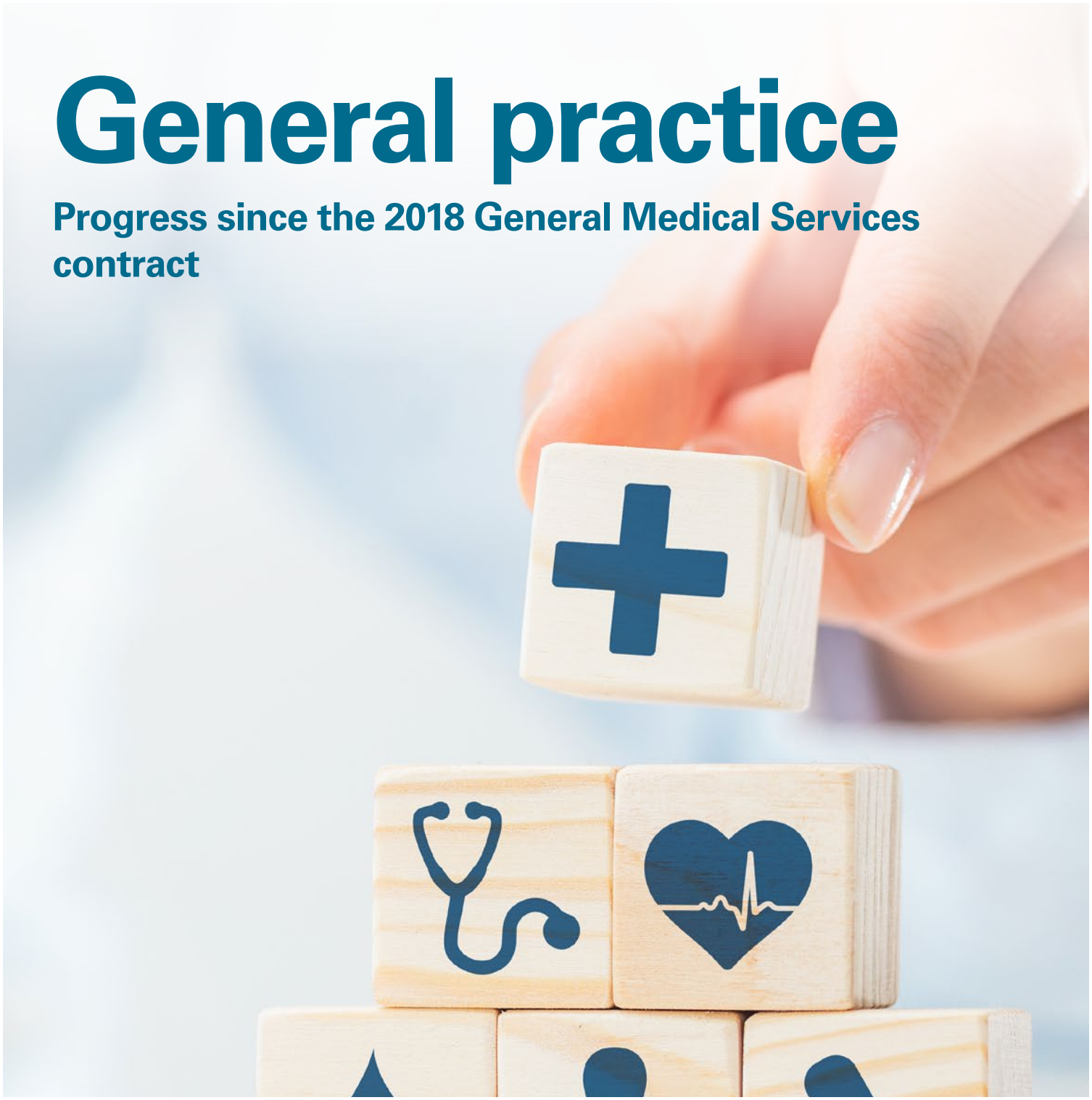
# General practice

## Progress since the 2018 General Medical Services contract



AUDITOR GENERAL

**Prepared by Audit Scotland**
March 2025

# Contents



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## Audit team

The core audit team consisted of: Leigh Johnston, Eva Thomas-Tudo, Fiona Lees, Naomi Ness and Chris Dorrian, under the direction of Carol Calder.

# Key facts

| | |
|---|---|
| **4,525** | GP headcount, excluding specialty trainees, in September 2024 |
| **3,453** | Estimated whole-time equivalent GPs, excluding specialty trainees, in March 2024 |
| **4,925** | Whole-time equivalent multidisciplinary team workforce, working in six priority services, in March 2024 |
| **6.5%** | Proportion of NHS spending directly on general practices in 2023/24 |
| **£1.09bn** | Spending directly on general practices in 2023/24 |
| **£194m** | Primary Care Improvement Fund spending in 2023/24 |
| **69%** | People rating the care at their general practice as excellent or good in 2023/24 |

# Key messages

1 General practice plays a critical role in Scotland's ambition to improve the population's health and keep people at home and out of hospitals. However, the pressure on general practice is increasing because of a growing and ageing population, enduring and widening health inequalities, and longer waits for hospital care. Compared to 2017, there are also fewer whole-time equivalent GPs, and the Scottish Government's commitment to increase the number of GPs by 800 is unlikely to be met by 2027.

2 There is uncertainty about the strategic direction of general practice. The 2018 General Medical Services (GMS) contract aimed to improve the sustainability of general practice and access to care. However, several commitments that were intended to be completed by 2021 have still not been fully implemented. The expansion of wider primary care teams to support general practice, to include more nurses, pharmacists, physiotherapists and other specialists, has been slower than planned. And people report finding it more difficult to access care. The Scottish Government has not been transparent enough about the progress made since 2018, and has not set out whether, or when, it will implement the outstanding GMS contract commitments.

3 The Scottish Government has committed to prioritising primary care but there is a lack of clarity about investment in general practice in the medium term. In 2023/24, the Scottish Government spent £1.09 billion on general practices. However, direct spending on general practice as a proportion of overall NHS spending decreased from seven per cent to 6.5 per cent between 2017/18

and 2023/24. Direct spending on general practice has also started to decrease in real terms, and between 2021/22 and 2023/24 it fell by six per cent, exacerbating pressures on practices.

**4** The data that the Scottish Government needs to make informed decisions on general practice planning and investment is inadequate. This is a long-standing issue. There remains a lack of robust information about general practice demand, workload, workforce and quality of care. This limits the Scottish Government's ability to know whether the changes introduced by the 2018 GMS contract represent value for money or have improved patient care. The Scottish Government is taking steps to improve the availability and quality of data from general practice. But longer-term work will be required to improve the consistency of data recording to support evidence-based national planning.

# Recommendations

## The Scottish Government should:

- As part of its work on a refreshed vision for primary care, publish a clear delivery plan for general practice by the end of 2025 that includes specific actions, timescales and costs. This should clarify whether and when it will implement the outstanding commitments from the 2018 General Medical Services contract, and include:
  - how it will work with Health and Social Care Partnerships (HSCPs) and the Scottish GP Committee to improve the way that general practice teams and multidisciplinary teams work together to provide services. This should focus on improving communication, collaboration, data sharing and clarity about responsibilities across the primary care workforce (paragraph 65)
  - a medium-term funding trajectory for general practice to provide certainty and enable better-informed financial and workforce planning (paragraph 44)
  - identifying appropriate financial and administrative support for GP clusters, and clear priorities for improvement (paragraph 71)
  - how it intends to better support general practices to contribute to tackling health inequalities (paragraph 77)
  - robust governance arrangements for how the Scottish Government will monitor, evaluate and publish progress, identifying what data is needed and how data will be obtained and validated (paragraph 42).
- Over the next six months, carry out scenario planning, based on interim findings of the phased investment programme to inform its response to this programme of work (paragraph 39).
- Within one year, work with Public Health Scotland and HSCPs to publish total spending across Scotland on the six priority services in their public financial reporting (paragraph 34).
- Within one year, work with HSCPs, GP leads and the General Practice Managers Network to develop a communications plan to increase public understanding of how and why general practice is changing. This should include targeted

national and local elements and align with the refreshed vision for primary care (paragraph 58).

- Within one year, set out its plans, including how progress will be monitored, for moving towards a model where GPs will no longer be expected to provide their own premises as part of its new approach to infrastructure planning and investment across NHS Scotland (paragraphs 102, 105 and 106).

# Introduction

## Background

**1.** Effective general practice is critical to the performance and sustainability of the health service, and in Scotland's ambition to improve the population's health and reduce health inequalities. A key strength of general practice is its unique position to focus on holistic care that considers the whole person rather than specific conditions. Anybody in Scotland can access general practice services without charge.

**2.** General practices are the main point of contact for people seeking general healthcare services in Scotland. General Practitioners (GPs) and wider primary care teams diagnose and treat common medical conditions, prevent illnesses and promote good health, and refer patients to specialist services where necessary. They also manage complex care in the community, preventing unnecessary admissions to hospital (Exhibit 1, page 9). This makes an effective general practice good value for money.

**3.** There are currently around 890 general practices across Scotland.[1] Most of these are run by GP partners as independent contractors, meaning they are private businesses that have contracts with the NHS, rather than employed by the NHS. General practices also employ staff such as salaried GPs, general practice nurses, practice managers and receptionists.

