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Public Audit Committee

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Session 6

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Pàrlamaid na h-Alba

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PUBLIC AUDIT COMMITTEE
20th Meeting 2025, Session 6

CONVENER

*Richard Leonard (Central Scotland) (Lab)

DEPUTY CONVENER

Jamie Greene (West Scotland) (LD)

COMMITTEE MEMBERS

*Colin Beattie (Midlothian North and Musselburgh) (SNP)
Stuart McMillan (Greenock and Inverclyde) (SNP)
*Graham Simpson (Central Scotland) (Con)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Stephanie Callaghan (Uddingston and Bellshill) (SNP) (Committee Substitute)
Andrew Chapman (Scottish Government)
Susan Gallacher (Scottish Government)
Caroline Lamb (Scottish Government)
Tim McDonnell (Scottish Government)
Dr Iain Morrison (British Medical Association Scotland)
Dr Chris Provan (Royal College of General Practitioners Scotland)
Dr Chris Williams (Royal College of General Practitioners Scotland)

CLERK TO THE COMMITTEE

Katrina Venters

LOCATION

The Sir Alexander Fleming Room (CR3)

Scottish Parliament

Public Audit Committee

Wednesday 18 June 2025

[The Convener opened the meeting at 09:30]

Decision on Taking Business in Private

The Convener (Richard Leonard): Good morning. I welcome everyone to the 20th meeting in 2025 of the Public Audit Committee. We have apologies from Jamie Greene and Stuart McMillan, but I am pleased to welcome Stephanie Callaghan, who is substituting for Stuart McMillan. She is attending the committee remotely.

Agenda item 1 is for the committee to consider whether to take items 3, 4 and 5 in private. Do we agree to take those items in private?

Members *indicated agreement.*

"General practice: Progress since the 2018 General Medical Services contract"

09:30

The Convener: Item 2 is further consideration of the Audit Scotland report "General practice: Progress since the 2018 General Medical Services contract". I am pleased to welcome our witnesses for the first session. We are joined by Dr Iain Morrison, chair of the Scottish general practice committee of the British Medical Association Scotland. Alongside him is Dr Chris Provan, chair of the Royal College of General Practitioners Scotland. We are joined remotely by the vice-chair of RCGP Scotland, Dr Chris Williams. Dr Williams, if you want to come in at any point to answer the committee's questions, indicate that in the chat box and we will endeavour to bring you in.

We have quite a number of questions to put but, before we get to them, I invite the representatives in the room to give us short opening statements. I will begin with Dr Morrison.

Dr Iain Morrison (British Medical Association Scotland): Thank you to the committee for the invitation. The 2018 contract was presented to the profession in 2017. General practitioners were promised that they would be the conductors of an orchestra comprising multiple team members who would deliver on five key areas that would reduce our clinical workload and release us to fulfil the role of the expert medical generalist in the community.

Of the five key areas, only one—vaccination services—has moved out of general practice in its entirety. However, that now costs the taxpayer significantly more than when it was delivered by general practice, vaccination rates are lower and NHS Highland is in the process of moving it back to GPs, because of significant pressures in the remote and rural setting.

Changes in the other four areas—community treatment and care services, or CTACs, which largely involve nursing and healthcare assistants providing wound care, blood tests, data collection and so on; pharmacotherapy; urgent care; and additional professional roles, which primarily involve mental health workers, link workers and physiotherapists—have all struggled to make a demonstrable impact across the nation to reduce the GP workload and allow for more proactive care in the community. Even when, in December 2020, health and social care partnerships were instructed to focus their efforts on the development of pharmacotherapy and CTACs, we saw little progress being made towards either being an

autonomous service that delivered on all the descriptions in the 2018 contract.

In addition to those services not being delivered, we have seen other elements, such as aims on premises and information technology development, not progressing at a satisfactory pace. Practice premises present an on-going risk to practice sustainability.

The contract was supposed to be followed by phase 2, which was to allow for the direct reimbursement of practice expenses to bring a level of stability to the current model. However, it has not been possible to progress that, and we are actively looking at alternative mechanisms to support the profession.

The reasons for the failures of the 2018 contract are multiple, and we welcome the fact that the Audit Scotland report highlights many of them. The fact that the contract provided anything but GP time is being felt acutely across the system, and the years of inflationary erosion and neglect in budgetary decision making mean that general practice is at crisis point.

With record levels of demand, we face the ridiculous paradox that GP underemployment is occurring at an exponential rate. The solution is direct investment into the most efficient and fiscally disciplined element of the national health service. We can then look to secure a better future for general practice and for the people we serve across Scotland.

The Convener: Thank you very much indeed. Dr Provan will now give his opening statement.

Dr Chris Provan (Royal College of General Practitioners Scotland): Thank you very much for the opportunity to give evidence. We welcome the Audit Scotland report and its recommendations. The report paints a stark picture of general practice on the front line and was no surprise to GPs who are on the front line.

The report shows that there is a pressing need to reprioritise general practice in the Scottish Government's healthcare strategy, because general practice feels as though it is in a state of perpetual crisis. With a shrinking general practice workforce and rising demand because of the complexity of the patients being seen and an ageing population, there is a mismatch between what we are expected to deliver and the resources that are available to us to deliver it, which is leading to the potential for moral harm to general practice staff, who are trying to do their best. We feel that the infrastructure—our premises and our IT—is not fit for purpose.

As chair of RCGP Scotland, I want to champion the value of general practice to patients and to the wider system. I would recommend to the committee our recent report "Whole person medical care: The value of the General Practitioner". It brings together evidence on how healthcare systems that are strong in community and primary care are more effective.

We need consistent, long-term and sustainable investment in general practice. As we have heard, several commitments from the 2018 GP contract have not been implemented, and there is uncertainty about the medium-term funding, which is creating difficulty for practices in employing staff and GPs.

Recent research has shown that the lack of perceived workload change since 2018 is leading to GPs reducing their hours or even leaving general practice to cope with the burnout from the intensity of the job.

There is a lack of data, which hinders our ability to assess the 2018 contract and its impact on patient care. That lack of data about the situation has obscured the activity and the strain in general practice and the cultural and systematic neglect of general practice, where our budget has gone down from 11 per cent to 6.5 per cent of the NHS budget. As we have heard, the GP contract is in the remit of Dr Iain Morrison, so I will not go into more specifics on that.

I sincerely hope that the committee's work and our discussions will mark a turning point, because I believe that there is a growing political will and consensus that we need meaningful investment and a focus on primary care to improve the care of patients.

The Convener: Thank you very much indeed. You have covered many of the topics that we will pick up this morning, including IT, premises, funding and the delivery of support and services.

I will begin with something that is a bit more political and practical, perhaps, by going back to the First Minister's programme for government statement. He spoke about the delivery of an extra 100,000 appointments in GP surgeries. What was your reaction to that?

Dr Morrison: We made our reaction public at the time. General practice provides 650,000 appointments per week, so 100,000 is fewer than the number in one working day. The figure of 100,000 that the First Minister identified was not for routine general practice; it was specifically for cardiovascular disease prevention. We have been instructed to draw in people who do not use services to try to identify hidden risk in the community, which is very separate from coping with day-to-day demand. We welcome the cardiovascular disease enhanced service, which we see as a demonstration of general practice's role in the preventative agenda. However, to deal with the capacity issues in general practice, we

need much more substantial investment than was proposed.

The Convener: You mentioned investment. I want to check with you on some of the figures that have been used. In paragraph 28 and exhibit 4, the Audit Scotland report talks about the funding situation. Basically, it says that, between 2017-18 and 2023-24, direct spending on GPs by the Scottish Government was up by 33 per cent in cash terms. The report describes that as a 7 per cent real-terms increase. It goes on to talk about a real-terms reduction of 6 per cent between 2021-22 and 2023-24. That is the overall impression that is created in the Audit Scotland report that is before us.

However, in the letter that you sent to the committee, Dr Morrison, and in some of the things that you have said this morning, you are talking about a funding shortfall of 22.8 per cent. The expression that you used in communications with the committee is:

> "The funding practices receive for every patient has been eroded year after year against inflation since 2008."

How do you reconcile the conclusion drawn by Audit Scotland with what you have been saying?

Dr Morrison: I think that the Audit Scotland figures are year on year, whereas we are looking at the entirety of the past 17 years. Hyperinflation has had a significant impact on GP practice cost pressures, and we have seen multiple pay awards in the contract that have not kept pace with inflation over the years. We are happy to share with the committee our workings and how we have come up with the figures, but we are absolutely clear that we have seen a significant erosion, and that is before we talk about our share of the NHS budget.

The NHS budget has naturally risen, because healthcare costs have gone up, yet our share of that budget has been significantly impacted. The share is now likely to be below 6 per cent this year, when in 2008 it was 11 per cent. The workload has gone up, but our share of the resource has fallen year on year.

The Convener: Other committee members might return to some of those points. I will move on to another aspect of the report, which I asked the Auditor General about when he was before us a few weeks ago. In the end, we are talking about a whole system, and the difficulties that are faced in secondary care in the national health service are pretty well documented. There are extensive waiting times and a large number of people on waiting lists. Will you describe for us—maybe Dr Provan can answer, too—the impact on general practitioners of that persistent and almost intractable increase in waiting times for people who are awaiting treatment in hospitals? You choose between yourselves who wants to answer first.

Dr Provan: Iain Morrison's microphone is on, so he can start and then I will come in.

Dr Morrison: The waiting times for definitive interventions mean that patients repeatedly come back to general practice with a worsening of their existing condition. We are seeing people with more analgesic requirements and using more alternative therapies until the definitive treatment is delivered. While that is happening, their level of general frailty tends to increase, which means that, when the definitive intervention takes place, they are more likely to suffer complications and their general frailty level is unlikely to return to the previous baseline. All that leads to more of an impact on overall general practice usage, because we are dealing with more frailty in the community that could have been prevented. It is a complex picture.

09:45

Dr Provan: I echo the point that patients are repeatedly coming back for further treatment from their general practitioners with problems that have not been sorted out in secondary care because of long waiting lists. That is difficult for the patients and their level of suffering, and it is difficult for GPs to help people in that situation. We have seen the erosion of general practice because it is being used as a shield to protect secondary care. Because of that, secondary care is potentially busier, because more is leaking through.

We need to shift the focus and funding to build up the system again in the medium term, to allow us to work in different ways and do more in the community. We need the infrastructure to be able to do that, and the evidence shows that we can do that.

The Convener: Dr Williams wants to come in on this question.

Dr Chris Williams (Royal College of General Practitioners Scotland): I want to explain that there is a new data set that we collect that can provide some insight into the busyness of general practice. Public Health Scotland publishes that data under the working title of "in-hours activity". Previously, we looked at appointment data such as the number of appointments. Especially during Covid, a lot of analysis was done on whether appointments were face to face or involved remote consulting.

We can see in the data that roughly the same amount of consultations are going on, but workload is increasing in the background—there is what we might call indirect activity, such as lots of looking at results, lots of reports and lots of

updating to specialists. When a patient is being referred and comes back to tell us that things are getting worse and that they want the team that has not yet seen them to be updated, the patient has no direct mechanism to do that. Some of that activity is visible through the data set.

The Convener: Okay. Thank you. Again, we will return to some of those themes during the morning.

I will ask a final question about placing the observations in the Audit Scotland report in the context of how things are affected on the front line. Multidisciplinary teams were very much a theme in the 2018 contract. They were part of the new era that was being heralded at that time. However, when I read the Audit Scotland report that is under discussion at the committee this morning, it is quite scathing in that it says that

"the expansion of MDTs has been slower than planned",

deadlines have not been met and there have been "implementation gaps". Could you describe what that looks like on the front line of the provision of GP services across Scotland? I will begin with Dr Provan this time.

Dr Provan: Unfortunately, the introduction of the multidisciplinary teams has not freed up our GPs to be the expert medical generalists that were hoped for. The research shows that they have not been freed from that workload in the way that was expected. We have many different skills in practices, but in rural areas they have not been able to recruit, and in certain areas there has not been adequate funding to make a difference. Having a pharmacist spend two hours of their time in a practice for a limited period does not necessarily allow them to make a big enough difference to help to free up GP time.

