief Pharmacist and the expertise within SAPG. Throughout the programme delivery, the strong connection to the Scottish Government Clinical Advisory Group, Primary Care Specialist Advisors, the national Pharmacotherapy infrastructure will ensure clinical and care risks are raised early within the programme and throughout delivery.

This table sets out the principles of the HIS Clinical and Care Governance Framework and the arrangements we will put in place to ensure the safe and effect delivery of the programme and project objectives.

Principle	Governance Arrangement
We have a supported, involved and engaged workforce	All relevant Agenda for Change policies and practises will be adhered to with regular meetings with HR partner.
There are clear lines of leadership and accountability	Establishment of a clearly defined programme governance structure as outlined in 4.1 (above) The programme plan will ensure transparent planning of activities against resources. The development of the SG national programme advisory board will support effective professional oversight across Health and Social Care.
We involve the people and communities who use services in all our programmes of work	Embedded social researcher and KISS will ensure contribution of people who use services, families and carers who coordinate care. Robust evaluation plan that includes engagement with people who use services.
There is transparent and informed decision making	Establishment of a clearly defined programme governance structure as outlined in 4.1 (above)
All clinical and care risks are identified, managed and acted upon	To connect to our existing structures within HIS, develop the clinical governance requirements as programmes are fully scoped, and ensure participating boards provide adequate care and clinical oversight and assurance to their sites.
We will uphold and demonstrate professional ethics, values and standards	Support an Equality Impact Assessment, and review when appropriate
We will continually share knowledge and learning with all our stakeholders	Through the development of our QMS learning system we will sustain and share our learning and insights across Scotland digitally and in person as appropriate.
Patient and public involvement	Internally and externally, we will ensure the contribution of patients and the public in the design and delivery of the Quality Management Approach This will be done in collaboration with Community Engagement colleagues to uphold best practise and support statutory duties.

Principle	Governance Arrangement
Staffing and staff management	Through the existing structures within HIS we will ensure engagement in staff forum.
Clinical effectiveness	We will ensure the appropriate level of clinical oversight to ensure adherence to care and clinical oversight.
Research and using information	In collaboration with internal colleagues, we will ensure the appropriate considerations for care and clinical governance are in place in the determination of research and using information.

4.3. Interdependencies and cross-organisational implications

The programme will connect internally through the governance and portfolios as established as part of the HIS planning process. The HIS/SG/PHS relationship will be supported through monthly meetings with additional connectivity as appropriate with other national organisations.

4.4. Stakeholder engagement

We will engage with a broad range of stakeholders including patients, national organisations, public bodies and colleagues across health and social care.

4.5. Equality impact assessments and ethical considerations

WE will endeavour to ensure that this programme is planned and delivered in alignment with HIS statutory duties to ensure fairness, equality, and inclusion. All decisions will meet the requirements of the Public Sector Equality Duty by eliminating discrimination, advancing equality of opportunity, and fostering good relations by ensuring our work is person centred and people led.

In addition, the programme will apply the Fairer Scotland Duty by actively assessing and addressing socio-economic disadvantage as part of support to implementation and through the evaluation of the 16 sites. Equality Impact Assessments and Fairer Scotland Duty assessments will be conducted by SG and published to demonstrate transparency and compliance online and updated to reflect changes to the programme as it matures.

4.6. Sustainability

These Walk in Services aim to improve access to care, supporting people to choose their care pathway at the right place, right time thereby reducing demands on secondary and unscheduled care. Through working collaboratively with partners and stakeholders and embedding a quality management approach, we aim to improve accountability and ownership of care quality and safety to reduce waste and create sustainable improvements to services

The programme logic models, and impact framework will identify a series of key measures to track over time that will evidence the attainment and achievement of these aims alongside those identified throughout this business case.

4.7. Project management arrangement

The programme management team will use HIS project management documentation to support the programme of work. This will include a Logic Model and Driver Diagram, Measurement Plan and Impact Tracking and Operational Plan (which will be reviewed monthly, with quarterly iterations developed if required).

5. Risks and mitigations

Given that this is an initiative announced by the First Minister and is not universally popular within general practice, many of the risks are outwith the control of HIS. The We will work with SG to ensure that risks and mitigations in these circumstances are captured by their own governance processes.