**4.** The Scottish Government and the Scottish GP Committee (SGPC) of the British Medical Association (BMA) negotiated and agreed the 2018 General Medical Services (GMS) contract.[2] This was the first time that a Scotland-specific contract had been negotiated, with previous arrangements agreed on a UK-wide basis. The 2018 contract set out system-wide changes that aimed to address challenges with recruiting and retaining GPs, alongside reported increases in demand for services and increasing complexity of care needs.

**5.** The contract was supported by an agreement between Integration Authorities, the SGPC, NHS boards and the Scottish Government, about how they would work together to deliver the wider support required by the contract.[3] The main ambitions from the 2018 GMS contract and the main ways the Scottish Government intended to achieve them are set out in Exhibit 2 (page 10). The Scottish Government planned to implement the new contract by 2021.

# Exhibit 1.

## Examples of primary care services in Scotland

This report focuses on general practice and multidisciplinary teams.

### Primary care

Usually the first point of contact for people seeking healthcare. Examples include:

**Within the scope of this report**

- **General practice:**

Provides advice and treatment for medical conditions, manages complex care in the community, and refers to other health and social care services when needed. Practices are staffed by a range of professionals, such as GPs, nurses, healthcare assistants, practice managers and receptionists.

- **Multidisciplinary teams (MDTs):**

Health and care staff across a range of professions, such as nurses, pharmacists and physiotherapists. They are mostly employed by NHS boards rather than general practices and are usually based in general practice, a central hub or both, and work across six priority services:

  - Vaccination Transformation Programme (VTP): includes most vaccination programmes.
  - Pharmacotherapy: providing pharmacy and prescribing support for general practices.
  - Community Treatment and Care (CTAC) services: a range of services such as wound care, phlebotomy and chronic disease monitoring.
  - Urgent care: mostly advanced nurse practitioners and paramedics focusing on urgent and unscheduled care.
  - Additional professional roles: a range of services including mental health services, physiotherapy and occupational therapy.
  - Community link workers: provide non-medical support for personal, social, emotional and financial issues.

**Examples not within the scope of this report include:**

- GP out-of-hours services
- Dentistry and oral health
- Eyecare
- Community pharmacy

Source: Audit Scotland

# Exhibit 2.

## The Scottish Government's ambitions from the 2018 GMS contract and how it intends to achieve them

| 2018 GMS contract ambitions | Key Scottish Government commitments that support the contract ambitions |
|---|---|
| **Improve access to care and free up GPs' time to lead multidisciplinary teams (MDTs), focus on patients with complex care needs and improve the quality of care provided** | • Rolling out MDTs across six priority services (paragraphs 16–22).<br>• Transferring the responsibility from GPs to NHS boards for providing vaccinations from October 2021, pharmacotherapy and Community Treatment and Care (CTAC) services from April 2022, and urgent care by 2023/24 (paragraph 23).<br>• Increasing the number of GPs by 800 between 2017 and 2027 (paragraph 78).<br>• Establishing GP clusters to focus on quality improvement (paragraphs 67–71).<br>• Changing the roles of general practice nurses, practice managers and receptionists (paragraphs 88–94). |
| **Changing the way general practices are funded to improve financial stability and sustainability** | • A new practice funding formula to better reflect practice workloads associated with older or more deprived populations (paragraph 95).<br>• Minimum earnings for GP partners and a practice income guarantee (Exhibit 7, page 38).<br>• By 2021, an income range and pay progression for GPs comparable with hospital consultants, and directly reimbursing staff and practice expenses (Exhibit 7, page 38). |
| **Moving towards a model where GPs will not be expected to provide their own premises** | • Interest-free sustainability loans for GPs who own their own premises (paragraph 99).<br>• NHS boards to take on the responsibility for leases with private landlords (paragraph 99). |
| **Improving GP IT systems and information-sharing agreements** | • New GP clinical IT systems to be in place by 2020 (paragraph 50).<br>• New information-sharing agreements that recognise GPs as joint data controllers with NHS boards (paragraph 51). |

Source: Audit Scotland and Scottish Government

**6.** In 2021, the Scottish Government and partners recognised that the commitments in the 2018 GMS contract that were originally intended to be delivered by April 2021 had not been fully implemented.[4] They acknowledged the impact of the Covid-19 pandemic on progress and set priorities and a new deadline of April 2023.

## About this audit

**7.** This performance audit aims to consider the performance of general practice since the 2018 GMS contract was introduced. To do this, it aims to answer the following questions:

- How are general medical services in Scotland provided and funded?
- What progress has been made in improving patient care since the 2018 GMS contract?
- What progress has been made in improving workforce challenges and financial pressures since the 2018 GMS contract?

**8.** This audit looked mainly at national progress with implementing the aims of the 2018 GMS contract. It did not cover the rationale for the 2018 GMS contract. The audit focused on services provided by general practice teams and wider multidisciplinary teams outlined in Exhibit 1. It did not cover other primary care services such as dentistry and optometry, or other community care staff groups such as district nurses.

**9.** Our findings are based on evidence from sources including:

- interviews with the Scottish Government, national NHS boards, other public sector and third sector organisations, the SGPC of the BMA, the Royal College of GPs (RCGP) Scotland, and other GPs
- review of documentation from the Scottish Government, national NHS boards, other public sector and third sector organisations, and academic research
- focus groups with community link workers
- analysis of data from audited NHS accounts, Public Health Scotland (PHS), NHS Education for Scotland (NES), and the Scottish Government.

**10.** We refer to real-terms changes in this report. This means that we are showing financial information from previous years at 2023/24 prices, adjusted for inflation. We use gross domestic product (GDP) deflators to adjust for inflation, which are published quarterly by HM Treasury. GDP deflators are the standard approach adopted by the Scottish Government when analysing public spending. The Covid-19 pandemic resulted in volatility across 2020/21 and 2021/22. To compensate for this, and to provide meaningful comparisons between years, we have used an average GDP growth rate across 2020/21 and 2021/22 in our calculations.

# 1. Service provision and funding

## Pressure on general practice has increased

**11.** Unlike secondary care, where waiting lists and times are regularly monitored, it is not easy to define or measure demand for services provided by general practice. There are, however, proxy measures that clearly indicate that pressure on general practice has increased. These include a growing and ageing population,[5] more people with one or more health conditions,[6] an increased impact of disease on the population,[7] and enduring and widening health inequalities (Exhibit 3, page 13).[8]

**12.** Waiting lists for diagnostic tests, appointments and treatments in secondary care are substantially larger, and waiting times considerably longer, than before the Covid-19 pandemic.[9] This is increasing pressure in general practices as GPs report having to provide additional support and care while patients wait for an appointment or treatment.[10]

**13.** The number of patients registered with a general practice in Scotland has also grown, but at a faster rate than the Scottish population.[11] The gap between the number of patients registered and the population is not new, but the gap has increased. In 2013, there were around 230,000 more patients registered with a general practice than were estimated to live in Scotland; by 2023 the gap had increased to around 450,000. The reasons for this are not currently fully understood but may be related to the transient student population. The Scottish Government has convened a short-life working group (SLWG) to look into the issue; this work is expected to be completed by summer 2025.

**14.** Despite growing demand for general practice, the estimated number of whole-time equivalent (WTE) GPs has decreased, increasing pressure further (paragraph 80).[12] This means that on average, each GP has a larger population to care for, so there is less GP time available for each patient. There were around 1,620 patients per WTE GP in August 2017; by March 2024 this had increased to 1,735 patients per WTE GP.

**15.** The number of patients per WTE GP varies widely across Scotland, from 721 in NHS Orkney to 2,373 in NHS Lanarkshire. Fewer patients per GP can indicate better access, but different areas have different needs based on geography and the demographics of the population, so some variation is to be expected.

# Exhibit 3.

## Indicators of increased pressure on general practice

Proxy measures clearly indicate that pressure on general practice has increased and may continue to increase.

| Indicator of increased demand | |
|---|---|
| **Growing population** | • 2013–23: Scottish population increased by 3.3% (+173,300 people). |
| **Ageing population** | • 2013–23: proportion of people in Scotland aged 65 and over increased from 17.8% (947,400 people) to 20.3% (1,116,400 people). |
| **More people with long-term health conditions and mental health issues** | • 2011–22: proportion of people reporting a long-term illness, disease or condition increased from 18.7% (988,400 people) to 21.4% (1,163,500 people).<br>• 2011–22: proportion of people reporting a mental health condition increased from 4.4% (232,900 people) to 11.3% (617,100 people). |
| **Increased impact of disease on the population** | • Annual disease burden forecast to increase by 21% by 2043, with two-thirds of the increase due to cardiovascular disease, cancers and neurological conditions. Many of these conditions are preventable. |
| **Enduring and widening health inequalities** | • Between 2019 and 2021, people living in the most deprived areas spent more than a third of their life in poor health. In the least deprived areas people spent around 15% of their life in poor health. |
| **Longer waiting times for secondary care** | • September 2024: 38,370 ongoing waits for inpatient or day case treatment, where patient had been waiting more than a year. Before Covid-19 (September 2019) there were around 1,640. |

Note: Long-term illness, disease or condition includes a range of conditions such as arthritis, cancer, diabetes and epilepsy.