MDTs have been implemented differently in different areas, with different approaches to spending and different views of what needs to be delivered through them. It has been estimated that it would cost another £125 million to fully implement vaccine, pharmacy and CTAC services. Unfortunately, MDTs have not really created enough head space for GPs to enable them to see the complex patients, as we would want them to do. There have also been delays in loans for premises, as the committee will be aware. Those factors create uncertainty and difficulty around funding and make it difficult to employ people.

Overall, we have not seen the impact from MDTs on the ground that we hoped for.

The Convener: Okay. Thank you. Dr Williams wants to come in—briefly, perhaps, because I need to move on to Mr Beattie's questions. Over to you, Dr Williams.

Dr Williams: I point out that, when the MDT arrangements came in, we did not have the IT licensing arrangements to match that. We had workers of different types who were spread across multiple practices, and that generated additional costs.

I want to highlight the situation with services such as first-contact physiotherapy. That is a fabulous new service, but it brings work into the general practice environment rather than freeing up GPs to be expert medical generalists.

As the Audit Scotland report notes, our patients do not understand a lot of those roles or how to access them. It is difficult for our patients to navigate the new system even when the information is prominently displayed on practice web pages and receptionists are trained to describe the roles to patients.

The Convener: Thank you—that is really helpful. Again, I am sure that that will be picked up by other members of the committee. I now invite Colin Beattie to put some questions to you.

Colin Beattie (Midlothian North and Musselburgh) (SNP): I should probably declare an interest, in that I have met Dr Morrison previously in his capacity as a senior partner of a medical centre in my constituency.

I turn to the subject of information, which the committee has talked about in many iterations. Publicly available information for the Government is, in general, of extremely poor quality across the NHS, and it has been difficult to pull it together. The information on GPs in particular is not very good, and the impact of poor-quality and incomplete data on decision making and the use of public funds has frequently been discussed at the committee. If we do not know the outcomes of what we are spending our money on, we do not know whether we are putting the money in the right place.

What role should GPs play in providing that information and supporting improved data collection? I will start with Dr Morrison.

Dr Morrison: As GPs, we play a key role in population health and management. The problem is that good data input requires robust IT systems that make it intuitive to have non-variable, highly collectable, impactful data, whereas our current IT systems are exceedingly poor. To be blunt, we are running Internet Explorer 8 software on 2004 servers and we have multiple systems trying to speak to legacy systems, so it is very hard for the IT system to capture robust data that is reliable and easy to interpret.

We have to focus on the data input capture before we look at the potential for greater analysis. There is huge potential there, and we are very

open to working with Government on how we can make that more transparent, because we are very keen to demonstrate the value of our work and our current incredible workload.

Colin Beattie: You touched on the Scottish Government. What do it and NHS boards need to provide in the way of support across the board in order to improve data collection?

Dr Morrison: Chris Williams may want to pick up on that, because he is more of an IT expert. However, we can compare our situation with what is happening in England, which has a secure cloud called the NHS spine portal that all systems can feed into. Scotland does not have that infrastructure, so all our systems have to speak to one other independently. That makes the collation of the data that exists in each system harder to centralise and, therefore, makes it harder to interpret robustly. Having some sort of central repository or spine would be hugely advantageous and would open up the potential for many more IT interventions to assist with workload and patient flow.

Colin Beattie: Dr Williams, you have had the finger pointed at you as an IT expert in this area. Do you have any input?

Dr Williams: Yes. I am happy to contribute and to back up Iain Morrison's description of the incredible potential that exists. We now have the ability to extract data from GP clinical systems in a way that we did not previously have. We now have a joint controller information-sharing agreement that is in operation between boards and between practices. In addition, practices are provided with support from data protection officers, so there is some infrastructure in place.

I draw your attention to GP quality clusters as a structure that should be able to undertake exercises with the data to ensure that there is good quality and improvement—for example, that people are entering the right information and things are findable in the right places. However, our GP quality cluster work is very underpowered. Some support is available from the local intelligence support team, although that was not properly in place during the Covid-19 pandemic because our data support analysts were diverted to Covid-related activity.

If the GP quality cluster arrangements were properly powered and there was adequate resource going in, with all types of data being supported and GPs being given the time that they need to do that non-clinical work, they would hugely improve the situation.

Colin Beattie: Dr Provan, I have become aware of the fact that we push pharmacists as a back-up for primary care. Pharmacists issue prescriptions, yet I am told that that aspect does not interface with the GP practice. That means that anything could be happening in the pharmacy, but there is no record of it.

Dr Provan: Pharmacists have a great contribution to make to the team. General practitioners hold risk and see patients, and they perform a different role. Again, however, the IT is not fit for purpose. People talk about artificial intelligence and other activities. That is important, but GPs just want a computer that works when they switch it on in the morning, and which communicates with other systems. I am being serious. We need to go back to getting core services that work for patients as we move forward.

We want to have electronic prescribing so that a GP can simply send a prescription electronically to the pharmacist. That is crucial—it is at the top of the lists and surveys of what GPs want. It would save so much staff time and GP time if we had that. That electronic communication has been asked for and promised for more than 10 years, so it is definitely a priority.

10:00

Colin Beattie: I will move on to something a little bit different. We have talked about people having difficulty in accessing healthcare in general, and the Auditor General's report highlights that

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

Here is an easy question for you: what are the reasons for that? Do you have a view on the steps that the Scottish Government has taken so far to address that? I will bring in Dr Morrison first.

Dr Morrison: Fundamentally, we have a higher number of people per GP and a higher number of people with disease. There is more disease prevalence in the community, we are caring for one of the most unhealthy nations in the western world, and we have more treatment options than ever before. All of that leads to exponential growth in our workload. The only mechanism by which that can be addressed is to have more capacity in the system.

However, the increasing complexity and comorbidity that we are dealing with means that we need more generalists in the system in order to take a much more holistic, patient-centred approach to how we manage that. That type of consultation also requires more time, but we are incredibly short of time because our capacity is really stretched. As much as the MDTs are able to help to release some of that capacity, whatever capacity it has introduced has not kept pace with the exponential growth in demand.

Colin Beattie: Dr Provan, what is your view on the steps that the Scottish Government has taken so far to address the issues?

Dr Provan: We have been working on the recruitment and retention 20-point plan because we need more GPs. We support that plan because GPs are leaving because of the workload and burnout. Fundamentally, we need more GPs, and that means investing in practices to enable them to employ those GPs. In NHS Lothian, the numbers of GPs in training have gone up, but we do not have resources in the system to employ those GPs in practices to provide services for patients.

Good work is going on to support people like me, who are towards the end of their careers, to keep going, and to support people who are mid-career, but we need a fundamental shift in how we resource the number of GPs to increase the number of GPs per patient.

The Audit Scotland report says that we are not going to hit the target of an increase of 800 GPs by 2027. The number of whole-time equivalent GPs has actually reduced by 4.2 per cent since 2015. We need that basic investment in practices, and things will not change until it arrives and practices can employ GPs.

As I said, GPs hold risk in the system and we are very busy supervising many of the other members of the MDT. That has been one of the consequences of MDTs—we spend a lot of time on training and supporting our team, so we need more of those people in order that GPs can effectively undertake all the roles that they perform.

Colin Beattie: I will come back to MDTs. You mentioned WTE GPs. What proportion of doctors are now working part time?

Dr Provan: The proportion is going up. Recent research shows that GPs are reducing their patient-facing hours simply to be able to cope with their workload.

Personally, I want to ban the term “part-time GP”, because the evidence shows that being a so-called part-time GP is a full-time job, with all the hidden aspects of the workload that sit behind it. However, we need more whole-time equivalents to be able to provide appointments for patients. Dr Morrison may know more about that.

Colin Beattie: Dr Williams, do you want to add anything?

Dr Williams: I will explain one point. The Audit Scotland report picked up on people’s experiences of access. I mentioned earlier the many tasks that arise in general practice and the many contacts that are not face-to-face consultations. People have a lot of encounters with general practice in which something is performed or a prescription or a fit note is provided but they do not feel that they have had a consultation with their GP in the traditional sense. We face some difficulties in how we describe the increased efforts in that type of activity while, at the same time, the experience of our services is reducing.

Colin Beattie: My final question is about MDTs, which were seen as a huge opportunity to improve the situation in GP surgeries. As has been touched on, the Auditor General refers in his report to the 2023 survey by Public Health Scotland, which found that

“MDTs in some cases created more work”

and increased GPs’ workload. That is partly because GPs spent more time on supervising and training.

I would like to understand what else is involved in that work, as there are obviously different strands to it. Do you have a view on that? What steps have been taken to improve the situation?

Dr Provan: We have many groups of people, such as physiotherapists and pharmacists, who have not worked in primary care before and need to learn about the intensity of the job and the number of patients they need to see. They are used to a different work rate and a culture in which they are not managing complicated things with the risk that that involves; they have usually just been looking at a section of one area, and it takes time for them to adjust and to be trained.

In my practice, I will often have three or four people waiting outside my door to ask me what to do about something. That is fine, but I am risk managing that. With the experience and broad knowledge that GPs have, we can say, “We need to do something about that now,” or even, “We need to send that person to hospital or refer them on,” although we take care of most people ourselves. We are performing that role, which was never really taken into account when the contract was first introduced. There is also a lot of work around supporting care navigators and training around that. The MDT has brought more skills to the practice, but that has created some more work as well as alleviating the demands of other work.

Colin Beattie: Is it not a case of short-term pain for long-term gain?

Dr Provan: To some extent it is, but pharmacists and other groups are not really trained at all in primary care during their training; they tend to be trained in secondary care or in universities. Whatever happens, therefore, they have to serve an apprenticeship in the practice—a bit like GPs do—in order to learn about the way things work, the culture and the types of workload and cases that we deal with.

Colin Beattie: Typically, how long does it take for someone to come up the line and to become fully effective without having to impinge unduly on you, as a GP?

Dr Provan: I think that they will always have to impinge on us, given the aspects of our job and the broad medical knowledge that is required to manage risk, which is our remit. I would be making it up if I gave you a figure, but I could say, off the top of my head, that it takes at least a year for somebody to begin to really work in a practice. That involves simply learning how they fit in with the team—it takes a long time for those groups to embed within the team. In some practices, that has not happened, and the training and focus have not been allowed to develop, and that has been part of the problem.

Colin Beattie: Dr Morrison, do you have anything to add that?

Dr Morrison: A major problem with MDT implementation is that we have never had contract specification, so there has been a high level of variance in what is done in each practice. Contract specification would have been hugely helpful in instructing health and social care partnerships on what was required to be delivered in order to provide consistency of approach and reduced variability. Instead, there are highly variable levels of service across every practice in Scotland, so the experience of provision becomes very much anecdotal.

Chris Williams mentioned that the advanced physiotherapy practitioner service is problematic. In my practice, the advanced physio service is superb; we cherish it, and it would be a real loss if we did not have it. We can triage directly to the service for any musculoskeletal condition and we have full confidence that those practitioners will handle it well and autonomously. However, although that is an example of how it can be, it is not replicated across Scotland.

In other areas of the contract, there is a definite culture clash when other practitioners enter primary care. The general practice culture is one of risk absorption and acceptance in which we make decisions based on benefit risk analysis and then continue with that, whereas some of the other elements, as soon as they identify any risk, withdraw from provision until the risk is resolved. That neglects the benefit aspect, which is the reason why the service was put on.

There are cultural issues and workforce issues and, fundamentally, there is the lack of specification, which leads to poor guidance to HSCPs on how we achieve consistency.

Colin Beattie: Do you have any last words, Dr Williams?

Dr Williams: To clarify, advanced physio, or first-contact physio, is a fabulous service and I absolutely would not have it taken away, under any circumstances—it offers something brilliant to our patients. However, it is an example of a new type of service, and we are still learning about how best to use it and how to use digital tools alongside it.

The Convener: I now invite Stephanie Callaghan to continue with the theme of the patient experience and other aspects of the Audit Scotland report.