Within HIS:

Risk	Mitigations
There is a risk that HIS are unable to engage fully with all required stakeholders because of the prioritisation of capacity towards service delivery and other identified priorities. This may result in the deliverables of the programmes not being fully realised within the required timeframes which could result in reputational damage to HIS.	• Escalation to HIS and Commissioners • Renegotiate deliverables with commissioners. • Track engagement and attainment of agreed deliverables with pilot sites
There is a risk that HIS are unable to access the required data to fully complete the evaluation or improvement work due to the national challenge in availability of data from primary care and the challenges of GPs being independent contractors and not obliged to share data.	• Maintain close working relationships with PHS and other national bodies and escalate to HIS and SG as appropriate • Engage with pilot sites and their Boards to try and secure data sharing agreements as early as possible and to review measures where this is not possible
There is a risk that HIS is unable to recruit the necessary staff required due to the fixed term nature of this funding resulting in potential reduced workforce to achieve deliverables within the timeframe resulting in reputational damage to HIS.	• Review recruitment and workforce and escalate within HIS to try secure additional support • Identification of challenges and gaps as a result and renegotiation of deliverables. • Engagement and discussion within HIS for direction and escalation to SG.

Risk Management Strategy

A RAID (risks, assumptions, issues, dependencies) log will be developed for this programme and will be managed as part of governance and assurance. All members of the team will have the opportunity to raise any risks during team meetings and delivery group meetings, which will then be discussed and escalated as appropriate at the Primary and Community Care Portfolio meetings. Existing risks will also be reviewed at the delivery group meetings and monthly meetings between the delivery leads and the Programme Manager.

Appendices

To include any further specific details of the proposals.

From: [REDACTED] ([NHS Healthcare Improvement Scotland](#))
To: [REDACTED]
Subject: FW: GP Walk-in centres- Commission update
Date: 02 April 2026 14:35:28
Attachments: [image001.png](#)
[ED edit New commission request GP walk in centres ET v1.0.docx](#)

From: [REDACTED] (NHS Healthcare Improvement Scotland)
Sent: 02 April 2026 14:35
To: [REDACTED] (NHS Healthcare Improvement Scotland)
[REDACTED] nhs.scot>; [REDACTED] (NHS Healthcare Improvement Scotland) <[REDACTED] nhs.scot>
Cc: [REDACTED] (NHS Healthcare Improvement Scotland) <[REDACTED] nhs.scot>;
[REDACTED] (NHS Healthcare Improvement Scotland)
<[REDACTED]@nhs.scot>
Subject: RE: GP Walk-in centres- Commission update

Hi [REDACTED]
Here you go, let me know if you have any questions. Changes to sections 2.3 and 2.5.
Best wishes
[REDACTED]

From: [REDACTED] (NHS Healthcare Improvement Scotland)
<[REDACTED] nhs.scot>
Sent: 02 April 2026 13:23
To: [REDACTED] (NHS Healthcare Improvement Scotland) <[REDACTED] nhs.scot>;
[REDACTED] (NHS Healthcare Improvement Scotland)
<[REDACTED] nhs.scot>
Cc: [REDACTED] (NHS Healthcare Improvement Scotland) <[REDACTED] nhs.scot>;
[REDACTED] (NHS Healthcare Improvement Scotland)
<[REDACTED] nhs.scot>
Subject: RE: GP Walk-in centres- Commission update

Hi [REDACTED]

Do you have your updated evidence section that you can share? I will pull together a proposal for SG based on the ET paper so that we can share this next week with them.

Thanks

[REDACTED]

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Healthcare Improvement Scotland

m: [REDACTED]

e: [REDACTED]

-
PA: [REDACTED]

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www.ihub.scot

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Facebook: www.facebook.com/healthcareimprovementscot

From: [REDACTED] (NHS Healthcare Improvement Scotland)

<[REDACTED][nhs.scot](mailto:[REDACTED]@nhs.scot)>

Sent: 01 April 2026 11:06

To: [REDACTED] (NHS Healthcare Improvement Scotland) <[REDACTED][nhs.scot](mailto:[REDACTED]@nhs.scot)>;

[REDACTED] (NHS Healthcare Improvement Scotland)

<[REDACTED][nhs.scot](mailto:[REDACTED]@nhs.scot)>; [REDACTED] (NHS Healthcare Improvement

Scotland) <[REDACTED][nhs.scot](mailto:[REDACTED]@nhs.scot)>; [REDACTED] (NHS Healthcare Improvement

Scotland) <[REDACTED][nhs.scot](mailto:[REDACTED]@nhs.scot)>

Subject: RE: GP Walk-in centres- Commission update

Hi

I think our initial overview still stands, though I do think it would be helpful to caveat some flexibility is required as the WICs are a new venture for all.