Source: Audit Scotland, National Records of Scotland and Public Health Scotland

## The way general medical services are provided has changed substantially but the expansion of MDTs has been slower than planned

**16.** The 2018 GMS contract introduced substantial changes to the way primary care is provided by GPs and wider teams. A key commitment was expanding **multidisciplinary teams (MDTs)** across six priority services to improve access to care and reduce GP workloads, enabling GPs to focus on complex patients and quality improvement (Exhibit 1, page 9). These services are:

- Pharmacotherapy
- The Vaccination Transformation Programme (VTP)
- Community Treatment and Care (CTAC)
- Urgent care
- Additional professional roles
- Community link workers.

**17.** At March 2024, more than 4,900 WTE staff were working in the six priority services.[13] Of these, just over 3,500 WTE were additional staff recruited specifically to expand MDTs in line with the aims of the 2018 GMS contract. This significant expansion in the primary care workforce shows progress, but the Scottish Government aimed to complete the roll-out by 2021, and then by 2023. It has not met these deadlines and implementation gaps remain.

**18.** In 2021, the Scottish Government, BMA, Integration Authorities and NHS boards announced that, while all six services remained areas of focus, they would prioritise three of the six services for 2021/22 – pharmacotherapy, the VTP and CTAC services.[14] Despite this, in 2023 the Scottish Government's analysis of Health and Social Care Partnerships (HSCPs) information submissions found that many HSCPs estimated that they had less than half the staff required for full implementation.

**19.** The Scottish Government's analysis also estimated a substantial shortfall of around £125 million in the funding required to fully implement these three priority services and maintain current levels of spending on the other three. This is likely to be underestimated, as it does not include non-staff costs, such as additional premises or IT equipment. It also does not include additional spending needed to fully implement the three remaining services.

**20.** The Scottish Government identified that HSCPs' submissions on the costs and workforce needed to fully implement services varied substantially. It found that HSCPs stating that they had fully implemented services reported a much lower WTE staff requirement per weighted population than other areas. This may indicate that these areas had not actually reached full implementation, or some other areas were overestimating their staff requirements.

**Multidisciplinary teams (MDTs)**

MDTs are groups of healthcare staff in a range of professions such as nurses, pharmacists and physiotherapists, working in the six priority services. They are mostly employed by NHS boards rather than general practices.

**21.** The Scottish Government recognised that it needs better data to better understand the funding and workforce requirements for fully implementing the three priority services. It has commissioned Healthcare Improvement Scotland (HIS) to support a primary care phased investment programme (PCPIP), which aims to provide a better evidence base for future investment (paragraph 37).

**22.** While the Covid-19 pandemic affected progress, even before the pandemic HSCPs' submissions consistently reported that they were not likely to meet the original deadline of 2021. HSCPs have routinely highlighted the availability of funding and workforce as key constraints to progress, alongside other barriers such as a lack of space to accommodate additional staff and IT and connectivity problems. Remote and rural areas have also faced specific challenges (Case study 1).

## Case study 1.

### Flexible arrangements for remote and rural areas enables local decision-making about the most appropriate model for service provision

The Scottish Government has recognised that remote and rural areas can face specific challenges with expanding MDTs, such as less predictable demand for services, longer journey times and difficulties with recruitment. It has developed a process for HSCPs to consider whether some GPs should continue to provide certain services because of these challenges.

This process enables HSCPs to assess local population needs and different options for service provision, to determine the most appropriate model for providing services that are accessible and good value for money. If they determine that the best option is for some general practices to continue to provide some services, they can submit a proposal for consideration by the national GMS Oversight Group and Scottish ministers.

To date, the GMS Oversight Group has reviewed and approved three proposals. Twelve general practices in Argyll and Bute HSCP area have retained responsibility for providing vaccinations, or CTAC services, or both. One general practice in NHS Borders is continuing to provide vaccinations.

Highland HSCP in particular has faced challenges with providing vaccinations services. In January 2025, the Scottish Government accepted a proposal by Highland HSCP to implement a mixed model of vaccine provision. This means that NHS Highland will retain responsibility for providing some vaccine programmes, while some general practices will be commissioned to provide other vaccines services. The Scottish Government stated that these were exceptional circumstances and that this arrangement should not be viewed as a precedent for other services or other HSCPs or NHS boards.

Source: Scottish Government, GMS Oversight Group and NHS Highland

## The Scottish Government has not fully implemented its commitments to transfer services to NHS boards

**23.** The Scottish Government and BMA committed to transferring the responsibility for providing the six priority services from general practices to NHS boards.[15] However, this has only partly been completed and the Scottish Government has not set out when it will fully implement these commitments:

- The Scottish Government amended regulations to transfer the responsibility away from GPs and to NHS boards, for providing vaccinations from October 2021, and pharmacotherapy and CTAC services from April 2022.
- The Scottish Government has not transferred the responsibility for providing urgent care services, as it originally committed to doing by 2023/24.
- The Scottish Government acknowledged that further work was needed to establish the 'endpoint' for the additional professional roles and community link workers commitments.[16]

**24.** Regulations alone, however, do not clarify the level of service that general practices are entitled to receive. Service specifications are also needed to set out the detail of, for example, how many appointments will be available. Without this, the workload may still fall to general practices, even though the responsibility for providing these services has been transferred to NHS boards. For vaccinations, the Scottish Government issued specifications, detailing how general practices would be paid if they needed to continue providing vaccinations.[17] But for CTAC and pharmacotherapy, the Scottish Government has not set out service specifications because MDTs are not sufficiently established.

**25.** The Scottish Government committed to providing transitionary services or payments where practices and patients do not have sufficient access to MDTs after April 2022.[18] It issued payments of £15 million in 2021/22 and £10 million 2022/23 to cover both winter support funding and transitionary support. This was £5 million less than originally committed – the Scottish Government said this was because of the impact of the UK spending review in 2022.[19]

**26.** These payments were not targeted, meaning that all practices received payments, regardless of whether they had full access to MDTs, no access or were somewhere in between. Since 2022/23, the Scottish Government has not provided any transitionary support, despite ongoing gaps in the availability of MDTs to provide these services.

**27.** It has instead advised HSCPs and NHS boards to implement local arrangements where necessary. This enables local areas to target support more equitably but relies on funding from existing budgets. This means that if HSCPs have fully spent their allocations on MDTs,

they may not be able to provide any transitionary support, even if their general practices do not have sufficient access to MDTs. The Scottish Government does not routinely monitor the extent to which local arrangements are in place.

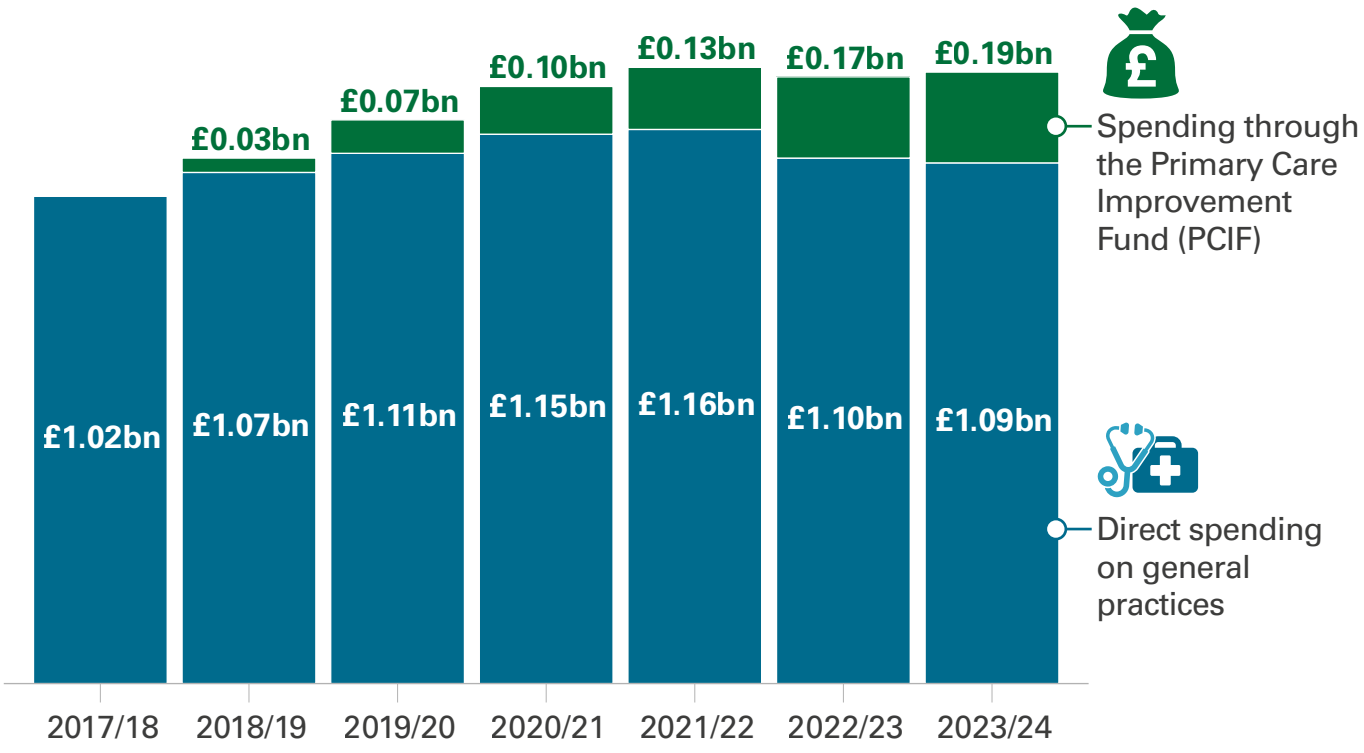
## Real-terms spending on general practice is starting to decrease at a time of increasing demand

**28.** In 2023/24, direct spending on general practices was £1.09 billion, a 33 per cent increase in cash terms since 2017/18.[20] The increase was just below seven per cent when taking inflation into account. Since 2021/22 however, real-terms spending has decreased by six per cent, at a time of increasing demand (Exhibit 4). Additionally, direct spending on general practices as a proportion of NHS spending decreased from seven per cent to 6.5 per cent between 2017/18 and 2023/24.[21]

# Exhibit 4.

## Real-terms spending directly on general practices and through the PCIF, 2017/18 – 2023/24

Real-terms direct spending on general practices is beginning to decrease, while the PCIF has increased.