Stephanie Callaghan (Uddingston and Bellshill) (SNP): I thank all the witnesses for joining us—it is much appreciated.

We all know that general practice is changing; the difficulty lies in getting that message across to patients so that they understand the evolving roles of the multidisciplinary teams. They need to understand that it is not necessarily always the best option for them to have an appointment with the doctor—it may be better for them to have an appointment with another member of the team, because a GP appointment just means that they will then be referred on, so they are waiting twice.

We have spoken about this a little bit already. How well do you think patients understand the evolving roles of multidisciplinary teams? Dr Williams, perhaps you can start by saying a bit about that.

Dr Williams: I would fly the flag for continuity as well. We know that when we can find continuity for our patients, especially continuity with a GP, their outcomes are much better, as is their experience.

I mentioned earlier the efforts that we have made in individual practices to try to make information available. Many of our patients feel that they have been redirected or rerouted—or fobbed off, sometimes—when they think that they are asking for the right person but it is explained to them that they need to use a different part of the system. I am grateful to our chief medical officer for mandating that practices have websites. There was a period in which the NHS 24 team worked to help practices, if they did not have a website, to develop websites with a recognisable format and similar types of useful content. However, not all practices have clear explanations on their websites about how to see different types of professional.

10:15

Stephanie Callaghan: Perhaps you could expand on that a bit and say what differences, in your view, those websites have made on the ground.

Dr Williams: First, they have enabled patients to navigate the site to understand the hours when a surgery is open or how many different GPs are there. That might seem obvious, but there are changes, so having a repository of updated information for each practice is helpful, without overwhelming or overloading patients. Having clarity is also useful. In addition, the website can be helpful for people who are carers and are seeking appointments for their elderly relatives, as it can initially be frustrating for them to find out that the practice with which their parents are registered operates differently from their own practice.

Stephanie Callaghan: I appreciate that.

Dr Provan: Research supports the assertion that patients do not know about the changes with regard to the multidisciplinary team. We have brought in a lot of new skills—physiotherapy has been a success in my practice, too. GPs themselves can provide whole-person care: patients often come with more than one problem, and we deal with that in a very efficient way and get to know the patient, which provides continuity.

My concern is about how we manage, within the MDT, the fragmentation of care that can sometimes occur when someone goes to different people for different aspects of their care, rather than receiving whole-person care. The research shows that continuity is a very effective tool in ensuring patient satisfaction and good patient outcomes, so we need to look at how we get the balance right in that regard.

Dr Morrison: I reiterate that, when we speak about the patient journey, it is far easier for patients to associate the GP with being the first port of call and the start of their healthcare journey. There is a real risk with regard to health inequalities when we try to introduce multiple layers or different services, because it becomes increasingly confusing for people to navigate that. It is fine for someone who is very health literate and is able to self-navigate, if you like, but the NHS can be a very daunting experience, and having general practice as the first point of contact has been shown to be very effective in getting it right for the patient first time.

Yes, the MDT can be of assistance with on-going management, but I think that, as GPs, we have to hold on to the element of being the first point of contact, and to the idea of care that is based on continuity of relationship, which we know leads to massive improvements in health outcomes and can address health inequalities.

Stephanie Callaghan: It is interesting that all of you have mentioned the importance of the feeling of continuity of care and trust from patients. That is an absolute priority and it is so important to patients' wellbeing. I will touch on health inequalities later on.

In your view, what action should the Scottish Government be taking just now to help patients to actively understand the evolving roles in the multidisciplinary team and to build trust more widely?

Dr Morrison: It is quite a difficult message to get across in any public messaging campaign. There were letter drops across NHS Lothian, for example, describing the various services available, but that did not really change the patient flow. We know that health messaging can be very difficult to get across and that it is adopted at very different rates across deprivation groups—for example, it took six months for the most well-off people in society to adopt the back to sleep campaign for babies but 15 years to see a similar uptake among the most deprived people in society. That type of messaging takes a long time to get through, and I genuinely believe that general practice must continue to be the first point of contact. However, there might be a different pathway from there and it is up to practices to educate patients on how that is the best for their needs.

Stephanie Callaghan: Do you have any positive examples just now of GP practices where that has been working quite well? Can we learn lessons from that? Could information be shared that would help improve the process across the board?

Dr Morrison: A number of practices use various triage tools to try to give patients a faster care pathway that maintains that first point of contact element, so that could be explored. However, we must have some sort of focus as well on continuity relationship-based care, because we know that that is what drives the best outcomes in society.

Relationship-based care also lets us address the fact that, quite often in general practice, the presenting complaint is not the main driver of the consultation—we call it the hidden agenda. The complaint about the sore knee might actually be about a lump that the patient is worried about elsewhere in the body. If that is just instantly put to a physio, that lump might not ever get addressed or be addressed in a timely manner. Therefore, we need to have a bit of capacity to be that first point of contact and deliver that continuity relationship-based care, but then use the MDT as and when required when they give best value.

Stephanie Callaghan: Thanks. I would be happy to take other comments.

Dr Williams: Our patients do not always react well to being redirected to other parts of primary care. For example, there has been a concerted effort to guide people who have an eye problem

towards an optician or people with a dental problem towards a dentist. Difficulties exist when patients are not registered with NHS dental practices, for example, or there might be other difficulties in the route towards a practitioner of choice.

As I mentioned, it is a very different thing with physiotherapy, in that we have a new role and in-house service, which requires a different form of explanation. However, even with that service, which we are so proud of, we find that patients still think that they need to see a GP. Although that might have been the way in which they have accessed physiotherapy in the past through an onward referral, we must try to explain to patients that those advanced practice or first-contact physios have a diagnostic role that the community physiotherapy service did not have in the same way previously. They are doing injections—they are doing new things—-but the issue is how we get the good-news messages out, as well as trying to help people to parts of the system that have relative capacity to absorb the work.

Stephanie Callaghan: Are there any specific things that the Scottish Government should be doing to support you?

Dr Williams: Like Dr Morrison, I see the difficulties in trying to run multiple public information campaigns. In the past, we have asked the Scottish Government for assistance in that. I am acutely aware that there are other bits of work that might be in train. There are issues around resourcing and timing, and not bombarding the public with too many messages, especially if those messages might conflict. We want to help our patients to know how to use our health service.

Stephanie Callaghan: It sounds like it is about trust and confidence in GPs. You were talking about physiotherapy. Your confidence in GPs' expertise perhaps also plays a role. Is there anything else that the Scottish general practitioners committee could be doing to help to tackle that issue?

Dr Morrison: Do you mean the issue of patient confidence?

Stephanie Callaghan: Yes.

Dr Morrison: Again, it comes down to the messaging at practice level when things are delegated to the physiotherapy service. Dr Williams mentioned the diagnostics element. When you tell patients that the physios can organise X-rays and refer to orthopaedics as required, that alleviates patients' concern that they are not getting a full service by not going to a GP. That engenders confidence and trust, and when patients have a good experience, that is embedded and they are likely to tell a few friends and so forth. There is a positive cycle there.

Could that be done at national level? How it is done at the level of every practice is highly variable. In my practice, we triage into physio and other areas. There is direct contact to physio outwith any practice control. It is impossible to provide any national messaging. The Government could push ahead with the contract specifications in order to have a standardised process and expectation of what should be provided to GPs and a service that is autonomous and reliable, in which GPs are not the backstop. That means that we can have consistency of approach and solid public messaging.

Dr Provan: Can I—

Stephanie Callaghan: Sorry—I am happy for someone else to come in, but I am really interested in the issue of the Scottish general practitioners committee supporting GPs to provide effective comms and tackle the current negative narrative around GPs. If you could comment on that, that would be great.

Dr Provan: I was just going to comment that patients want to know that we are all working as a team and sharing information on our skills. For example, I was talking about a physio waiting to have a conversation about a patient with me, in between patients. That is a really good use of our time, but I need to trust that physio and the way in which they risk manage the situation. One of the barriers to that is premises. In a recent survey, 80 per cent of practices said that there are not enough consulting rooms. The MDT works best when it is in the same location. Otherwise, you are not members of the same team.

It is difficult to put out a single campaign—or even multiple campaigns—to inform patients about the change, because they will not know about it until they actually need to interact with our services. At that point, because of their experience, they will have to learn how to navigate the system, which can be difficult for some groups.

10:30

Stephanie Callaghan: I will move on to GP clusters. The Auditor General's report stated—I think that this is something that can be agreed on—that the Scottish Government has made limited progress on creating the necessary conditions for GP clusters to succeed. What has been the impact of the recommendations in the 2019 guidance on GP clusters not being implemented or fully funded?

Dr Provan: The guidance is there to support clusters on having enough administration support; having local intelligence support team—LIST—

support around data, as Chris Williams said; and having a culture of being supported by the health board and being listened to when they come up with suggestions for service changes. Our recent survey, which we did with the BMA, showed that there is not enough time for a clinical lead to carry out quality improvement activity or to bring their teams together, and there is not really enough support for protected learning time for practices.

We do not need to reinvent the guidance and we do not need another round of reviews; we just need to think about how we implement what we are doing. A huge amount of quality improvement work is going on—there are already 400 projects—and the research shows that the quality leads want to do more. However, they do not have the infrastructure, time or head space to do that.

When GPs come up with things and say, "Why don't we do things differently?"—one of the roles of the clusters is to suggest service changes—they are not really listened to. That frustrates them and, because they are not listened to, they do not carry on producing ideas. We need to think about how we relaunch and re-empower clusters, because the evidence is that that professionally led system works to improve patient care.

Dr Williams: I will build on what Dr Provan said. There is this desire from our cluster—[*Inaudible*.]—cluster leads, and demonstrated this and inconsistent support. Further resource would have advantages.

I highlight that it is not only Scotland that does cluster work. It is an established way of improving quality and our services by, as one of the—[*Inaudible*.]—building bridges between practices to help improve consistency and understanding of each other. Protected learning time is one way to improve cluster working and the integration of MDT members.

Dr Morrison: I support Dr Williams on protected learning time. We used to have 10 afternoon sessions per annum with NHS 24 cover, but that was withdrawn a long time ago. NHS 24 refuses to cover that, even when local out-of-hours services would support GP practices to take the time. We have also seen a complete flatlining of the practice quality lead remuneration, which has not been uplifted since 2017, so there has been significant inflationary erosion of that.

As much as we can have our cluster meetings and some of the practice quality lead time, without PLT, it is very hard to scale and spread work across practices. You need dedicated head space to work with your entire practice team to make practice systems more efficient and productive and to make the patient experience far better.

Stephanie Callaghan: On that point, would having those 10 afternoon sessions back have a huge impact, or have things moved on from there so that you would now be looking for something different?

Dr Morrison: It is a matter of real regret that the loss of PLT coincided with the 2018 contract, because, when new members of the team are being added to practices, it would be ideal to have proper integration and head space to work together to work out patient flows and the best way to work out patient communications. Practices were not given that opportunity, so we would welcome a return to PLT and the ability to work together across the entire MDT space to make the patient experience much smoother, with better outcomes for all.

The Convener: Stephanie, we are quite short of time. If you agree, we will move on and I will invite Graham Simpson to put questions to the panel.

Stephanie Callaghan: Yes—thank you, convener.

Graham Simpson (Central Scotland) (Con): Good morning. I should say that, like Mr Beattie, I have previously met Dr Morrison. We had a very useful chat on Friday.

I will go back to the convener's first question, which was about the First Minister's announcement of an extra 100,000 appointments in GP surgeries, to be focused on things such as high blood pressure. When I heard that, I thought that it was a load of baloney because, when I get my annual blood pressure check, that is usually with the nurse, not the GP. I have a choice of a couple of places to go to in East Kilbride, where I live. The place that I choose to go to is not my GP practice. I go along and have my blood pressure taken, and they might do a blood test and check my weight. Last time, the result was a bit alarming, so I need to do something about that. However, I do not see a GP at that time, so that is not really getting people to see GPs, is it?