Thanks

[REDACTED]

[REDACTED]

[REDACTED]

Healthcare Improvement Scotland

[REDACTED]

From: [REDACTED] (NHS Healthcare Improvement Scotland) <[REDACTED]@nhs.scot>
Sent: 31 March 2026 09:59
To: [REDACTED] (NHS Healthcare Improvement Scotland)
<[REDACTED]@nhs.scot>; [REDACTED] (NHS Healthcare Improvement Scotland) <[REDACTED]@nhs.scot>; [REDACTED] (NHS Healthcare Improvement Scotland) <[REDACTED]@nhs.scot>; [REDACTED] (NHS Healthcare Improvement Scotland) <[REDACTED]@nhs.scot>
Subject: RE: GP Walk-in centres- Commission update

Morning

Just to let you know we are working on an update to the evidence section and hope to have it ready to share today/tomorrow. Is anyone else doing an update?

[REDACTED]

From: [REDACTED]@gov.scot <[REDACTED]@gov.scot>
Sent: 30 March 2026 14:34
To: [REDACTED] (NHS Healthcare Improvement Scotland)
[REDACTED]@nhs.scot; [REDACTED] (NHS Healthcare Improvement Scotland)
<[REDACTED]@nhs.scot>; [REDACTED] (NHS Healthcare Improvement Scotland)
<[REDACTED]@nhs.scot>; [REDACTED] (NHS Healthcare Improvement Scotland)
<[REDACTED]@nhs.scot>; [REDACTED] (NHS Healthcare Improvement Scotland)
[REDACTED]@nhs.scot; [REDACTED] (NHS Healthcare Improvement Scotland)
<[REDACTED]@nhs.scot>; [REDACTED] (NHS Healthcare Improvement Scotland)
<[REDACTED]@nhs.scot>; [REDACTED] (NHS Healthcare Improvement Scotland)
<[REDACTED]@nhs.scot>; [REDACTED] (NHS Healthcare Improvement Scotland)
<[REDACTED]@nhs.scot>; [REDACTED] <[REDACTED]@nhs.scot>
Cc: Rosie Walters [REDACTED]@gov.scot; [REDACTED]
<[REDACTED]@gov.scot>; [REDACTED] <[REDACTED]@nhs.scot>; [REDACTED]
<[REDACTED]@gov.scot>; [REDACTED] <[REDACTED]@gov.scot>; [REDACTED]
<[REDACTED]@phs.scot>; [REDACTED] <[REDACTED]@phs.scot>; [REDACTED]
<[REDACTED]@phs.scot>; [REDACTED] <[REDACTED]@phs.scot>; [REDACTED]
(NHS Healthcare Improvement Scotland) <[REDACTED]@nhs.scot>
Subject: GP Walk-in centres- Commission update

Good afternoon colleagues,

I hope all is well.

Further to the commission which was sent on 27th February, we are hoping you can provide an update on your proposal. We had a productive meeting with PHS colleagues last week and, given the significant interest from stakeholders, we are keen to move forward in developing the national monitoring and evaluation framework.

If there is anything you need to discuss please let me know if it would be easier to arrange a meeting.

Many thanks,

[REDACTED] | General Practice Policy Division | Primary Care
Directorate | Scottish Government | St Andrews House |



abcd

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From: [REDACTED] (NHS Healthcare Improvement Scotland)
To: [REDACTED] (NHS Healthcare Improvement Scotland); [REDACTED] (NHS Healthcare Improvement Scotland); [REDACTED] (NHS Healthcare Improvement Scotland); [REDACTED] (NHS Healthcare Improvement Scotland); [REDACTED] (NHS Healthcare Improvement Scotland)
Cc: [REDACTED] (NHS Healthcare Improvement Scotland); [REDACTED] (NHS Healthcare Improvement Scotland); [REDACTED] (NHS Healthcare Improvement Scotland)
Subject: RE: GP WiC commission update
Date: 20 April 2026 09:02:10
Attachments:
Importance: High

Hi

I attach the paper for the board. Let me know if I am to submit to Board Admin.