Source: Audit Scotland, Public Health Scotland and Scottish Government

**29.** The Scottish Government has invested substantially in expanding MDTs across the six priority services through the Primary Care Improvement Fund (PCIF). By 2023/24, HSCPs reported that spending through the PCIF had increased to £194 million per year (Exhibit 4). When combined with direct spending on general practices, there has been no increase in real-terms spending since 2021/22.[22]

**30.** In November 2024, the Scottish Government announced an additional recurring £13.6 million in general practice funding from 2024/25, to help ease cost pressures.[23] It has also set aside £10.5 million in its 2025/26 budget to develop a targeted service within general practice for early intervention and prevention in areas such as frailty and cardiovascular disease.[24] However, the details of this service have still to be agreed with GPs.

## Scotland-wide spending on the six priority services is not transparent, making it difficult to assess total spending and value for money

**31.** The Scottish Government does not publish spending on the six priority services, which limits transparency and public scrutiny. Spending through the PCIF on these services is reported by HSCPs to the Scottish Government through regular trackers, but spending data is not included in the Scottish Government's published annual progress reports.

**32.** The trackers do not include spending on these services from other sources, so the Scottish Government has not assessed how much is being spent in total across Scotland. This could potentially be a considerable amount of additional spending. The Scottish Government's most recent annual progress report highlights that 3,540 WTE of the 4,925 WTE staff working across the six priority services at March 2024 were funded by the PCIF.[25] That means more than 1,300 WTE staff were funded through other sources.

**33.** The Scottish Government aims to better understand the impact of spending in some HSCPs through the PCPIP (paragraph 37). However, robust, comprehensive and public reporting on spending across Scotland on the six priority services is needed.

**34.** The Scottish Government should work with PHS and HSCPs to publish spending across Scotland on the six priority services in PHS' public financial reporting. This would help enable the Scottish Government and HSCPs to assess the full impact and value for money of MDTs and improve transparency and public scrutiny of this spending. It would also enable a better understanding of differences in spending in different geographical areas and if spending is targeted where it is most needed.

## Limited information about the impact of MDTs is a barrier to making well-informed decisions

**35.** While some local areas have carried out analysis of the impact of MDTs, robust, routinely available information across Scotland on the impact of the roll-out of MDTs is lacking. This means that:

- the Scottish Government has not been able to define what full implementation means, in terms of appropriate staffing numbers, skill mix, or how much additional funding is required
- the Scottish Government and partners have not been able to fully scrutinise the impact of the investment in MDTs on their key aims of improving patient care or reducing GPs' workloads, or whether it is providing good value for money.

**36.** The Scottish Government monitors progress through regular trackers submitted by HSCPs. These submissions provide some detail about progress, such as staff numbers and qualitative information on achievements and barriers to progress. The Scottish Government has also tried to collect data on capacity and activity. However, this relies upon the Scottish Government requesting, and HSCPs providing, meaningful information. The Scottish Government's own analysis shows that data availability and quality issues limit the conclusions that can be drawn from this information.

**37.** The Scottish Government recognises that it needs better data to understand the impact of MDTs across Scotland. It has commissioned the PCPIP to inform its longer-term investment in MDTs. The PCPIP consists of two main parts:

- providing additional funding and support across four sites in Scotland – Ayrshire and Arran, Borders, Edinburgh City and Shetland – to demonstrate what a model of full implementation of pharmacotherapy and CTAC could look like in practice, while maintaining delivery of the VTP
- providing primary care teams across Scotland with the option to participate in improvement work and share learning.

**38.** The PCPIP has the potential to provide a better evidence base for decision-making. It aims to evaluate the impact of MDT working, using qualitative and quantitative data. But there are significant risks to the success of this work:

- The Scottish Government has commissioned the PCPIP until the end of December 2025. This is a very short timescale for the four sites to fully recruit staff, gather evidence and demonstrate impact.
- If the findings show that substantial additional investment is necessary to fulfil the Scottish Government's commitments, this level of funding may not be available.

- The PCPIP is focusing on fully implementing pharmacotherapy, and CTAC, while maintaining the VTP, so it will not demonstrate the impact of fully implementing all six priority services.

**39.** The Scottish Government should carry out scenario planning, based on interim findings of the PCPIP to inform its response to this programme of work.

## The vision and strategic direction for general practice is not clear and the Scottish Government is working to refresh this

**40.** The Scottish Government's vision and strategic direction for general practice and wider primary care provision is unclear. There is also insufficient clarity about expected investment in general practice over the medium term. This is making it more difficult for GPs and HSCPs to plan services and reform ways of working:

- The Scottish Government has committed to increase investment in primary care by 25 per cent by the end of the parliamentary term, but it has not set out how much of this increase will be for general practice.[26] In January 2025, the First Minister committed to increase the proportion of new NHS funding that goes to primary and community care, but this also lacks detail on the proportion for general practice.[27]
- Several commitments in the 2018 GMS contract have not been implemented and the Scottish Government has not set out its plans for implementing the remaining commitments.
- There is a lack of clarity about how much additional investment will be available to fully implement MDTs across the six priority services.

**41.** The Scottish Government is currently developing a new plan for primary care reform. This work includes developing a refreshed vision, outcomes and strategic approach for primary care, aligned with wider health and social care reforms. The Scottish Government plans to publish this in summer 2025.

**42.** As part of this work, the Scottish Government should clarify whether, and when it will fully implement its outstanding commitments from the 2018 GMS contract by publishing a clear delivery plan, informed by evaluations of the changes to date. It should include specific actions, timescales and costs. It should also set out robust governance arrangements for how it will monitor and evaluate progress including identifying what data it needs, and how it will be obtained and validated.

**43.** The Scottish Government has refreshed its national governance arrangements relating to general practice, in recognition that previous arrangements focused too narrowly on the implementation of MDTs.

In January 2025, it established the General Practice Programme Board, replacing the previous GMS Oversight Group. The wider focus on all aspects of general practice policy is welcome, and the Scottish Government should ensure that this board has full oversight of the programme of work that will contribute to a published delivery plan for general practice (paragraph 42).

**44.** While the Scottish Government has committed to prioritising investment in primary care, including general practice (paragraphs 30 and 40), it should also set out a medium-term funding trajectory for general practice. This would provide certainty for GPs and HSCPs, enabling them to carry out well-informed medium-term financial and workforce planning.

## A lack of robust data makes it difficult for the Scottish Government to make informed decisions or evaluate progress

**45.** The Scottish Government published a monitoring and evaluation strategy in 2019, setting out a ten-year approach for assessing the impact of primary care reform in Scotland.[28] We welcome the focus in the strategy on outcomes for people, workforce and the system. However, further work was needed to improve the data and arrangements in place for monitoring and evaluating progress, and this work has not progressed as planned.

**46.** PHS published a national baseline report highlighting gaps in the data and evidence in 2020.[29] But plans to set out annual priorities, improve national indicators and publish a series of progress reports did not go ahead as expected. Scottish Government and PHS analysts were instead needed to support the response to the Covid-19 pandemic, and post-pandemic work priorities have changed. The Scottish Government now plans to review the primary care outcomes and indicators, and update them if needed, as part of its work on primary care reform.

## National data to inform, monitor and support general practice is still inadequate

**47.** We have long highlighted the lack of national data available for general practice and called for improvements.[30] Despite this, robust national data about demand, activity, workload, workforce and quality of care in general practice is still lacking. For instance:

- Data on the general practice workforce (apart from GP headcount) relies on estimates from an annual survey. Only around 85 per cent of practices currently provide information.[31] There is no standard definition for a vacancy in the survey and vacancy data is not completed consistently by practices. It is also not clear how many hours GPs are contracted to work (paragraph 81). NES and NHS

National Services Scotland (NSS) are working with practices to improve data collection and quality. A new application introduced by NSS in 2024 will allow practices to update workforce data throughout the year and incorporates some inbuilt data validation functionality.