Dr Provan: No. The practice nurse would run that programme, which is designed to reach hard-to-reach populations for screening around cardiovascular health. That is a good target, because there is evidence that this is a difficult group, but those are not front-line GP appointments. We welcome any increase in the percentage of the budget moving into primary care but, as Dr Morrison said, that is really a tiny proportion, and we need a step change in the way in which we do things.

Graham Simpson: In that case, I ask all three of you: do you accept that there is an issue in that people are not able to see GPs? That is not necessarily GPs' fault, and I am keen to explore the reason for that. Perhaps the difficulty comes down to the fact that there are not enough GPs in

Scotland, which is a point that Dr Morrison has made in recent days.

Dr Morrison: I would not necessarily agree that there are not enough GPs. There is not enough core funding to employ the number of GPs that Scotland requires. We recently did a BMA wellbeing and funding survey, in which we asked those in our locum community whether they were underemployed, and a large proportion of them said that they were. We identified 180 whole-time equivalents in underemployed GP time. That is just the locum market, which is very much the canary in the coal mine of overall general practice provision.

If the locum market is struggling for work, that means that there are also fewer substantive posts in general practice on offer. Where GP partner joins are falling or not keeping pace with the intended Review Body on Doctors' and Dentists' Remuneration uplifts, as we have seen for several years, GP partners will generally reduce their sessional commitment to offset the financial loss.

There is a huge amount of GP underemployment across the system that could be restored with core funding—that is the only mechanism by which that time can be realised. Far more capacity is available than is currently being provided.

Graham Simpson: The situation that you described earlier is that people are training to be GPs and are becoming qualified as GPs but are unable to get work as GPs. Dr Morrison, you just said that locums are also underemployed. We have a number of people who, I presume, have been trained in Scotland and are unable to get work. That situation seems crazy. Can you put a figure on that? Do we know how many trained GPs are just sitting there unable to get jobs?

Dr Morrison: Our survey shows that it is 180 whole-time equivalents. That is more than 180 people. We need to move away from talking about head count when we talk about GPs and focus on whole-time equivalents as a better understanding of what is provided to the system.

Graham Simpson: Yes, but I am interested in the number of actual people who are trained to be GPs who cannot get work.

Dr Morrison: It is several hundred.

Graham Simpson: Several hundred.

Dr Morrison: Several hundred people are underemployed. They are not unemployed; they are getting some work, but not as much as they could offer.

Dr Provan: We have increased the training numbers in Scotland, which is welcome, but there is no plan for how we retain that workforce at the end. We need funding and infrastructure. There is pressure from inflation and increases in charges to practices, and the national insurance increase did not help. All those things coming together mean that practices are not sure about whether they can spend.

The Audit Scotland report talks about certainty around medium-term funding. It would be useful to know what the funding situation is so that we can plan for how to use these highly trained, highly skilled GPs. Some of them have come from abroad to train here. We try to make international medical graduates very welcome so that they put down roots and support us in the future. At the end of their training, it can be difficult and stressful for those people to apply for a visa, after they have spent many years training in this country.

We want to support all GPs, because we have great people coming through, but we cannot employ them.

Graham Simpson: That strikes me as a ludicrous situation. Dr Morrison, you identified that there is a £290 million funding gap. If the Scottish Government was to come up with £290 million, what would that get us?

Dr Morrison: We would see a significant increase in the number of GP whole-time equivalents across Scotland. GPs are exhausted by the intensity of their workload, and the only way in which we can truly offset that is by having more colleagues to work alongside us and spread the workload in a more sustainable manner.

10:45

Dr Provan: Extra funding would reduce the number of patients per GP. Many colleagues in my age group have retired because of the job's intensity, and people coming through are finding it difficult. In a recent survey, 67 per cent—two thirds—of respondents said that patient safety was potentially compromised by excessive workload, which is caused by the pressure of seeing patients.

We want to provide a service. I am fitting in patients, who I have known for many years, left, right and centre because I want to provide a service, but it is very difficult because we have only a certain amount of time in the day. The funding would increase the number of GPs who are able to manage risk in the community. All the policy documents talk about more care taking place in the community, but in order to realise that, we need to provide the infrastructure for patients.

Graham Simpson: The statistic that you quoted—two thirds of your members saying that patient safety is compromised—is extremely alarming.

Dr Morrison, over the weekend, you issued a press release on your own survey, which showed that a large number of GPs—about half—say that they have "no realistic chance" of meeting patient demand.

Dr Morrison: That is correct.

Graham Simpson: That is astonishing. How do we rectify that?

Dr Morrison: It is rectifiable. We have made a position statement that identifies what would happen if we had inflationary restoration and moved towards budgetary restoration of 11 per cent. That would transform the face of general practice and allow us to get the average number on the patient list per whole-time-equivalent GP, which is currently 1,760, down to about 1,000. That would mean that we had more time to provide proactive preventative care to the people who need us most, which would have huge knock-on health economic benefits.

Investing £1 in general practice returns £14 to the wider economy. That figure is supported by the King's Fund. We at the BMA have a paper called "The Value of a GP", which identifies a lot of international evidence that shows that, if you get general practice, primary care and medical intervention right, you reduce the huge health burden that is on the nation.

Graham Simpson: I have a question for all three of you, although you do not all have to answer. One big issue that comes up in political circles is the so-called 8 am rush. You know what I am talking about: it is a booking system that some—not all—GPs operate. In order to get an appointment, you have to phone up at 8 am, and it will often be only appointments for that day that are available.

When we chatted on Friday, Dr Morrison, I told you quite honestly that I was registered with a GP that used such a system. I realised that, because of my working practices, I would never be able to see my GP ever again if the practice persisted with that system. Therefore, I changed GPs, and I now have one who I am able to see because they do not operate that system. Do you recognise that as a problem?

Dr Morrison: Absolutely. Practices adopt their systems to suit their local communities, but if there is a demand-capacity mismatch, there will always be victims. Until we address capacity, we will always have the 8 am rush, which has become endemic. If patients had confidence that they could phone and get an appointment at any time of day that was suitable for their needs, because the system had capacity, they would very quickly realise that they did not have to enter the 8 am queue.

It is very hard for practices to overcome that while such confidence does not exist and there is such a rush. It is impossible for any practice to answer several hundred phone calls in the first 30 minutes, so very long call wait times are inevitable, which adds to patient frustration and so on—it makes the whole patient experience poor. The solution is to address capacity.

Dr Williams: I absolutely agree that we are suffering from a demand-capacity mismatch. You can smooth some of the peaks in demand by using digital telephone systems, enabling people to submit forms that explain more about their inquiry or medical problem, or triaging the inquiries. However, in essence, if a large section of the population has lots of reasons to contact your practice, you must somehow absorb that and sift through what needs to be dealt with straight away and what might be better dealt with in another part of the system.

General practices have responded admirably to that challenge, but the situation remains very difficult—even after practices reorganise their appointment systems or try to influence patients' behaviour—because of the demand and level of need in our registered population. It can take months or years to bed in behavioural changes in our patient population. Dr Morrison adequately summed up that we would be in a much better place if patients felt that they could trust our system, but we need greater capacity and more GPs.

Graham Simpson: Do we have any data on how many practices operate the 8 am system?

Dr Morrison: No.

Graham Simpson: Why is that?

Dr Morrison: Scotland has 900 practices, which are generally independent contractors. They have a duty to provide care to the undifferentiated and undiagnosed, but there is no set contract formation on what mechanism is in place to deliver that, so variability is high. Most practices are driven by their local population's needs, and the demographics vary highly from practice to practice.

Graham Simpson: The data question is quite important for the whole of the NHS, is it not? It would be good to know how many patients GPs are seeing, what the booking system is—that is only part of it—how many people are going through the system and what they are being seen for. In England, I believe that GPs are now required to provide a certain level of information, which they are doing, but we are not doing so here.

Dr Provan: I want to emphasise that the first point is the capacity issue for practices. Most

practices work out a system for which triage and book-ahead appointments are suitable for their local population, and they use their capacity to get to the patients who need care the most.

You are talking about potential targets for access, which we do not favour, because the whole situation is much more complex than that. You cannot just say that everybody needs to be seen in a certain period, because we do not have the capacity to enable that. Practices are using triage systems because triaging to other members of the team allows us to get at the patients who need to be seen that day.

We always want to work with practices on situations. One example is how practices could use the clusters to reflect together on their appointment systems and learn from each other.

We want to temper fast access with that continuity that we keep coming back to. If you see the same person, you do not have to tell your story again, so it is a better experience, and you do not have to go round and round in the system.

GPs acknowledge the difficulties that patients have in getting an appointment. We find that difficult as well, because seeing patients is why we get up in the morning. The whole issue of access is complex, and there is difficulty with capacity around that.

Graham Simpson: Dr Williams mentioned websites and IT. Some of the websites for GP practices around Lanarkshire are not as advanced as those that are south of the border. My mother, who is in her 80s, lives in Carlisle. If she logs into her GP practice website, she gets a lot more information than I can get. I think that she is able to book appointments online, and she can get details of what drugs she has been prescribed. I cannot get any of that in Scotland. We seem to be in the dark ages here. Is that a fair comment?

Dr Williams: I am happy to shed some light on the background. There are some online patient services, and the practice's website will link to a further website in order to access them. Although it is not done through the practice's website, there are ways, as you have picked up on, of ordering prescriptions or seeing what prescription items you have ordered recently.

I mentioned the project through which NHS 24 was helping practices to develop websites and access ready-made websites and material. There were thoughts, maybe five years ago, that that project might have some quite technical features and that, as you said, more advanced things might be available and websites might be able to do snazzier things. As far as I understand, only limited funding was available to start that project. A decision was made around the simplicity of the websites that were produced. A range of different companies produce websites for practices.

It is desirable for us to move to a situation in which we have the capability to offer online services and help patients do things without them having to go through the practice telephone switchboard.

Graham Simpson: What needs to happen in order to achieve that? Does that need Scottish Government help?

Dr Morrison: It goes back to my previous comments about the NHS spine portal. We do not have that central repository with ease of access for multiple systems to speak to each other and feed from, which is how the English NHS app works. Through the app, patients can access GP appointment data, prescription data and some of their healthcare record. There are also online systems, which are widely disseminated across England, such as Accurx, which is a digital solution that provides access to information about appointments within and outside of the practice.

Scotland has gone from being the first nation to have an electronic healthcare record and index linking of patients to now being way behind on health IT. England has had digital prescribing since 2010, and we are now looking at that happening maybe in 2030. We really have been left behind.

Graham Simpson: So I am right about that.

My final question is for Dr Morrison. We have got a situation in which GPs are up against it. Some GPs are suffering burnout and leaving the profession. We have got GPs who are qualified but cannot get enough work. You have described some GPs as feeling that the service is on the brink. Are we getting to the stage when GPs are prepared to take action about that?

11:00

Dr Morrison: I am a mid-career GP who took on this role in August because I see this as a crucial point in our profession. I do not see a sustainable future on the path that we are on and neither do my colleagues. When we did the wellbeing and funding survey, 90 per cent of GPs said that they had reached a point when they would consider disruptive action. It is really upsetting to hear that from an incredibly altruistic group of doctors who want to do the best for their patients and their communities.

I have spoken to the cabinet secretary several times about this. We see the £290 million as the mechanism by which we stop the sinking ship going under, but we need to have a proper look at how to create a much more optimistic and sustainable future for general practice. We believe

that that is deliverable by addressing the patient list size per whole-time equivalent GP, which would realise the potential of general practice. The potential is incredible, and it is a wonderful career if you have the right time to do it and are able to build relationships with your patients and see them through their care journeys. When it is performed well, it is an absolute privilege, but it is really demoralising when you know that you could be doing more and better.

Graham Simpson: You have presumably said to Neil Gray that 90 per cent of your members say that they are prepared to take disruptive action. What was Neil Gray's response?

Dr Morrison: We are speaking collegiately and Neil Gray understands the pressures that we are under. He has spoken to multiple practices across Scotland and is hearing the same messages. Essentially, realising the potential of general practice and rescuing it comes down to the core funding and the balance of budgetary decision making. We are working at pace with the primary care directorate to de-escalate from where we are. I can only hope that that comes to fruition.