Thanks

[REDACTED]

[REDACTED]

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m: [REDACTED]
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From: [REDACTED] (NHS Healthcare Improvement Scotland) <[REDACTED]@nhs.scot>
Sent: 16 April 2026 16:38
To: [REDACTED] (NHS Healthcare Improvement Scotland)
<[REDACTED]@nhs.scot>; [REDACTED] (NHS Healthcare Improvement Scotland) <[REDACTED]@nhs.scot>; [REDACTED] (NHS Healthcare

Improvement Scotland) <[REDACTED]@nhs.scot>; [REDACTED] (NHS Healthcare Improvement Scotland) <[REDACTED]@nhs.scot>; [REDACTED] <[REDACTED]@nhs.scot>; [REDACTED] (NHS Healthcare Improvement Scotland) <[REDACTED]@nhs.scot>

Cc: [REDACTED] (NHS Healthcare Improvement Scotland) <[REDACTED]@nhs.scot>; [REDACTED] (NHS Healthcare Improvement Scotland) <[REDACTED]@nhs.scot>; [REDACTED] (NHS Healthcare Improvement Scotland) <[REDACTED]@nhs.scot>

Subject: RE: GP WiC commission update

Importance: High

Hi [REDACTED]

Given the scale of the commission, [REDACTED] has asked for the updated paper to be turned into a formal board approval paper. He's going to check in with [REDACTED] but he'd like to circulate it ahead of the board development day next week on the 22nd.

Appreciate this is a very tight turnaround time but expect it's just formatting changes that are required. Thank you.

[REDACTED]

From: [REDACTED] (NHS Healthcare Improvement Scotland) <[REDACTED]@nhs.scot>

Sent: 16 April 2026 13:44

To: [REDACTED] (NHS Healthcare Improvement Scotland) <[REDACTED]@nhs.scot>; [REDACTED] (NHS Healthcare Improvement Scotland) <[REDACTED]@nhs.scot>; [REDACTED] (NHS Healthcare Improvement Scotland) <[REDACTED]@nhs.scot>; [REDACTED] (NHS Healthcare Improvement Scotland) <[REDACTED]@nhs.scot>; [REDACTED] (NHS Healthcare Improvement Scotland) <[REDACTED]@nhs.scot>; [REDACTED] <[REDACTED]@nhs.scot>

Cc: [REDACTED] (NHS Healthcare Improvement Scotland) <[REDACTED]@nhs.scot>; [REDACTED] (NHS Healthcare Improvement Scotland) <[REDACTED]@nhs.scot>

Subject: RE: GP WiC commission update

Hi [REDACTED]

Thanks very much, and yes good meeting with SG colleagues on Tuesday. Great to see the letter come in so quickly.

Keen to join the f2f meeting to contribute to the scope and responsibilities discussion – certainly someone from Evidence will be at this meeting. Please can you keep us posted / discuss further developments on likely day/time?

For the Adastra demonstration, it's important that [REDACTED] and/or [REDACTED] is at that meeting.

MoU-wise, I have a preference to instead focus on our commissioning/ET paper and the deliverables set out in that paper. That said, I recognise that further work is required to agree/coordinate specific activities. For example, as we develop our evaluation framework we'll have to be much clearer about what we're collecting, who is collecting it, reporting etc. Perhaps one for discussion at the internal follow-up? Also, is the updated (and now agreed) commissioning proposal going back to ET even for awareness?