- PHS publishes data about clinical and administrative activity in general practices covering around 95 per cent of the population.[32] But variation in how data is recorded means that it is not yet comparable across practices or consistent enough to fully support national planning.

**48.** NSS and PHS are supporting general practices to improve the consistency of activity data. They have developed guidance and a dashboard to allow practices to scrutinise their own data. Unlike secondary care, however, general practice does not routinely employ people to gather and code data to support NHS board and national decision-making. So improving the data relies on practices having the capacity and motivation to implement the guidance. There are also no arrangements for validating practice data to ensure it is consistent and comparable across Scotland. PHS only carries out basic quality checks to highlight potential data-quality issues.

**49.** NHS England reports more detailed appointment data from general practice clinical systems, including the number, type and duration of appointments, and the time between booking and the appointment. All practices in England were directed to record data in a standard way to enable this to be collected more consistently and are financially incentivised to do so. NHS England, however, does not report wider clinical or administrative activity for appointments.[33]

**50.** The Scottish Government acknowledges that primary care data and the infrastructure to support it is inadequate and has said that improving this situation is a priority:

- NSS is supporting GPs to implement a new GP clinical IT system across Scotland, a programme that was originally planned to be completed by 2020. This means that all practices will be using the same system, presenting an opportunity for more consistent activity and appointment data to be gathered in Scottish practices. However, the system supplier entered administration in December 2024. This presents a substantial risk to this programme of work, and it is currently unclear whether the new system will be fully rolled out to all practices by 2026 as now planned. NSS has formed an incident management team and has stated that arrangements are in place to ensure immediate service provision while the administrators seek a buyer. Once in place, practice teams will need time to learn how to use the new system.
- It has set up the primary care data and intelligence programme with PHS and NSS, to improve access to, and the quality of, primary

care data. The programme's current priority is to establish a primary care data and intelligence platform by March 2026.[34] It is currently unclear how this programme may be impacted by any delays to the GP clinical IT system roll-out.

**51.** The platform will have access to clinical coding information from all Scottish GP clinical systems. This will be used for direct care and public health surveillance purposes. It will also have access to other data, such as activity data, that can be used for other purposes including research; however, only general practices that agree to participate will have their data used for these purposes. Information governance is a major component of this project and work to agree necessary governance arrangements is ongoing. It is likely that longer-term work will be required to improve the consistency of data recording to support evidence-based national planning.

# 2. Progress improving patient care

## People are finding it more difficult to access healthcare at their general practice

**52.** The biennial Health and Care Experience (HACE) Survey is the main way in which access to general practice is measured and monitored in Scotland. The results of this survey show that people are finding it more difficult to access healthcare at their general practice. For example, in 2023/24, 24 per cent of survey respondents said that it was 'not easy' to contact their general practice in the way that they wanted to. This was an increase from 13 per cent in 2017/18.[35]

**53.** The Scottish Government recognises that access to general practice is a major public concern and has commissioned several initiatives to help address this. One example is the HIS Primary Care Access Programme (PCAP). This programme supports general practice teams to use data to explore challenges, identify areas for improvement and improve an aspect of access over a seven-week period.[36]

**54.** The PCAP has helped practice teams to improve some aspects of capacity or demand, but it tends to focus on small-scale changes in individual practices. Improvements are shared more widely through national learning events and resources. The PCAP does not enable system-wide improvements and does not aim to address the most significant challenges in improving access to care, such as workforce shortages.

**55.** In 2023, the Scottish Government also published a set of General Practice Access Principles.[37] These principles help to define what good and appropriate access looks like and can help set and manage expectations about access to general practice. But factors such as limited capacity also affect access, and the Scottish Government has been clear that the principles are not standards that practices are measured or monitored against. It is therefore difficult to assess how well the principles have been implemented across Scotland or whether they have helped to improve patient access.

## The public does not fully understand how and why general practice is changing

**56.** Research shows that changes in the way primary care can be accessed, and how it is provided, are not well understood by the public.[38]

To help address this, the Scottish Government ran a public awareness campaign in March 2022 to promote greater understanding of MDTs and the role receptionists have in helping people to access care.[39]

**57.** Towards the end of 2022, a survey of more than a thousand people who had recently consulted a GP found that most people still lacked awareness of the full range of MDT professionals working in general practice.[40] Furthermore, 29 per cent of respondents were unhappy with receptionists acting as care navigators, a view expressed more prominently by people in deprived-urban areas and people living with multiple health conditions. In-depth interviews with 30 of the survey's respondents found that people could see the value of MDTs, but they were generally unaware of the 2018 GMS contract and thought recent changes were largely a response to the Covid-19 pandemic.[41]

**58.** The Scottish Government has taken steps to improve this. For example, since October 2022 all general practices have been required to maintain a website showing up-to-date information about the services they provide and how to access them.[42] To help practices meet this requirement, NHS 24 has created a free-to-use national standardised website to display information specified in practice leaflets, designed in line with the GMS contract. Helping the public to understand how and why general practice is changing is an ongoing process and will require continued engagement at national, local and practice level.

## Satisfaction with the care that people receive from their general practices has decreased

**59.** Progress in improving outcomes for people using general practice services is measured through the HACE survey.[43] The most recent survey results indicate that people were less satisfied about the care they received from their general practice in 2023/24, compared with 2017/18 (Exhibit 5, page 26).

**60.** When asked to rate the overall care provided by their general practice, 69 per cent of survey respondents said the care was excellent or good. But this is 14 percentage points lower than in 2017/18, a substantial decrease. Positive responses had already begun to fall before the Covid-19 pandemic; but they dropped sharply in 2021/22 when rigorous infection prevention controls were used to help mitigate the spread of Covid-19.

**61.** Positive responses increased only slightly in 2023/24, remaining substantially below pre-pandemic levels. The proportion of people describing the overall care at their practice as excellent or good increased only by two percentage points between 2021/22 and 2023/24.

# Exhibit 5.

## Health and Care Experience Survey 2023/24

People are less satisfied about the care provided by their general practice than in 2017/18.

| Primary care outcome indicators for people | 2023/24 (%) | Percentage point change from 2017/18 |
|---|---|---|
| Rated the care provided by their general practice as excellent or good | 69 | -14 |
| Said they understood the information they were given | 91 | -4 |
| Said staff helped them to feel in control of their treatment and care | 66 | -16 |
| Found it easy to contact their general practice in the way they wanted | 76 | -11 |
| Could book an appointment three or more working days in advance | 50 | -18 |
| Could see or speak to a doctor or nurse within two working days, when urgent | 84 | -3 |
| Thought arrangements for speaking to a doctor were excellent or good | 63 | -3 |
| Thought their treatment and care was well coordinated | 74 | -4 |
| Said they were given the chance to involve people that mattered to them | 49 | -10 |
| Felt they were listened to by the healthcare professional they saw | 87 | -6 |
| Thought they were given enough time by the healthcare professional | 83 | -5 |
| Felt they were treated with compassion and understanding | 84 | -4 |

Note: All percentage point changes are based on unrounded results. The question about people feeling in control of their treatment and care has been updated since the 2017/18 survey, and this may have influenced how people responded to this question.

Source: Audit Scotland, Scottish Government and Public Health Scotland

**62.** People's experiences vary widely according to a combination of factors such as age, whether the person has a disability, socio-economic status and where the person lives. People living in the most deprived areas reported poorer experiences than people in more affluent areas, and people from island board areas reported higher satisfaction than average:

- Sixty-three per cent of respondents living in the most deprived areas rated the overall care provided by their general practice as excellent or good; eight percentage points lower than people living in the least deprived areas.[44]
- Overall care was rated positively by 86–90 per cent of respondents in island boards; in NHS Shetland positive ratings increased by four percentage points between 2017/18 and 2023/24.[45]
- In NHS Lanarkshire, respondents were substantially less positive than average; only 55 per cent of respondents rated the overall care at their general practice as excellent or good, a decrease of 24 percentage points since 2017/18.

## MDTs' potential to improve patient care and reduce general practice workloads is not yet being realised

**63.** The expansion of MDTs has the potential to improve patient care and free up GP time to focus on the most complex patients and on quality improvement, but this potential has not yet been realised. In November 2023, PHS published a report covering a survey of GPs' views on the expansion of MDTs.[46] Almost all GPs that took part felt that there was potential for the MDTs to make a positive difference. But four themes emerged as barriers to achieving this:

- There are not enough MDT staff to make a meaningful difference and to meet the needs of the GPs and patients – this was the most strongly highlighted issue.
- The input from MDTs is not reliable – staff availability was inconsistent, making planning difficult. There was a lack of cover for clinics and for time off, and short-notice absences cause disruptions and additional pressures.
- The variation in skills, experience and ways of working among the available members of staff caused challenges. Experienced and qualified staff were seen as sufficiently resilient but there were concerns about less experienced staff because of ongoing training needs and in some cases a slower pace of work.
- Some GPs felt that the MDTs had actually increased their workload. Some respondents reflected that this was because MDTs in some cases created more work, and GPs needed to spend a lot of time supervising and training MDTs.

**64.** PHS also surveyed MDTs for their feedback.[47] This found that MDTs were broadly positive about the impact of their roles on GP workloads but more mixed for the impact on wider practice teams' workloads. The roll-out of MDTs has not been completed, so the impact on GPs and practice teams' workloads is likely to improve with greater availability of MDT staff. But increasing staffing alone is not enough. Challenges with different ways of working and a lack of shared expectations and teamwork are limiting the potential success of the expansion.