Graham Simpson: I hope so, too. Thank you.

The Convener: On that rather stark warning note, we are going to have to draw this session to a close. We had some other questions that we wanted to put to you, but we have run out of time. I would propose that, if you agree, we put those questions in writing and make sure that you get an opportunity to give us answers. We did not get on to premises and other areas that we think are important to you and are part of the 2018 contract.

With that, I thank Dr Chris Williams, who joined us online, for your input. I thank Dr Chris Provan for being in the committee room and giving us the benefit of your expertise. Dr Iain Morrison, I thank you also for your time and for the evidence that you have given us this morning. It has been a very useful session, and I thank you all for your participation.

I suspend the meeting, because we need to change over witnesses.

11:04

Meeting suspended.

11:09

On resuming—

The Convener: Welcome to the second half of the meeting. We are looking at the Audit Scotland report, "General Practice: Progress since the 2018 General Medical Services contract".

I am pleased to welcome a team from the Scottish Government, led by Caroline Lamb, who is the director general of health and social care and the chief executive of NHS Scotland. Good morning. Alongside Caroline Lamb are Tim McDonnell, who is the director of primary care; Susan Gallacher, the deputy director of general practice policy; and Andrew Chapman, the unit head for the general practice contract and operations. We have some questions to put to you.

Stephanie Callaghan joins us online, and I will bring her in at the appropriate time. Before we get to our questions, director general, I invite you to make an opening statement.

Caroline Lamb (Scottish Government): Thank you for inviting me to discuss the Audit Scotland report on general practice. I thank Audit Scotland for the report and confirm that, as is our normal practice, we have engaged fully with Audit Scotland during the process of producing the report.

The 2018 contract was a landmark agreement between the British Medical Association and the Scottish Government. It represented our joint statement of intent as to the future of general practice. It was, and it remains, an ambitious, complex and major change programme, with multiple workstreams and timeframes in a continually evolving delivery landscape.

As with any complex programme, there have been challenges, which Audit Scotland has helpfully drawn out. Our partners had different starting points and differing abilities to operate at pace in implementing the change programme. Access to good-quality data has been a long-term endeavour, with known issues and risks. The Covid pandemic had a significant impact on progress, as did the changing societal context that followed, with pandemic recovery, the cost of living and inflationary pressures, increased demand for general practitioner services and UK-wide fiscal constraints all impacting on progress.

I do not shy away from the challenges that have been identified in the report, but we must now build on what we have learned and what we have delivered, and focus on what comes next to improve access, quality and continuity in general practice.

A key aspect of the contract was the development of the multidisciplinary team, which created a fundamental change to how we deliver the service in Scotland. We have significantly expanded that workforce, with more than 5,000 staff working in those services as at March 2025.

Recognising the importance of the GP workforce, we are also now implementing our action plan on GP recruitment and retention, which

was co-produced with GP stakeholders and has been welcomed by the Royal College for General Practitioners. We have refreshed and published "Transforming Roles Paper 6: The Role of the General Practice Nurse - 2025", in which we are very clear about the value of general practice nurses in supporting people's health outcomes. Along with NHS Education for Scotland, we have developed and published a competency framework for practice managers, which guides them in the vital roles that they play to support practices and patients. That is not all; we have also improved the data that is available in relation to general practice and invested in tackling health inequalities.

The work that we are doing in general practice does not stand alone. It is a vital part of the wider primary care ecosystem and of our broader health and social care system. Earlier this year, the First Minister committed to increasing investment in primary and community care, and yesterday saw the publication of the service renewal framework and our population health framework, which sets out our priorities of supporting a more preventative and community-orientated approach to health and social care.

The primary care route map, which we have committed to publishing during the next year, will set out the detailed vision, outcomes and practical actions for primary care—including general practice—to deliver the service renewal framework in the context of wider NHS reform.

It is clear that many things have changed since 2018, and we need to reflect that in our future plans. The service renewal framework, the population health framework and wider ministerial commitments are evidence of our commitment to reform and renewal. General practice, alongside wider primary care, is central to that ambition.

This is an opportune moment to pause and reflect on the snapshot of delivery that Audit Scotland has provided, and to consider how we build on what we have delivered and the lessons learned so far to ensure that general practice has a bright future at the heart of the NHS. We welcome the committee's questions.

The Convener: You said at the start of your statement that the Scottish Government engaged in the production of the report and, at the end, that it was an opportune time to pause and reflect on the report. Do you accept the findings and recommendations of the report?

Caroline Lamb: Yes, we accept the report's recommendations and we are already taking actions to deliver against them.

11:15

The Convener: You accept the key messages that are set out at the beginning of the report, including message 1, which says that the

"commitment to increase the number of GPs by 800 is unlikely to be met by 2027".

You accept, presumably, that commitments that were part of the contract and were supposed to be completed by 2021

"have still not been fully implemented"

that things have been "slower than planned", that the Scottish Government has not been transparent, that there is a lack of clarity and that direct spending to GPs has decreased. Do you accept all those findings?

Caroline Lamb: What I am reflecting is that, as I said in my opening remarks, there have been a number of challenges to complete implementation of the ambition that was set out in the 2018 contract. I have said that I do not shy away from the challenges set out in the report. We accept that there is much more to be done and I am very happy to describe to the committee the work that we are taking forward. I am sure that you will want to ask us about each of the areas—workforce, funding, data and monitoring—but I believe that we can demonstrate that we are making progress. It might not be as fast or as complete as we would want, but we are making progress in all those areas.

What we need to do now, and what we are doing now, as indicated through the service renewal framework, is to say what the next steps are that we need to take to make sure that we deliver general practice as part of a wider primary care environment that is sustainable and fit for the future.

The Convener: We all accept that, yesterday afternoon, a service renewal framework was set out by the Cabinet Secretary for Health and Social Care. However, we are talking about a contract that really has its roots back in 2016. I return to my question. Do you accept the report's findings, which include criticisms of the Government's tardiness and the extent to which the Government has been transparent?

Caroline Lamb: I accept that we have not progressed as quickly and as completely as we might have wanted to. There are a number of reasons for that, not least of which is the fact that we had a Covid pandemic in the early stages of starting to implement the contract.

I accept that we have more to do around data and making sure that we have the robust data to be able to be transparent. I believe that we are also taking steps forward on that. Just yesterday, we had the latest publication on the

multidisciplinary teams, the numbers of staff and the amount of funding dedicated to each of the six priorities.

Yes, there is more for us to do, but I believe that we are making progress.

The Convener: Okay, but I am not going to allow you to get away with blaming the pandemic, because the consultation on this contract began in November 2016, the document was produced in November 2017 and phase 1 of its implementation began in April 2018, which is almost two years before the pandemic. You really cannot blame the pandemic for a failure to implement most of the objectives that are set out in the contract.

Caroline Lamb: It is important not to underestimate the impact of a global pandemic that meant that it was necessary for all our capacity and attention to switch to fighting it, as well as the length of time that it took not just to deal with the initial waves of that pandemic but the subsequent waves of infection flowing through all our health and care systems. We should not underestimate that, but there are also other factors.

As I highlighted in my opening remarks, implementation of the contract did not depend only on actions from the Scottish Government but on actions from our partners, including health and social care partnerships and health boards. It is clear that not everyone was in the same place in terms of their ability to implement the contract rapidly.

The Convener: Before I go to Graham Simpson, I will ask you about paragraph 100 of the report. I have never seen this language in an Audit Scotland report in all the time that I have convened the committee. It says quite bluntly, and Audit Scotland witnesses repeated it when they gave oral evidence to us, that the Scottish Government, in a press release in February 2019, was misleading, because it claimed that 172 loans to GP practices to improve or to purchase or to sell on their premises had been applied for successfully, when it turns out that only 63 had.

Caroline Lamb: My understanding of what happened is that, in the process of producing a press release, there was an unfortunate summarising of the data which meant that data that was about the number of practices that had applied was conflated with the number of practices that had actually been successful and were in receipt of that funding. I will just look to my colleagues to double-check that that is in fact the case.

Andrew Chapman (Scottish Government): Yes, that is in fact the case. When we were developing the policy, there was a call-out to practices about making an expression of interest in the loan scheme, as it was described in the contract, and that figure represents the number of practices that were interested in a loan at the time. The scheme was not live at the time. In the process of making a press release, we work with our communications colleagues in the Government and with special advisers and, as Caroline has pointed out, unfortunately, the press release came out as that. However, in no way was there an attempt to deliberately mislead people with that press release.

The Convener: Well, these are not my words; these are the words of the Auditor General, who said that the Government was “misleading”.

Just for completeness, instead of £30 million being made available in sustainability loans for GP premises, only £15 million has been loaned out. That is half the headline figure that is in the 2018 document. Why is that?

Caroline Lamb: I will refer you to Andrew to confirm this, but my understanding is that it is about readiness. This is not just about us having the funding to give out, but the readiness of GP practices to be able to avail themselves of that funding.

Andrew Chapman: Yes, I think that that is broadly correct. This is a novel financial instrument funded by financial capital. It relies not just on our good will as the Government, but on practices having their deeds in order and on banks, which rightly want to probe the status of the loans, considering the loans and doing their due diligence in terms of ranking agreements and whatnot.

There has been a significant amount of work—on the part of the Scottish Government and the chief legal officer of NHS Scotland, on the part of practices to get their paperwork, and on the part of banks—to get the scheme up and running over the past few years. We have been able to successfully complete on just over 60 loans, with another 40 in the pipeline, which are fundamental to the on-going viability of each of those individual practices.

There are operational issues that we have had to work through above and beyond the issues to do with the funding being available. There have also been issues centrally with the UK Government around the availability of financial transactions capital.

The Convener: Okay. It seems to me that this should not have come as a surprise. At the time of the publication of the contract in November 2017, it clearly stated that

“the contract offer proposes significant new arrangements for GP premises”,

so there was an acknowledgement that this was pioneering, it was significant and it was new. I am

therefore a little bit puzzled as to why some of the difficulties have come as a bit of a shock to the Government.

I will move on and invite Graham Simpson to put some questions to you.

Graham Simpson: Thanks very much, convener. Before I get into my questions, one point that I would make is that when you are putting out a press release, somebody should check it. Do we not have a proper system in place to check the information that is going out in Government press releases?

Caroline Lamb: Yes, my understanding is that absolutely, we check. There is a back-and-forth process to ensure that the interpretations that have been put on information by our communications colleagues are not actually leading to misleading statements. This one was obviously missed.

Graham Simpson: You probably did not see the whole of the previous evidence session. It was all pretty stark, but it ended with a figure from the BMA's survey of its members, which found that 90 per cent of GPs in Scotland were prepared to take disruptive action because things have got so bad out there for doctors. They are under stress, they are suffering burnout and there are not enough of them. How have we got to a situation in which 90 per cent of Scotland's GPs are prepared to take disruptive action?

Caroline Lamb: I accept that the BMA is concerned about the level of funding for general practice, and ministers continue to be in discussion with it about that. The Scottish Government has been doing a lot to try to support general practice. We have increased GP funding every year since 2018. We need to remember that the 2018 contract was premised on an investment in a multidisciplinary team with the objective of releasing capacity and time for general practice. As I said in my opening remarks, that team now sits at more than 5,000 people working in a way that is designed to free up time for general practitioners. The figures that were published yesterday or the day before demonstrate an investment in that team of £200 million. So there have been things that we have done.

We have also successfully implemented the element of the 2018 contract that is about the funding formula for general practice, reflecting workload and, in particular, the impact on workload of working in areas of deprivation. We have also managed the minimum income expectation.

However, I think that we would all accept that the demand on GP practices has increased. The demand on health services in general has increased, partly as a result of the backlog from the pandemic. GPs are picking up the pressure resulting from people wanting more support from their general practice while they are waiting for support in other sectors.

We also need to recognise that that multidisciplinary team may not have been alleviating the pressure on general practice in the way that was envisaged when the contract was agreed. The BMA also believed that that was the thing that would make a difference and release time for general practitioners to be expert generalists. We put in place the primary care phased improvement programme to enable us to get under the skin of and understand what a good, high-performing multidisciplinary team looks like.