Thanks again

■

From: ■ (NHS Healthcare Improvement Scotland)
<■@nhs.scot>
Sent: 15 April 2026 08:49
To: ■ (NHS Healthcare Improvement Scotland)
<■@nhs.scot>; ■ (NHS Healthcare Improvement Scotland)
<■@nhs.scot>; ■ (NHS Healthcare Improvement Scotland)
<■@nhs.scot>; ■ (NHS Healthcare Improvement Scotland)
<■@nhs.scot>; ■ (NHS Healthcare Improvement Scotland)
■@nhs.scot>
Cc: ■ (NHS Healthcare Improvement Scotland)
<■@nhs.scot>; ■ (NHS Healthcare Improvement Scotland) <■@nhs.scot>
Subject: GP WiC commission update

Hi

■ met with SG yesterday to discuss the proposal. There are further discussions to be had around the evaluation and clarity on what PHS can provide in terms of data versus what may be manual collection, which is most likely to be improvement and implementation data. SG will send us a funding letter/letter of comfort up to £1.07m over 2 years and we should receive that this week to allow for recruitment to commence.

We have agreed to come together f2f in the Gyle in a couple of weeks, likely 30 April or 7 May to work through in detail the scope and responsibilities between HIS/PHS/SG and should be able to agree the governance structure once Parliament resumes following the pre-election period. Advice has been sent to Ministers by the policy team.

Following this, I wonder if we enter in to some form of MOU in relation to this work given the risks of scope creep and the likely continued interest in such a significant investment.

■ mentioned briefly the suggestion that Ministers may want as many as 30 sites and of course we have costed support based on the currently proposed 16 so it will be important

to have this clearly recorded.

SG are going to try to set up an ADastra demonstration so that we can see what data is going to be collected and we will try and do this either before the proposed session as above or on that day.

I will arrange a follow up internally for us to discuss next steps around mobilising the various element of the work.

Thanks

[REDACTED]

[REDACTED]

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E: [REDACTED]@gov.scot

To: NHS Territorial Board Chief Executives

Copy: NHS National Board Chief Executives

Via email

Date: Monday 17 November 2025

Call for Proposals - Walk-In Services Pilots

Dear Colleagues

On 12 October, the First Minister announced plans to pilot a new network of walk-in GP services, open seven days a week, providing easier access for people to see a clinician without the need for an appointment. This has since been publicly confirmed as Scottish Government policy, reaffirming that improving access to primary care and shifting more care into community settings are key priorities for this Government.

Following this clear ministerial commitment, I am writing to you to set out how this policy will now be taken forward. The Scottish Government is requesting every NHS Board area to submit costed proposals to pilot these walk-in services in their areas. Pilots should be operational by March 2026, with evaluation continuing through 2026–27.

Further details on objectives, eligibility, and assessment criteria are set out in the attached Call for Proposals. Submissions should be no more than six pages per site or model, signed by you and the relevant HSCP Chief Officer, and returned to [REDACTED]@gov.scot by 28 November 2025 close of business.

Queries ahead of submission can be directed to [REDACTED], General Practice Policy Division [REDACTED]@gov.scot).

Thank you for your leadership and collaboration as we take forward this new area of government policy to strengthen access to primary care across Scotland.

Yours sincerely

[REDACTED]

Caroline Lamb
Chief Executive of NHS Scotland and Director General for Health & Social Care

Annex A

Call for Proposals

Purpose

The Scottish Government requests costed proposals from all NHS Boards to pilot at least one primary care 'walk-in' service in their area. This will inform the selection and development of a series of pilots to be operational by March 2026, followed by wider rollout in 2026-27, with all pilots expected to operate until the end of 2026/27 for workforce planning and evaluation purposes.

All proposals will be assessed by representatives of Scottish Ministers in line with the Scottish Public Finance Manual. Scottish Ministers will make a final decision on proposals having regard to advice from DG Health and Social Care as Accountable Officer for the Health and Social Care Portfolio.

Objectives

The First Minister announced plans to establish a new nationwide network of walk-in services, open seven days a week, providing easier access for people to see a clinician without the need for a prior appointment.

The pilots will test and evaluate:

- The feasibility and sustainability of the walk-in model;
- Impact on access, patient experience, and system performance, including demonstrable contribution to reducing waiting times and alleviating pressure across the wider health and social care system;
- Specifically, alignment with and effect on emergency departments, in-hours general practice, wider primary care services and out of hours services, particularly in terms of sustainability, patient flow, relative value for money and opportunity cost;
- Impact on and evidence regarding continuity of care (e.g. communication with usual provider of care), clinical safety, access and health inequalities (including public sector equalities duties);
- Cost-effectiveness and resource requirements for potential future expansion.