**65.** The Scottish Government needs to work with the SGPC and HSCPs to set out clear actions that will improve the way that general practice teams, MDTs, and wider community-based primary care teams work together to provide services. This should include how it will improve communication, collaboration, data sharing and clarity about roles and responsibilities across the whole primary care workforce. This work should draw on the findings of the PCPIP.

## There is insufficient transparency and assurance about the quality of care in general practice

**66.** The quality of services in general practice is not routinely monitored, which limits transparency and assurance about the quality of care. Between 2004 and 2016, the **Quality and Outcomes Framework (QOF)** was used to record and report on the quality of care. Several studies have highlighted examples of both benefits and limitations to this approach:

- QOF provided data to measure the quality of healthcare, which is essential to effectively plan services, address health inequalities, carry out clinical research and provide assurance about value for money.[48]
- QOF accelerated the shift towards multidisciplinary care of long-term conditions, for instance nurse-led clinics for diabetes and cardiovascular and respiratory disease.[49]
- Because QOF provided financial incentives, it may have led GPs to prioritise improvements in managing the conditions included within QOF at the expense of more patient-centred care.[50]

**67.** In 2016/17, the Scottish Government removed QOF and replaced it by establishing **GP clusters**.[51] Clusters have two key roles – improving the quality of care in general practice and influencing the wider healthcare system on priorities and how services work.

**68.** GP clusters have the potential to achieve these aims but are not yet working as intended. The Scottish Government and HSCPs have not done enough to create the conditions for clusters to succeed. The Scottish Government issued guidance in 2019 that set out the role of clusters and recommended minimum inputs required for Practice Quality Leads (PQLs) and Cluster Quality Leads (CQLs). It also recognised that administrative support is critical to the success of clusters.[52]

**Quality and Outcomes Framework (QOF)**

The QOF was a voluntary system that aimed to incentivise general practices to provide high-quality care by paying them for meeting certain quality indicators. These indicators focused on specific long-term conditions such as diabetes, asthma and heart disease, and on carrying out targeted health checks such as blood pressure monitoring and cervical screening.

**GP clusters**

GP clusters are groups of between five and eight general practices within a geographical area. Each general practice is represented by a Practice Quality Lead in a GP cluster. Each GP cluster has a Cluster Quality Lead to facilitate quality improvement work and engage with the wider healthcare system.

**69.** The Scottish Government has not, however, fully funded these recommendations or prioritised implementation of the guidance. This has led to variation in the extent to which GP clusters have been funded and supported across Scotland:

- The RCGP and BMA surveyed PQLs and CQLs in 2024, which found substantial variation in the time they spent in that role.[53] The survey identified that additional funding and administrative support is needed to increase the focus on quality improvement in general practice.
- In 2022, HIS published a report covering progress with GP clusters, which found that implementation had not been fully supported or prioritised.[54] It identified that the main barriers to effective cluster working were a lack of time, support, meaningful data, and clarity about the purpose, roles and responsibilities of clusters.
- Other research has identified similar challenges that clusters are facing, and many of these were identified when clusters were established.[55]

**70.** Establishing GP clusters has brought some benefits. It has brought GPs from different practices together for the first time to discuss quality issues. This has improved collaboration and HIS found that it proved invaluable during the Covid-19 pandemic – clusters enabled peer support, sharing information, and working together to continue providing services during the pandemic. HIS has also established a cluster improvement network that aims to support cluster working and share learning.

**71.** However, this has not addressed the fundamental issues that clusters are facing. Since QOF was removed, recorded quality of care has decreased for most performance indicators.[56] The Scottish Government should identify appropriate financial and administrative support for clusters, clear priorities for improvement and robust governance arrangements for monitoring progress.

## The Scottish Government's efforts to support general practices to address health inequalities have had limited impact

**72.** General practice has a long-standing role in helping to address health inequalities, but the Scottish Government has not done enough to maximise its potential. A recent report funded by the Health Foundation found that:

- there is a major implementation gap between Scotland's policy ambitions to address health inequalities, and sustainable implementation of improvements
- despite higher levels of need in the most deprived areas, there were fewer GPs, clinical staff and administrative staff per patient in

general practices serving the most deprived areas compared with the most affluent areas

- it is not clear whether additional MDT staff have been adequately distributed based on local population need.[57]

**73.** Addressing health inequalities is one of the Scottish Government's priorities. Despite this, there was very little detail in the 2018 GMS contract that focused on this. The commitments that do link to addressing health inequalities have not progressed as well as planned:

- Community link workers have a direct remit in addressing health inequalities, but they were not one of the three services prioritised from 2021 (paragraph 18). Short-term funding and contracts make the service and workforce vulnerable to budget cuts (Case study 2, page 31).
- A key part of GP clusters' role was to reduce health inequalities, but clusters have not progressed as intended (paragraphs 67–71).
- The new practice funding formula better reflects the impact of deprivation on practice workloads than the previous formula (paragraph 95). Despite this improvement, stakeholders have raised concerns that the formula still does not sufficiently account for the workload associated with deprivation, avoidable mortality and disability, and the burden of disease.[58]

**74.** Some programmes of work have aimed to address inequalities through general practice. For example, the Scottish Deep End project was established in 2009 comprising GPs, both clinical and academic, working in the 100 most socio-economically deprived communities. It has advocated for service developments, education and research to help general practice better address inequalities.

**75.** More recently, the Scottish Government has taken steps to increase its focus on how general practice and primary care can help address inequalities. It has established an inequalities unit in the primary care directorate and commissioned a primary care health inequalities SLWG, which has now evolved into a reference group. These developments have helped to improve the way that the Scottish Government considers health inequalities within primary care, but much of this work is at an early stage.

**76.** The Scottish Government also provided additional funding of £2.3 million between 2022/23 and 2024/25 for around 66 Deep End practices in Greater Glasgow and Clyde. This funding has allowed general practice teams to provide extended consultations and outreach appointments, access enhanced training and improve patient participation forums.[59] While this is promising, the funding is short term, relatively small scale and limited to some practices in Greater Glasgow and Clyde serving some of the most deprived communities.

## Case study 2.

### Community link workers are vital parts of the primary care workforce, but their roles are often insecure and vulnerable to budget cuts

Community link workers work with general practices to help patients access non-medical support for personal, social, emotional and financial issues. They often support people with complex needs and people facing socio-economic deprivation. The Scottish Community Link Worker Network has reported increasing demand for a wide range of support, particularly for mental health and for social issues such as loneliness, housing and financial support. It also highlighted that patients often require longer-term support because of the complexity of their cases or while they are on waiting lists for other services. This can add pressure to link workers' workloads and reduce the opportunity for others to access support.

Community link workers are usually employed by third sector organisations. Short-term funding and contracts for third sector organisations mean that link workers' jobs are often insecure and vulnerable to budget cuts. The Scottish Government provided Glasgow City HSCP with £3.6 million additional funding over three years from 2024/25 to maintain its link worker programme. However, link worker services across Scotland remain at risk because of financial pressures.

Variation in service models and inconsistent monitoring and evaluation makes it difficult to assess the impact of community link workers and the extent to which support is targeted to those most in need. A report funded by the Health Foundation found several factors that made success more likely. These included embedding link workers within practices, good engagement and support from the practice team, continuity of care, clarity of roles, sustainable funding, adequate room space, IT and administrative support, and learning from monitoring and evaluation.

The Scottish Government is carrying out a national review of community link worker services. This will cover funding, data and evidence, and workforce. The Scottish Government should use the findings from this review to set out a long-term plan for link worker services (paragraph 77). HSCPs also have a role to ensure they commission link worker services in ways that most effectively meet the needs of their communities.

Source: Audit Scotland, Scottish Community Link Worker Network, Health Foundation and Scottish Government

**77.** Tackling health inequalities requires cross-sector, systemic action that is targeted and sustained. The Primary Care Health Inequalities SLWG highlighted the pivotal role of primary care in mitigating the effects of health inequalities but found that existing commitments to reform primary care would not alone be sufficient to address the challenges of health inequality.[60] The Scottish Government needs to set out a clear plan for how it intends to better support general practices to contribute to tackling health inequalities.

# 3. Progress addressing financial and workforce challenges

## The commitment to increase the number of GPs by 800 is unlikely to be met by 2027

**78.** In 2017, the Scottish Government committed to increasing the number of GPs working in Scotland by at least 800 by 2027.[61] In our NHS in Scotland 2022 report, we noted that this commitment was not on track. Based on progress to 2024, this commitment will not be met. Between September 2017 and September 2024 the number of GPs, excluding specialty trainees, increased by 135 (Exhibit 6, page 34).[62]

**79.** Our NHS workforce planning – part 2 report highlighted that this commitment is based on a headcount of GPs, rather than WTE. A headcount target does not sufficiently demonstrate the intended increase in GP capacity. The estimated number of WTE GPs has decreased since 2017, indicating that increases in headcount will not necessarily translate to additional WTE GPs.