We also recognise that the contract had an ambition to move activities such as vaccinations away from general practice and have them delivered by health boards. Some of that work has been very successfully delivered and has been done without us adjusting in any way the funding to general practice. However, there remains much more to be done. We are in a position where it is not just general practice that is under pressure but every part of our health and social care system. I do not know whether any of my colleagues want to add to that.

Tim McDonnell (Scottish Government): Thanks, Caroline. Both the BMA and the RCGPS are core to the dialogue that we have with the professions about improvements and change that we can put in place. The 2018 contract is not just a Government endeavour. We have quadripartite governance with the BMA, the NHS and chief officers in health and social care partnerships to try to get the contract implemented and work through some of the challenges that underpin the survey that Mr Simpson has just referenced. I think that Audit Scotland recognises that that governance improvement is welcome. That means working through those challenges with partners in the profession and looking at the future of not just core funding to general practice but how we get the phased investment programme taken forward on a national basis.

11:30

Caroline referred to pressure. The work that we have tried to do on recruitment and retention—a plan was published before Christmas to cover many aspects of that—is attempting to meet some of the challenges that have been expressed by the BMA, not just in its public appearances here at the Parliament or in its surveys of its members but also in its private and continuous dialogue with the Government. Reflecting on that and ensuring that we learn and take forward the lessons from Audit Scotland will help us to make sure that we

alleviate and move forward to address those pressures.

Graham Simpson: Alongside the 90 per cent who are prepared to take disruptive action, we also heard that two thirds of respondents to another survey of doctors said that patient safety is being compromised. The BMA says that there is a funding shortfall of £290 million. What is being done to address that?

Caroline Lamb: The work that Tim McDonnell referred to on the primary care phased improvement programme is about establishing what a good multidisciplinary team looks like, given that the original agreement between us and the BMA back in 2018 was to invest in that to try to alleviate some of the pressures on general practice. There are good examples in some systems of how multidisciplinary teams are doing that. However, we need to understand how those teams best work and then drive the level of investment that is required. We all accept that more investment is required, but we need an evidence base for that, which is why we are developing a business case alongside running the phased investment programme. We need to evidence that programme with what works well for people—for the workforce and, indeed, for patients.

This is not about having a formula that will suddenly give us a magic number that we need to invest; it is about developing that business case and having the evidence base that demonstrates what is needed and what results we can expect from the additional investment.

Graham Simpson: You might not want a formula, Ms Lamb, but the BMA has come up with a figure, which is £290 million. It has also come up with a figure for the number of GPs who do not have enough work. There are people who are qualified as GPs in Scotland but cannot find enough work—that is an astonishing situation.

Caroline Lamb: The—

Graham Simpson: I have not finished. That is 180 whole-time-equivalent GPs. Doctors are sitting there without enough work, and yet we need more doctors.

Caroline Lamb: The Government invested £13.6 million last year in practices to improve recruitment and retention. We are continuing to work, including with NHS Education for Scotland, to identify the reasons why trained GPs are not working. Part of the recruitment and retention work is about identifying where the barriers to employment are. For example, we need to put in place improved structures to ensure that international medical graduates can access visas.

Tim McDonnell, do you want to come in on that?

Tim McDonnell: I will say two things. First, I absolutely agree with Caroline. The BMA's figure does not include the non-core funding that has gone into multidisciplinary teams. The cost of the 2018 contract, for those 5,000 staff members that Caroline referenced, equates to around £190 million of funding each year—on yesterday's numbers, it is £200 million a year. It is important to take core funding alongside MDT funding.

Secondly, we are engaging in bilateral dialogue with the BMA to find out what more can be done to target core funding in a way that addresses that very problem. That is alongside the work that Caroline mentioned is being done with NES to ensure that the training pathway allows us to fill posts that are available and that need to be filled in the system.

Graham Simpson: Mr McDonnell, do you accept that there is a problem of people qualifying as doctors and not being able to get enough work in Scotland?

Tim McDonnell: Our recruitment and retention plan identifies problems with how we ensure that the number of people who we are training translates into people who are in and stay in the profession, so we recognise that.

Graham Simpson: You recognise that. Presumably, you also recognise that, in order to achieve that aim—although this might be difficult—we will need more investment in GP services, which is what the BMA is calling for.

Tim McDonnell: There are two questions in that regard. First, there is what we do with the long-term MDT funding. As Caroline Lamb mentioned, we have a business case under development to address that. Secondly, there is core GP funding. I accept that that is a discussion that we need to have with the BMA—and we are having that discussion, with the cabinet secretary's full blessing.

Those aspects will address that very question of whether we have the right level of core funding in general practice, alongside the funding for MDTs and the investment that is needed to deliver the 2018 contract.

Susan Gallacher (Scottish Government): I would like to come in on the unemployment of general practitioners, which largely seems to be an issue in the central belt. I am told that there are general practitioner vacancies elsewhere in Scotland. As part of our discussions on funding, we are working with our partners to explore what more we can do to support general practice in the central belt.

Graham Simpson: Why is it an issue in the central belt in particular?

Susan Gallacher: We are not really clear about that, but we are exploring the issue with our partners.

Graham Simpson: Should you not be clear about the reason for that?

Susan Gallacher: If we ask the SGPC, it will say that it is to do with the funding for core practice.

Graham Simpson: That is what it says; that is the whole point of this discussion.

Susan Gallacher: As Tim McDonnell has just pointed out, we are in active dialogue on core funding.

Graham Simpson: It all comes down to core funding.

Caroline Lamb: We must also be conscious that the same factors will apply in the central belt as apply elsewhere. As Susan Gallacher said, there are vacancies in the more remote and rural practices, so it is about ensuring that people are encouraged to work in areas that are outside the central belt of Scotland, too.

Graham Simpson: I will move on to IT. I have asked you before about an NHS Scotland app, similar to the one that they have in England. We explored the matter in the earlier part of the evidence session. It is quite clear that we in Scotland are way behind what is happening south of the border. The level of information that a patient in England can get by logging on is far greater than a patient in Scotland can get.

The doctors in the earlier evidence session described our IT systems. To be frank, they are creaking, and are in desperate need of upgrading. We heard about the NHS spine digital system in England. We are way behind. Ms Lamb, you have come to the committee before and promised that progress is being made, but progress has not been made. Where are we with all this?

Caroline Lamb: On our digital priorities, there are three big elements. The first is the digital front door, which is our gateway into NHS services. It is on track to be launched in NHS Lanarkshire in December. That will be the first stage of the roll-out, and we will incrementally build on that, with plans to roll it out across Scotland more broadly during 2025 and 2026.

The digital front door is being developed to enable access to not just health records but social care records, because we recognise the importance for social care, primary care and acute care of joining up the record and the importance for people of not having to repeat their story and their history. That integrated health and care record is the second of our big priorities.

The third priority, which also impacts significantly on general practice, is around digital prescribing and accelerating the progress on that to release primary care capacity.

Graham Simpson: As somebody who lives in Lanarkshire, I am very interested in that, but I want to know how it will affect me as a patient who uses a GP occasionally. What information will I be able to get through the app from NHS Lanarkshire? Will I be able to use it for digital prescribing or for booking appointments, or is the app not for that?

Caroline Lamb: The first stage of the development of the app will allow hospital appointments to be booked and rescheduled.

Graham Simpson: Will it be only for hospital appointments?

Caroline Lamb: At the start, the app will be for hospital appointments only and it will then be extended to general practice. The starting point will be hospital appointments and the ability to get test results and that sort of data.

Graham Simpson: People often get tests done at their GP practice. Will they be able to get those results through the app?

Caroline Lamb: The ambition is that, over time, you will be able to get all your test results through the app, regardless of where the test was done. It will also help that, no matter where you are seen, clinicians will be able to see that data, too.

Graham Simpson: The answer is no, they will not be able to get those results, initially. It is just a hospital app really, is it not?

Caroline Lamb: As with anything, we have to start somewhere and test it comprehensively before we roll it out.

Graham Simpson: Okay. You do not seem to have learned from what has been done in England. We are way behind here.

Caroline Lamb: That is not entirely accurate. My colleagues in the digital team spend a lot of time talking to colleagues in England, including looking to see what elements of their approach we can adopt.

Graham Simpson: I am sorry to keep mentioning England, but it just seems to be more advanced in many areas. As you know, in England, GPs are required to provide a certain amount of information. Presumably, that allows NHS England to plan better—because it has more data from GP practices. Why are we not doing that here?

Caroline Lamb: The approach here has been to work with the BMA, through the 2018 contract to support, first of all, consistency in data—when you have more than 800 GP practices, issues will

inevitably arise in relation to exactly how data is being recorded on practice systems—but also to encourage all GP practices to make the data available.

We have also been working with NHS National Services Scotland to ensure that there is a national platform—we have been building it—that will enable the data to be visible to practices but also to be used, as you say, for research and the planning of services. I am looking to my colleagues for confirmation, but I think that it is still the case that not every GP practice makes its data available, and we continue to work with the BMA to look for its support to increase that coverage.

Graham Simpson: Ms Lamb, were you looking at Mr Chapman for some help on that?

Caroline Lamb: I do not know whether any of my colleagues want to add to that.

Graham Simpson: No, they do not.

Susan Gallacher: On what happens in England, it is important to remember that the contract set-up in England is different from the contract in Scotland. It enables England to get more specific information from general practice than the design of the 2018 contract in Scotland allows. We can talk a bit further about that. I will pass that to my colleague Andrew Chapman, if you wish to ask more.

Graham Simpson: No, you are absolutely right. It is a contractual arrangement. I just do not know why we do not have it here, and why we have not tackled the issue.

Susan Gallacher: It is because the contractual arrangement is as set out in the 2018 contract—

Graham Simpson: I know that it is, and I know that there is a different contractual arrangement in England that allows NHS England to get more information from GP practices. I do not get why we cannot do the same here. We do not know even basic information, such as the number of hours that GPs are working in Scotland—

Susan Gallacher: Can I come back in?

11:45

Graham Simpson: I am on a roll here, Ms Gallacher.

We do not know how many GP practices operate the appointment system that is described as the 8 am rush. We asked about that earlier, and we do not have that information. Do you not think that we should?

Susan Gallacher: I think that we need to have more information, but this work is being done through a very strong partnership model. On the number of hours that GPs work, we know how many sessions they do and are examining getting more information about the length of those sessions.

Graham Simpson: Is that it?

Susan Gallacher: No. We continuously look to see where we can improve our data sources, but it is key that we work in partnership with the profession.

Graham Simpson: That is just a buzz phrase; it means nothing. We do not have the information.

I see that Mr McDonnell is trying to come to your rescue.

Tim McDonnell: We have data on monthly GP activity, which we publish with Public Health Scotland. We are tracking every element of employment and output from the primary care improvement fund.

When it comes to having teeth, we can direct health boards under current regulations to request data from general practices to help with that planning and management activity, and that must have a consultative element with the SGPC.

What we need to do, particularly as we consider the next phase of the phased investment programme and core general practice funding, is to think about how we link more and better data to outcomes. That will involve a broader discussion not just about data but about the role that general practice can play within a reformed health and social care system.

During my tenure since 2021, I have seen a progressive improvement in the overall data, particularly at a macro level, that is available on general practice, and that data is now broken down to health board level on a monthly basis. We have a very good dialogue with the SGPC under the GP programme board about improving data quality and availability, and I absolutely want to link that to the funding dialogue that we are having at the moment.

Graham Simpson: Thank you, convener.

The Convener: I invite Stephanie Callaghan to put some questions to the witnesses around access to GP services. As I mentioned earlier, Stephanie joins us online.

Stephanie Callaghan: I am hoping that you can hear me okay, convener; my sound was a bit strange earlier.

The Convener: We can hear you, but we cannot see you, Stephanie.

Stephanie Callaghan: Oh!

The Convener: There you are. Please proceed.

Stephanie Callaghan: I ask Caroline Lamb whether she can explain the reasons why patients are struggling to access GPs and why they are less satisfied with GP services relative to 2017-18.