Key Characteristics

Proposals must reflect the principles of the Service Renewal Framework, ensuring that walk-in services strengthen multidisciplinary primary and community care, support early intervention, and operate as an integral part of local urgent and unscheduled care pathways.

Each proposal should demonstrate the following characteristics:

- a) Operate seven days a week, Monday to Sunday, from 12:00 to 20:00, or during alternative hours that provide equivalent extended access;
- b) Ability to 'walk-in' throughout that period;
- c) Offer urgent care primary care services in line with presentations to GP Out of Hours services. The focus will be on same-day assessment and minor illness treatment for

conditions that do not require emergency care, specialist care, or longer term, complex management;

- d) Key audience is those having issues accessing their in-hours GP for urgent care;
- e) Complement existing local service provision;
- f) Access to at least the emergency care summary and communicate actions to the usual provider of care;
- g) Preferably hosted within an existing NHS Board or GP estate to minimise setup time and cost;
- h) Location convenient for patient 'walk-ins' (e.g. good accessibility, areas of high footfall);
- i) Analysis of system flow, risk, benefit and patient experience and wider evaluation capacity built-in from outset;
- j) Where locally deliverable in terms of cost, workforce and premises and aligned with existing diagnostic strategies, Boards may propose the inclusion of community diagnostic capacity within pilot sites.

Note Boards should work collaboratively with their local independent contractors and/or localities in developing proposals. This could include proposals (where appropriate and in line with all necessary contracting arrangements) which are delivered by practices or groups of practices in partnership with the Board.

Note that proposals may either provide open access for any patient regardless of whether / where they are registered or be limited to specific localities or catchments. Boards may make proposals covering multiple sites and models.

Eligibility and Selection Criteria

Proposals are invited from NHS Board Areas that demonstrate:

Criterion	Description
Readiness	Commitment and capacity to deliver a pilot site operational by March 2026.
Workforce feasibility	Access to, or ability to recruit, staff for extended hours operation without adversely affecting existing service provision.
Anticipated Benefit to Patients	Clear articulation of how the proposal will improve patient access, experience, or outcomes beyond existing provision and reduce healthcare inequalities. Submissions should set out how the service provides additional value beyond existing provision and avoids duplication or displacement of current capacity.

Estate suitability	Availability of suitable premises requiring minimal adaptation to enable rapid mobilisation.
Integration and coherence	Strong existing links across general practice, Out-of-Hours, NHS 24, and Flow Navigation Centre pathways
Governance	Clear local governance arrangements and senior clinical leadership for oversight.
Evaluation capacity	Ability, within a national framework, to collect and share KPIs and other evidence on activity, outcomes, and costs – both for the pilot site and related services which may be impacted. Evaluation is expected to start at the time of mobilisation throughout 2026/27
Funding estimate	Clear indication of minimum viable funding arrangements required to deliver the pilot successfully, including set-up and running costs
Commitment to collaboration	Willingness to work closely with national boards and professional bodies to shape national learning.

Boards should submit a proposal of no more than six pages per model/site, signed off by the Chief Executive of the NHS Board and Chief Officer of the relevant HSCP area.

Each area will be assessed against these criteria, which will inform recommendations to Ministers alongside qualitative comments on readiness, impact, and equity considerations.

Additional context on population, geography, and wider applicability may be considered but will not be assessed directly.

Selection and Governance

Proposals will be reviewed by a Recommendation Panel comprising officials from across the Directorate-General for Health and Social Care and independent external representatives. The proposals will be assessed in line with the principles set out in the [Scottish Public Finance Manual - gov.scot](#). Successful proposals will ultimately be authorised by the Cabinet Secretary for Health and Social Care.

A National Governance Board will be set up to oversee and support the overall delivery of the pilot sites. Healthcare Improvement Scotland will provide national improvement support and work with Boards to ensure consistent data collection and local evaluation across all pilot sites. The terms of reference and membership, including linkage to ongoing evaluation will be drafted and shared in due course.

Next Steps

Proposals should be submitted electronically to: [REDACTED]@gov.scot by 28 November 2025 close of business.

Queries in advance of submission can be directed to the General Practice Policy Division, Primary Care Directorate, Scottish Government to [REDACTED]@gov.scot .