**80.** Between August 2017 and March 2024 the estimated number of WTE GPs, excluding specialty trainees, decreased by 67, or 1.9 per cent.[63] By comparison, over a similar period (September 2017 – March 2024), the number of WTE medical and dental consultants working in NHS Scotland territorial boards increased by 791 WTE, or 15.6 per cent.[64]

**81.** There is, however, no official information about the number of hours worked by GPs in Scotland. The General Practice Workforce Survey defines GP WTE as eight contracted sessions per week, and assumes a session length of four hours and ten minutes. But it does not record the number of hours actually worked per session. In August 2017, the average number of sessions worked by GPs was estimated to be 6.4; by March 2024 this had decreased to 6.2 (-0.2 sessions). But the length of a session varies among practices.[65] It is therefore not clear if the average number of hours worked has also fallen. This makes it difficult to assess the extent to which workforce capacity has changed since the GP commitment was introduced in 2017.

**82.** The Scottish Government's National Health and Social Care Workforce Plan noted that the commitment to increase GP headcount by 800 would require constant monitoring and review.[66] While headcount numbers are routinely published, no formal review arrangements were put in place to monitor whether progress towards this commitment

was increasing GP capacity as anticipated, particularly in terms of WTE. Furthermore, the Scottish Government has not provided practices with specific additional funding to achieve this commitment, and a lack of robust data means it is not clear whether general practice is able to afford this level of increase. It is also not clear that an additional 800 GPs is sufficient to meet population health needs (paragraph 96).

## Exhibit 6.

### GP headcount, 30 September 2017 – 30 September 2024 and estimated GP WTE, August 2017 – March 2024

While GP headcount increased between 2017 and 2024, the estimated number of WTE GPs has decreased since 2017.

| GP headcount | September 2017 | September 2024 | | Change |
|---|---|---|---|---|
| **GPs (excluding specialty trainees)** | **4,390** | **4,525** | ↑ | **+135** |
| GP specialty trainees | 514 | 687 | ↑ | +173 |
| GPs (including specialty trainees) | 4,904 | 5,211 | ↑ | +307 |
| **Estimated GP whole-time equivalent (WTE)** | **August 2017** | **March 2024** | | **Change** |
| **GPs (excluding specialty trainees)** | **3,520** | **3,453** | ↓ | **-67** |

Notes: Headcount figures for September 2024 are provisional. A GP can be recorded as having more than one type of post, so the sum of GPs (excluding specialty trainees) and GP specialty trainees may not equal GPs (including specialty trainees). Whole-time equivalent figures are estimated based on data collected via an annual survey.

Source: Audit Scotland and NHS Education for Scotland

## The number of GP trainees has increased, but retaining the existing workforce is also vital to increasing GP capacity

**83.** There has been progress in increasing the number of doctors training to become a GP in Scotland, known as GP Specialty Trainees (GPSTs). This has the potential to increase the GP workforce in future. Between 2017 and 2024, the number of GPSTs on placement in general practice increased by 173 (Exhibit 6). These figures are a snapshot as at September 2017 and 2024, and do not include GPSTs working in hospital posts as part of their GPST training. NES has confirmed that there are more than 1,200 GPSTs in Scotland in total.

**84.** Between 2018 and 2023, the number of people starting the GPST programme also increased, from 292 to 342, and nearly all training places

were filled in 2023. The GPST programme, however, often takes longer than the standard three years and the number of applications to work less than full time has risen. NES told us that trainees sometimes opt to work less than full time to help manage the challenging workload, but GPST places are currently funded on a headcount basis. This could result in fewer WTE GPSTs.

**85.** The current pipeline of GPSTs is not, on its own, sufficient to increase GP capacity in Scotland. There are no guarantees that GPSTs will complete the programme and go on to work as GPs in Scotland. NES told us that between 2017/18 and 2023/24, more than 1,800 people completed their training in Scotland. However, after accounting for GPs who have joined or left the GP workforce, the number of GPs, excluding specialty trainees, working in general practice has increased by only 135 since September 2017.

**86.** Attracting and retaining the GP workforce is therefore key to increasing capacity. In November 2024, the Scottish Government published an action plan, based on the recommendations of the GP Retention Working Group.[67] The plan sets out 20 actions to improve GP recruitment and retention to 2026 and has been welcomed by the RCGP.[68] The plan also confirmed that its implementation would require an increase in funding for general practice.

**87.** Many of the plan's actions describe continuing current activity, exploring opportunities for improvement, or enhancing understanding and data quality over the next two years. Some actions also await the publication of ongoing evaluation work to inform next steps. It is therefore not yet clear what changes will be implemented or what the impact of those changes will be. The Scottish Government has committed to reviewing progress against the plan annually.

## Success in transforming the role of general practice nurses depends on practice priorities and GP support

**88.** The 2018 GMS contract aimed to support general practice nurses (GPNs) to become expert nursing generalists, supporting patients to manage short- and long-term health conditions. This refocused role for GPNs aims to help meet the demands of a growing and ageing Scottish population with higher levels of need (Exhibit 3, page 13).

**89.** Work to refocus the GPN role is ongoing and is supported by a refreshed definition of the role and work to align competencies and training with population healthcare needs.[69]

**90.** Transforming the role of GPNs requires GPs, as their employers, to actively support GPNs in making this change. Competing priorities in general practices can reduce the amount of time GPNs have to focus on prevention or to support patients with long-term conditions. For example, GPNs may need to focus on responding to unscheduled care demand, or work in a practice without sufficient access to wider MDT support.

**91.** Unlike for GPs, there is no commitment to increase the number of GPNs, but there are indications that there may be fewer nurses available to work in general practice in future years. This is a particular concern given that more than half of GPNs are aged 50 years or over:

- Between August 2017 and March 2024, the estimated number of WTE GPNs in Scotland increased by 11 per cent to 1,710 but numbers have levelled off since 2019.[70]
- Intake targets for pre-registration nursing and midwifery undergraduate education have increased since the contract was introduced, but applications have dropped in the last three years and intake targets were not achieved in 2022 or 2023.[71]

## Non-clinical staff are a key part of the general practice workforce but the progress towards, and impact of, planned changes to these roles is not clear

**92.** Non-clinical staff form a critical part of the general practice workforce. Approximately 9,000 administrative and non-clinical staff work within general practice.[72] This includes around 1,200 practice managers and 5,600 receptionists. As with GPs and GPNs, the 2018 GMS contract set out an enhanced role for practice managers and receptionists:

- practice managers would take on an additional role in coordinating MDTs
- receptionists would take on a greater role in providing information for patients about the range of services available to them.

**93.** Information is lacking to determine the extent to which these changes have been achieved. While GPs and MDT staff have been surveyed to help understand the impact of primary care reforms on their roles (paragraphs 63–64), similar evaluations for non-clinical staff have not been carried out.

**94.** The Covid-19 pandemic accelerated changes, particularly for receptionists' role in informing patients about how and where to access services, before support and training resources were in place. The Scottish Government and NES have taken steps to address this gap by introducing a competency framework for practice managers and administrative staff in September 2023. However, the impact of this work has yet to be evaluated.[73]

## There are substantial risks and uncertainty about fully implementing changes in how general practices are funded

**95.** The Scottish Government has not fully implemented contractual changes aimed at improving financial stability in general practice.

These changes were intended to be implemented across two phases (Exhibit 7, page 38). Phase one was completed but phase two was delayed. This means that financial pressures faced by GPs have not fully been addressed:

- The new practice funding formula better accounts for workload associated with deprivation and older patients than the previous formula, but it is based on out-of-date data and does not address unmet need.
- GPs in rural areas have highlighted that current funding arrangements do not address the higher costs, unique workload, and workforce challenges that rural areas face, all of which are contributing to financial challenges for practices.

**96.** The Scottish Government delayed work towards phase two because of the Covid-19 pandemic and challenges collecting data from practices, but progress since then has been slow. The Scottish Government is working with the SGPC to prioritise and plan how it will implement the second phase of changing how practices are funded. This work will be complex and the Scottish Government has not set out how long it will take. It involves:

- collecting data on GP earnings and practice expenses, to improve transparency and enable practice expenses to be directly reimbursed
- agreeing an income range and pay progression comparable to NHS consultants
- identifying the GP workforce needed to meet population health needs and contribute to addressing health inequalities and the challenges faced by rural communities.