Caroline Lamb: The components of access are around having the right capacity, which means having the right workforce and workforce availability, and having the right processes, such that practices can triage people in order to manage appointments and manage demand. As I have described, through the contract, the Scottish Government has taken action to significantly increase the number of multidisciplinary team professionals who are available to practices. Each practice has, on average, access to five and a half members of a multidisciplinary team. We have also taken action in a number of ways to support practices. For example, NHS 24 can set up standard websites for them that they can use to help patients to understand and access the services that are available. We have worked quite hard to try to create conditions that support access as well as possible.

However, there is significant variation across the country, and we can all tell stories or anecdotes about how hard or, in some cases, how easy it is to access GP appointments or to access an appointment with an appropriate member of the multidisciplinary team. Clearly, we do not want that—we want far more consistency across Scotland.

One of the reasons why we have been working through the phased investment programme is to understand what helps to make access easier and faster. Other on-going work includes the collaborative that Healthcare Improvement Scotland is running across primary care and our encouragement of our health and social care partnerships to learn from one another about what works well so that we can try to reduce variation across the country. Clearly, data is absolutely essential to that work.

Andrew Chapman: I understand patients' frustrations with what has been characterised as the 8 am rush. Patients ask, "Why can't I get through in the morning? Why can't I see my named clinician in a timely fashion?" It is worth mentioning that access, in and of itself, is an extremely complex issue for general practice. It has many facets, each of which we are trying to do something about. We completely get that there is a need to increase capacity, on which we are in dialogue with the BMA—that builds on what Mr Simpson said earlier.

We are also doing work on processes. For example, we have mentioned our support on digital prescribing, which is key to freeing up some of the administrative burden on GP practices. Support is being provided for the transition to digital telephony. We put a bit of money into that throughout the pandemic and continue to support practices on that path as analogue services are switched off across Scotland and the rest of the UK. Work is being done to reduce demand on general practice through all the initiatives that we have in place around not just MDTs but pharmacy first, for example, which has been successful in alleviating some of patients' more minor concerns that, in the past, they would have gone to their general practice about. Now, patients can engage their pharmacist directly at the counter for advice on lotions, ointments and whatnot.

As was trailed in the operational improvement plan, quality is really important. In January, the operational improvement plan committed to developing a quality framework, which will help to create clearer and, I hasten to add, reasonable, public expectations of GP services. That will be part of the dialogue that we are having in partnership with the profession, through the BMA and the RCGP, as well as through our governance arrangements with health boards. Of course, health boards are ultimately responsible for the day-to-day management of contracts and ensuring that the access arrangements are in line with what they expect, and with what our health and social care partnerships, as our commissioning bodies, expect.

I completely get the frustration about the 8 am rush; I just wanted to point out that there are complex reasons behind it. For each of those reasons, we have initiatives in play to drive improvements forward which, ultimately, will help to improve access for our public.

Stephanie Callaghan: Presumably, that is about increased pressure, with the older demographic increasing. The committee has also heard about the impact of waiting lists for secondary care. I am also interested in the plans that are in place to improve the public's understanding of the changes to the way that services are provided, which we have also spoken about.

Caroline Lamb: You raise an important point about communication with the public about the change in the range of ways in which they can access health and care services. The publication yesterday of the service renewal framework is an important moment for re-triggering that discussion on what people can expect, what services will look like and what changes need to happen to services, so that people understand the value of the multidisciplinary team and where to go for help.

As Andrew Chapman described, pharmacy first has been an important development. The pandemic showed us how trusted pharmacies are by the local community when people are looking for advice and support. However, we need to—

and will—continually work with our health and social care partnerships and others to build on the messages around getting the right care in the right place to add to the understanding of what is different and how best to access services.

Stephanie Callaghan: Is that enough? We heard earlier that the continuity and trust in the personal relationship with GPs are really important for patients. Have we got the balance right? Does there need to be more focus on that aspect? What are your thoughts on that?

Caroline Lamb: I do not think that you will find disagreement on the importance of continuity of care and the benefits that that brings, particularly for people who are living with long-term conditions and need more regular access. That continuity of care might not always come from a general practitioner; it might come from a physiotherapist, a pharmacist or another member of the multidisciplinary team, who sometimes is—dare I say it?—better equipped to support an individual's specific needs. However, we all recognise the importance of continuity of care. As we move forward with the development of the primary care route map, which goes beyond just general practice, we absolutely want to look at how we can get back to the idea of a named practitioner who is responsible for an individual's care, depending on what they are living with and managing in their life.

Stephanie Callaghan: Is there a recognition of the importance of GPs having that holistic view of a patient's overall health?

Caroline Lamb: It is important for GPs and for those working in primary care more broadly, including the multidisciplinary team, pharmacists and others, to have that view of the whole person, and for people to be clear about who in the team is best placed to support them.

Stephanie Callaghan: I will move on. The recent programme for government aims to target the prevention of cardiovascular disease. Will you explain how you expect that to improve overall access to general practice?

Caroline Lamb: As you note, the programme for government identified a specific action to target interventions that are aimed at reducing the impact of cardiovascular disease, for which funding of £10 million has been identified. I look to my colleagues on the detail. Andrew, will you pick that up?

Andrew Chapman: Yes, I am very happy to.

A couple of months ago, we issued terms for general practices to participate in an enhanced service for cardiovascular disease prevention. I am happy to say that we have an uptake of more than 90 per cent; I think that we are sitting at around the 94 per mark at the minute.

Under the enhanced service, practices are asked to engage with patients aged between 35 and 60 who might not have come in for regular checks on cholesterol, blood pressure, diabetes or smoking in the past few years. They will get them into the practice, do those tests and see where they are in terms of their cardiovascular health. If their cardiovascular health is in a good place, they will get a lifestyle consultation, ensuring that they have access to appropriate resources in the community. If it is not in such a good place, the conversation will be about whether their lifestyle needs to change, or maybe even about prescribing medication. We have made provision for 100,000 people a year to benefit from that service.

The service is focused on prevention, and it is targeted at areas of higher deprivation. If we look at the data, we see that people in Scottish index of multiple deprivation 1 areas are more than 240 per cent more likely than the average person to die early of a CVD-related illness. We have done something quite novel with the funding to ensure that it is targeted at the areas where people are most at risk of developing a cardiovascular condition earlier on in their lives.

12:00

That will not pay immediate dividends when it comes to access, but it will, I hope, keep people in good health for longer and improve the quality of their lives by allowing them to get the care that they need in a timely fashion, which will pay dividends in the long run. That community-first, prevention-based approach is a key part of the service renewal framework.

Tim McDonnell: As Andrew said, the enhanced service is very targeted, with clear outcomes, a clear funding mechanism, clear activity tracking and a very clear role for general practice to play. It is a model for delivering for other enhanced services that will use the benefits of evaluation and targeted prevention.

The enhanced service for cardiovascular disease prevention involves a large quantum of funding and is at scale—it has funding of £10 million-plus for 100,000 appointments, as Andrew said. Building on it by using both the SRF approach to prevention and early intervention and the general practice model in a clear way to deliver clear outcomes with a clear focus on the things that we know are core determinants of good health is indicative both of a strategic approach in general practice and a strategic approach in wider health and social care, which is embedded in the document that the Government published yesterday.

Andrew Chapman: I will add to and build on Tim's point. We have not done an enhanced service in a while, so for the first time nationally, we are using the enhanced services contracting reporting option—EScro—system, which is an information technology system that was developed by Albasoft, a National Services Scotland contractor. In order for practices to get paid, which is on an item-of-service basis, they will need to code their intervention with the patient in a particular way. That will allow us to get more real-time data on how many people have been seen by the service, their SIMD category and what intervention was used.

I am mindful of the committee's point about data. The way in which we are doing this enhanced service could provide a model for other enhanced services, if that is something that we want to do in the future. As a corollary, the way in which we are asking contractors to code the data in order to be remunerated will improve the data that we get from general practice.

Stephanie Callaghan: That is a really interesting prospect. I have not yet had a chance to read yesterday's report.

I have a final question. From what you have said already, I wonder whether there is any intention to consider incorporating, for example, mental health issues or adverse childhood experiences in the future, or is the approach more about directing the service to areas of deprivation, where perhaps those issues are more likely or more common?

Caroline Lamb: As Tim and Andrew have described, this is the first time in a while that we have looked at having an enhanced service. We have laid the foundations for a really strong evidence base so that we understand how it works—and how the targeting works. I think that we would absolutely want to consider that model going forwards.

Andrew Chapman: Through the primary care improvement plan and the investment in multidisciplinary teams, we are investing in 392 mental health workers to work in and support general practices. There are other ways and means by which we are increasing the mental health provision and support in general practice.

In relation to your question, that is something that we could consider through core general practice and enhanced service investment.

Stephanie Callaghan: Thank you.

The Convener: Thank you Stephanie; that is much appreciated. I turn to Colin Beattie, who has some questions to put to the witnesses.

Colin Beattie: I have some questions about the multidisciplinary teams and about progress in transferring services to NHS boards, which apparently has not been going well.

The Auditor General's report makes it clear that there are still implementation gaps and that there is insufficient data about the value for money and impact of MDTs. What is the impact of not fully implementing MDTs? The ambition is to reduce GPs' workloads and to enable them to focus on the more complex patients and on whole-system quality improvement, so what is the impact of that delay?

Caroline Lamb: You have clearly articulated the intention behind the establishment of the multidisciplinary teams. We have some local data about the impact and success of those multidisciplinary teams. In Glasgow, a pharmacist-led pain clinic was set up, which reduced GP appointments by 67 per cent compared to the six months prior to that. Pain scores also improved by an average of 33 per cent, so there was a benefit for general practitioners and, importantly, a benefit for patients too. We have a number of other examples like that.

I will invite Tim McDonnell and Andrew Chapman to say more, but the work that we have been doing on the primary care phased investment programme has been about understanding the impact of multidisciplinary teams at a far more detailed level. It is also about knowing what good looks like and what we must ensure we have in place across the country in order to get the full benefit from that £200 million investment and from having 5,000 members of staff working alongside general practice. That is an important part of understanding how far we have got, how much further we must go and what the potential is. We also need to understand what makes the difference. A lot of what we have learned so far suggests that it is important for teams to work together and trust each other.

Tim McDonnell: The transformation that was envisaged in 2018 was that MDTs would transfer services out of general practice. There was a joint agreement between the BMA and the Government, based on prior academic evidence and on an understanding of the impact that that would have. It was also about ensuring that some of the employment risks held by general practice were transferred to health boards.

I accept what the Audit Scotland report clearly says about pace, which is that there has not been full implementation of MDTs across the priority services. The Scottish Government faced an important choice in 2022 between spending over £150 million recruiting nationally to close the implementation gap and prudently determining how to achieve an evidence-based implementation of the remaining elements of the contract to recruit to fit the population needs, informed by health and

social care partnerships and health boards, working with local medical committees and partners. That is what we chose to do.

Healthcare Improvement Scotland has worked, both in the four demonstrator areas and nationally, to try to inform what full implementation would look like and the benefits that Caroline Lamb identified. We now have a dedicated resource in my team to translate the results of that phased investment programme into a strategic outline case, using green book best practice to determine what the next steps should be, with those sitting alongside core investment in general practice. The benefits will absolutely be targeted to be clear about outcomes and will allow us to know how we can most effectively transfer workload and ensure that outcomes are supported at practice level.

Colin Beattie: In his report, the Auditor General said that there is insufficient data about the value for money and impact of MDTs, yet, in specific cases, you have been able to give me percentages of improvements. That does not seem to fit together.

Caroline Lamb: The Auditor General is highlighting that we did not have that overview at a national level. Because it is important that the development of MDTs is led locally and based on local needs, we have taken a different approach to what has been prioritised for MDTs across Scotland. Although we have some evidence from local surveys, the work that we have been doing on the primary care phased improvement plan in four different areas of the country has been based on gathering more systematic evidence of what works, so that we can inform the next development of the MDTs.