Request for Monitoring and Evaluation Framework Commission: GP Walk-In Services

This paper requests an urgent formal commissioning for a full monitoring and evaluation framework, led by Healthcare Improvement Scotland **and** PHS, enabled by health boards, bringing in other stakeholders as needed, for the GP-led walk-in service pilot.

The genesis of the policy was set out by ministers at the [SNP conference](#), and was adopted by the Scottish Government as policy in October 2025. Policy objectives, defined by ministers, are to:

Reduce barriers to accessing primary care without an appointment “reduce the 8am rush”	Reducing wider system pressures “reducing inappropriate attendances at ED”
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Running through all the above noted objectives, and the letter set out to boards, is the Scottish Government’s commitment to combat health inequalities, and any evaluation should seek to assess any impact on those.

The pilot key aims and objectives were set out via the letter issued to boards by Caroline Lamb on the 17th November [[Call for Proposals - Walk In Services - 17 Nov 25 .pdf](#)] Following an expert panel and ministerial approval, 13 sites across 11 boards were selected for phase 1 mobilisation. These will be operational by late summer. With the exception of Lochee GP practice, which is testing the model in a practice, all of these sites are using AdAstra to record data, which should be factored into the evaluation proposal. Three boards have been asked to explore plans for sites using shopfront or former retail premises, and subject to commercial and clinical processes, will be operational later in the year.

The evaluation and monitoring framework should analyse activity delivered by the phase one pilot sites, through a healthcare improvement and data led approach as well as any subsequent impacts on the wider healthcare system.

The proposal should set out deliverables including but not limited to:

- An evidence review, using examples and data from similar models of care worldwide
- Quantify system wide effects on GP, ED, OOH, Pharmacy First and community services
- Ability to collect, review, and publish data from the pilot sites on a no less frequent than monthly basis, alongside existing data streams. We would expect the relevant data agreements to be managed through the framework
- Ongoing analysis and QI work to support pilot sites, including demand and flow

- Test whether the model delivers against the key objectives and aims set out in the letter on 17 November, and Ministerial ambitions.
- Assess patient experience, flow, equity, and clinical safety
- Understand workforce feasibility and value for money
- Provide evidence to inform the potential for national scaling and long term investment decisions

This framework will also support transparent reporting to Ministers and governance structures and guide refinement of operational models.

The Framework should be backdated to include data from the service launch and run throughout initial operation, with interim reporting to the Programme Board and a final summative report to inform future policy decisions.

E: [REDACTED]@gov.scot

To: Robbie Pearson – Chief Executive –
Healthcare Improvement Scotland

CC: Christine McLaughlin- Chief Operating Officer
and Deputy Chief Executive- NHS Scotland
Tim McDonnell- Director of Primary Care and
Policy Sponsor

Date: 15 April 2026

GP Walk-in Services Pilot Programme

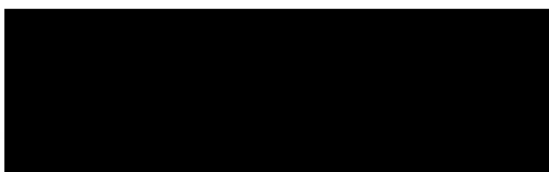
Dear Robbie,

1. Thank you for your proposal in response to the Scottish Government's commission request for a Monitoring and Evaluation Framework for the General Practice Walk-In Services Pilot Programme.
2. I am writing to formally confirm that the Scottish Government will fully fund your proposal for the Monitoring and Evaluation Framework.

Financial Management

3. A non-recurring allocation will be provided in 2026-27 as detailed in Annex A to support your participation in the pilot.
4. As this is a novel pilot programme, funding will be released in tranches during 2026-27 to support appropriate financial control, assurance and effective cash management.
5. We look forward to working with you and taking forward this programme of work which is critical to ensuring our continued focus on improving access to primary care and shifting more care into community settings.

If you have any further queries at this stage, please contact [REDACTED]@gov.scot.



Dr [REDACTED]
Deputy Director, General Practice Policy
Primary Care Directorate

ANNEX A – Allocation

Funding for national Monitoring and Evaluation Framework for GP walk-in pilot.

	2026-27 Funding (£)
Healthcare Improvement Scotland	Up to £1,063,042