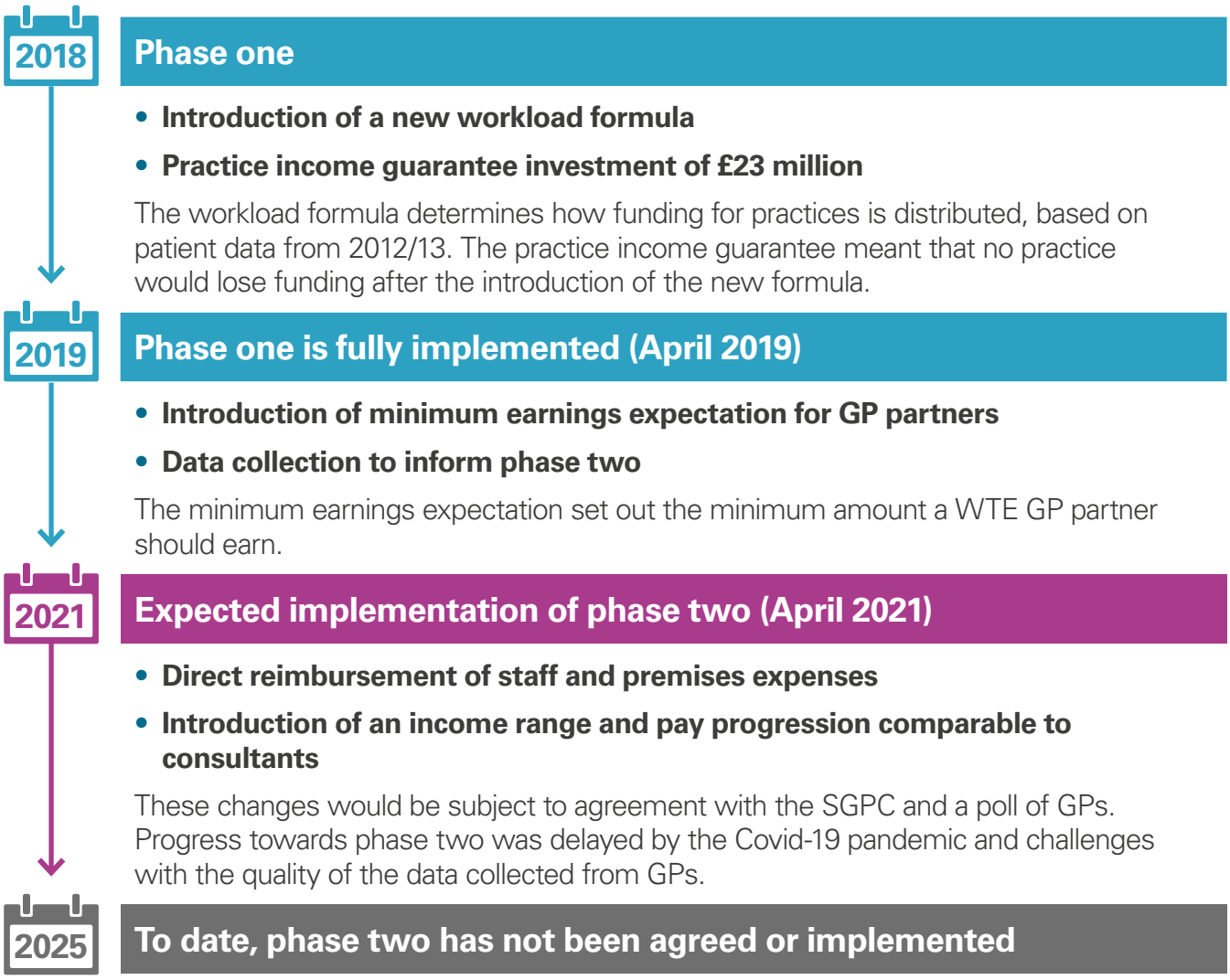
**97.** In the 2018 GMS contract, the Scottish Government recognised that it does not have a full understanding of what phase two will look like in practice or how much it will cost. It does not have a full understanding about the current expenses of running a general practice or how much GPs earn. It could therefore not provide assurance that this model is affordable. But it has not set out what it would do if this model is deemed unaffordable. This lack of strategic and financial planning has created uncertainty for GPs about how they will be funded in future.

**98.** Progressing with phase two has the potential to address substantial challenges. Better data from general practices would improve transparency and enable a better understanding of the investment needed to meet the needs of Scotland's population. Directly reimbursing expenses would support the long-term sustainability of general practices. Without this, GPs are at risk of bearing the financial burden of increasing costs, which risks damaging trust with GPs and buy-in for future reforms or contractual changes.

# Exhibit 7.

## Timeline of proposed changes to practice funding arrangements

The Scottish Government has not fully implemented commitments to change how practices are funded and it is not clear when it will implement the outstanding commitments.




Notes: The practice income guarantee of £23 million has reached £30 million in 2023/24.

Source: Audit Scotland and Scottish Government

## The Scottish Government has not been transparent about progress with premises commitments and barriers to implementation remain

**99.** The 2018 GMS contract set out the Scottish Government's plans for moving to a model where GPs are no longer expected to provide their own premises, as part of measures introduced to reduce risks for GP partners. To facilitate this change in responsibility, the Scottish Government and the SGPC agreed a National Code of Practice for GP Premises, which outlines responsibilities for GPs, NHS boards and the Scottish Government.[74] The main commitments were:

- GPs who own their own premises would be eligible for an interest-free sustainability loan of up to 20 per cent of the value of the property every five years, with the intention that the NHS board will own the premises by 2043.
- GPs who lease their premises would be eligible to apply for their NHS board to either negotiate a new lease for the GP premises, take responsibility for the current practice lease, or provide the practice with alternative, board managed, premises. The transfer of leases is expected to take place over a 15-year period.

**100.** The Scottish Government has not been transparent about the investment in sustainability loans and has made a misleading announcement about the uptake of the loans:

- The Scottish Government committed £30 million for the sustainability loan scheme, at £10 million per year between 2018 and 2021.[75] In 2019, the Scottish Government said it was increasing investment to £50 million by 2021.[76] However, delays to the scheme meant that no loans were issued until 2020/21, when just two loans totalling £0.6 million were provided. Unused funding was not able to be carried forward to the next year. The scheme was paused in March 2024 because it was oversubscribed, after just £15.1 million of loans were issued over a period of five years.
- In 2019, the Scottish Government reported that 172 practices had successfully applied for the sustainability loan scheme.[77] However, to date just 63 loans have been issued. The Scottish Government told us that the 172 figure actually referred to the number of practices that expressed interest in the scheme.

**101.** Since 2020, NHS Scotland has been monitoring progress regularly and has found the pace of progress to be slow. Common barriers found to be impacting the progress of loan applications include the high cost of legal fees, work required to correct historical issues, and securing agreements with mortgage providers. It also found that boards may be reluctant to take on some leases because of the level of maintenance costs required for the properties.

**102.** Future funding for the loan scheme is uncertain, which means its successful implementation is at risk. The scheme relied on financial transaction capital issued by the UK Government. Since 2024/25, the Scottish budget has not included any financial transaction capital for the health portfolio.[78] The Scottish Government has not yet confirmed an alternative source of funding and is currently reviewing options. Following this work the Scottish Government should set out whether and how it plans to implement the loan scheme.

## The Scottish Government does not have sufficient oversight of whether GP premises are fit for purpose

**103.** The Scottish Government commissioned a national survey of premises owned or independently leased by GPs in 2018 to benchmark the condition of the estate. The survey results showed that there was a maintenance backlog of £59.2 million for premises owned or independently leased by GPs. Twelve per cent of the maintenance required was classed as high or significant risk.

**104.** An extract from NSS' Strategic Asset Management System (SAMS) from July 2024 shows that the maintenance backlog for premises owned or independently leased by GPs, classed as high or significant risk, has decreased to nine per cent. The cause for this reduction, however, is not recorded. For example, it could be that maintenance work has been carried out and SAMS has been updated accordingly, or that some premises are no longer in use, or that ownership of the premises has changed, including the transfer of leases to NHS boards. SAMS is a dynamic system and is updated as required, therefore system reports represent a snapshot in time. It is NHS boards' responsibility to ensure that data in SAMS is kept up to date.

**105.** The National Code of Practice for GP Premises states that there is a need for GP premises to be surveyed on a regular basis. No further national surveys have taken place, but NHS boards are required to survey their estates on a regular basis. The Scottish Government asked NHS boards to provide an infrastructure plan by January 2025 as part of a new approach to infrastructure planning and investment across NHS Scotland.[79]

**106.** These plans should include details of the condition of GP owned and leased premises, as required by the National Code of Practice for GP Premises. This will provide an up-to-date picture on the condition of GP premises nationally to help inform the NHS national capital investment strategy. This is important, given the expectation that NHS boards will be taking on responsibility for more GP premises over the coming years.

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# Appendix

## Advisory group

We establish advisory groups for most performance audits, with members coming from outside of Audit Scotland. We choose members of advisory groups based on their knowledge and expertise of the topic area, and the organisations they work for.

The advisory group provided advice and feedback at key stages of the audit process. However, Audit Scotland retains responsibility for, and ownership of, the audit work, the audit report, and the judgements contained within this.

We would like to thank the members of the advisory group for their contributions to this audit:

- Evan Beswick – Chief Officer, Argyll and Bute IJB
- Lorna Kelly – National Strategic Lead for Primary Care, Health and Social Care Scotland
- Dr Carey Lunan – Chair, Scottish Deep End Project
- Dr Susan Gallacher – Deputy Director, GP Policy, Primary Care Directorate, Scottish Government
- Professor Stewart Mercer – Professor of Primary Care and Multimorbidity, University of Edinburgh
- Dr Iain Morrison – Chair of the Scottish GP Committee, BMA, preceded by Dr Andrew Buist until August 2024
- Dr Chris Provan – Chair, Royal College of GPs Scotland
- Margaret Reid-Arbuckle – Director of Development, the Alliance
- Elaine Strange – Head of Service, Data and Digital Innovation, Public Health Scotland

# General practice

## Progress since the 2018 General Medical Services contract

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ISBN 978 1 915839 66 4 AGS/2025/3