Andrew Chapman: It is worth mentioning that the MDTs have grown during a short and, with the pandemic, turbulent period. We went from zero in 2018 to about 3,750 people being funded to work through the primary care improvement fund, and an overall cohort of around 5,000 MDT whole-time equivalent staff. To do that type of service redesign and have the NHS working with contractors in that intimate way that they had not done in the past, within five years, is a phenomenal pace for the whole-time equivalent figure.

However, at the same time, and partly because we were working through the pandemic period, we need to do that work on the impact of more investment in the multidisciplinary team at this stage. You will all be aware of the constrained finances within which we are working. Every pound that we put into the multidisciplinary team is a pound that we cannot put into core general practice or elsewhere in the health and social care services and the wider public sector landscape.

As Tim McDonnell said, it is only right that we pause, if we can call it that, the phased investment programme, which has been a huge amount of work for him and the demonstrator sites in the past two years, to give us clearer information on the impact and whether we have got the prioritisation right.

Halfway through that time period, we decided to prioritise pharmacotherapy, CTAC services, nursing support and vaccinations in order to inform policy development and our investment. As it is configured, the business case is going to look at core general practice and MDTs in the round. That is how we move things forward.

Colin Beattie: I refer you to paragraph 35 of the Auditor General's report, which says:

> "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."

He goes on to give some more information on that. Do we have data, or do we not?

Caroline Lamb: The situation as reflected in the report and the figures that I just quoted you, as well as others that I could quote you, is that some areas have done their own impact assessment, but there are other areas where the data is more sketchy and more difficult. Because different areas have prioritised different aspects and different demographic factors are associated with different areas, it has been more challenging to get a national picture.

Tim McDonnell: We have tried to make sure that, as a priority task for the entire organisation, HIS is supporting not just the phased investment programme but a national improvement collaborative. Its work to systematise and improve data to meet that very point in the Auditor General's report is uppermost in our mind. The oversight board, of which Andrew Chapman and colleagues are members, gathering data in a robust way, ensuring that it is available and used within the next phase of MDT implementation, and drawing from available local data that Caroline Lamb talked about, while making it academically robust and more broad, is key to being informed. If we look at the governance of that programme, the tasking to HIS and the work with academic partners, we have a good story to tell and we are actively working to address the gaps that the Auditor General referenced.

12:15

Colin Beattie: How are you going to address the lack of transparency and understanding when it comes to spending on each of the six priority services?

Andrew Chapman: The report on primary care improvement plans was published yesterday and, for the first time—this meets the Audit Scotland recommendation—it includes data on financial expenditure on each of the services. That is what the £200 million figure, which is broken down by service area, does, as Tim McDonnell said.

Colin Beattie: I have not had the opportunity to read that report. Do you believe that that criticism has now been addressed?

Andrew Chapman: Yes.

Colin Beattie: I look forward to reading the report.

You have had long-term challenges with recruiting people into MDTs. Have the sites that have taken part in the phased investment programme fully recruited into pharmacotherapy and CTAC services. Has enough been done to inform the evaluation?

Andrew Chapman: Collectively, they have recruited 135 whole-time equivalent additional members of staff, which is a significant achievement in a short time. That period of time had to be short because we are coming to the end of the parliamentary session and we want the phased investment programme outputs to be ready to inform dialogue and debate during the next parliamentary session.

Colin Beattie: Are you saying that the sites have fully recruited?

Andrew Chapman: I do not think that they have fully recruited in line with the plans that they submitted as part of the phased investment programme. However, there is learning from that, which we need for the future.

Colin Beattie: Can you give some idea of the shortfall in those areas?

Andrew Chapman: I am happy to share the plans and where those sites are at in their recruitment with Mr Beattie.

Colin Beattie: I do not know whether they are 10 bodies short or 100 bodies short. What does "fully recruited" mean? It would be helpful if you could give those figures to the committee.

Moving on, you gave transitionary funding to all general practices, regardless of access to MDTs. What was the rationale for giving it to every practice, including those that already had MDTs? Then, of course, you stopped the funding.

Andrew Chapman: As you can imagine, there were very long discussions with the profession, health boards and health and social care partnerships at that time about how to implement the commitment to transitionary funding arrangements.

I hasten to add that we were working in a pandemic environment, and given that it was so challenging to catalogue each practice's individual benefit—for want of a better word—from the MDT investment, it was felt that a flat payment was the prudent approach at that time. We wanted the focus to be on the implementation of MDTs, and we still want the focus to be on that.

The other route that we could have gone down would be to give an item of service payment, but that would have created significant bureaucracy and it would have risked us taking our eyes off the prize, which was MDT implementation. That is why we agreed with the BMA to the flat payment structure rather than doing something that might have been a bit more nuanced but would have created significant bureaucracy during the pandemic environment.

Colin Beattie: How do you assess the feedback from doctors that MDTs have—at least in some cases—created more work because of training needs and so forth? One doctor said that it takes a year before people who come in are properly integrated into general practice.

Tim McDonnell: I am not underplaying the need for integration and whole-system delivery, but one key benefit is that the boards take on responsibility in their organisation and structures for such training, and they provide elements of assurance. We have to look for a model whereby board-employed staff come with a sense of assured delivery and sit alongside what is delivered in core general practice. I want to focus on the structures and processes for the future, so that we ensure that integration is efficient, timely and delivered in a way in which the benefits that we are tracking are delivered.

Colin Beattie: The point has been made to us that primary care is very different from secondary care and that the transition will take time and a different mindset. How effective will any training that is done by NHS boards be when they move into primary care?

Tim McDonnell: Yesterday, we published the SRF, which sets out the idea that fixed and firm distinctions between primary and secondary care will not be the future operating model of the NHS. The nature of interface care between primary and secondary care and the need to ensure that we are tracking continuity for the person and focusing on things that are in a preventative space are very much the focuses of the board, board chief executives and—in a training space—the NES.

I accept that it takes time to ensure that you are equipped to operate in a primary care or general practice environment, but I do not necessarily accept that the fixed distinction is apparent everywhere, nor must it exist going forward.

Colin Beattie: Have you consulted GPs to get their opinion on the transition, how long it will take and what different skills will have to be developed?

Tim McDonnell: General practitioners are not only part of the programme board that oversees the overall programme; they conduct training delivery and the development of clusters. We work jointly, particularly with the Royal College of General Practitioners Scotland, to ensure that we understand what is required in order to integrate the MDT alongside core general practice. We absolutely want to do that and continue to take feedback on it.

Colin Beattie: Based on the feedback from doctors, it sounds like you have a bit of work to do to understand the transition.

Susan Gallacher: I want to highlight that the phased investment programme is looking at the differences between general practitioners and MDTs and how they interface. Much more specific evidence will be generated by the four demonstrator sites—that is what we call them—as part of that programme. I also want to highlight that the programme's interim report is also due in July.

When it comes to direct feedback outwith the evidence-based programme, we have been told that we have work to do by SGPC colleagues, which we take very seriously. We are taking that into consideration as part of the evidence base that we are gathering from the phased investment programme, but we are also working very closely with the health and social care partnerships, which are not part of the programme, due to the evidence base that they are generating.

Colin Beattie: Okay. I will move on from MDTs and go back to the availability of data. You have been putting a new clinical IT system in place for GPs, but the supplier has gone into administration. Is the timescale for rolling out the GP clinical IT system by 2026 still valid? What is the situation with the supplier?

Caroline Lamb: I need to be a bit careful about what I say about this, given that the supplier has gone into administration. NHS National Services Scotland is working on that process on our behalf and it is also supporting the roll-out. We are very keen to stick as closely to the original timetable as possible.

Colin Beattie: Is that feasible?

Caroline Lamb: I think that it will depend on how quickly the administration process concludes.

Colin Beattie: So, we do not have any idea of when it will be.

Caroline Lamb: It is out of our hands at the moment.

Colin Beattie: What is your back-up?

Caroline Lamb: This is not about a back-up. We are confident that the process will conclude successfully. Even if I knew, I do not think that it would be appropriate to discuss the timetables, given the impact that that might have on the process.

Colin Beattie: Do we have funds at risk?

Caroline Lamb: No.

Colin Beattie: Okay. What are the implications of a delay in the roll-out of the GP clinical IT system for the plan to create a primary care data and intelligence platform by March 2026?

Caroline Lamb: The roll-out of a new GP IT system consistently across Scotland will greatly facilitate our ability to access all the data that we need to access. Andrew described how Albasoft is being used to extract data from GP IT systems across Scotland and, at the moment, that situation still exists. That means that we can still produce data and we have been improving the data that we produce. The roll-out of the new GP IT system will just move that on a level.

Colin Beattie: In order to make material improvements in the quality and availability of data, is there specific support that you consider to be necessary for general practices, to help them consistently collect and record the data that is required? Historically, there have always been slight differences in the way data is collected across different practices. How can we tackle that?

Caroline Lamb: Correct me if I get the name wrong, but the primary care data improvement programme has been working on supporting practices to code things consistently. The new IT will also help with that by providing more prompts in terms of the correct way to record things.

When you have multiple areas for inputting data, it is always a challenge to make sure that that data is input on a consistent basis.

The Convener: I have two final questions to put to you, director general. The first may have been answered, not so much in the cabinet secretary's statement, but in the associated paperwork that accompanied his statement, which I think Mr Chapman alluded to, in part, earlier on. I look back to the evidence that we took from the Auditor General on 14 May, which is reflected in paragraph 42 of the report. He said to us that

"the Scottish Government still needs to clarify its plans for general practice and to set out the actions, timescales and cost to deliver that."—[*Official Report*, *Public Audit Committee*, 14 May 2025; c 4.]

What he is asking for there is very clear. Do you plan to publish that information?

Caroline Lamb: As you have recognised, we published the "Health and Social Care Service Renewal Framework 2025-2035" yesterday. It very clearly identifies the direction of travel for health and social care services and the real importance of primary and community care and general practice in among that. It also set out our intention to publish the primary care route map, which will absolutely get down into the detailed actions alongside that.

The Convener: Did we get timescales yesterday?

Caroline Lamb: We said within a year.

The Convener: Okay. Everything within a year?

Caroline Lamb: No, sorry, the primary care route map.

The Convener: The next plan about the plan will be published within a year?

Caroline Lamb: The route map.

The Convener: The route map will be published within a year. What about action? What about the implementation of the terms of the 2018 contract?

Caroline Lamb: That does not mean that we are not continuing to take action. The route map is about the next steps, the next vision and the next objectives for primary care. This is not about us not continuing to take action. We have already, through the operational performance improvement plan, taken actions in primary care. We are collecting the evidence base for the next stage of development for the multidisciplinary teams through the phased investment programme and through the development of a business case. We continue to take action, and we continue to be in dialogue with the BMA around the investment that is needed to deliver all that.

12:30

The Convener: In the fullness of time, you might perhaps be able to pause and reflect on the evidence session that we had with the BMA and the Royal College of General Practitioners before you came in, because they gave a rather different picture of the action that was needed.

I will ask you one final question, director general, which again relates to yesterday's announcement. One of the things that was announced was the merger of National Services Scotland and NHS Education for Scotland. Mergers and reorganisations often deflect organisations from their core purpose. In the evidence session that we had before you came in and in this one that you have been involved in, it has emerged that both those institutions—both those parts of the delivery of services—are critical to meeting the aspirations and the ambitions of the 2018 contract. Do you not think that merging those organisations might deflect them from the things that we want them to get on with, including data collection and ensuring that GPs are properly and fully employed?

Caroline Lamb: We have been really clear in the discussions that we had with both boards in the run-up to yesterday's publication that business as usual must continue unaffected. We think that there are huge opportunities for both organisations, and for a bigger organisation to do more on behalf of the NHS across Scotland.

At the point at which we are in the development of our approach towards health and social care services, it was really important that we took the opportunity to build on the expertise, the capability and the capacity that is in those organisations in a way that will enable a combined organisation to do more. We will be working very closely with the leadership of those organisations to ensure not only that the eye is not taken off the ball during that process but also that we are grabbing those opportunities to do more and to go further and faster.

The Convener: You just described the process as creating a bigger organisation. Presumably, part of the thinking behind merging two organisations is to rationalise and look at whether there is duplication, and whether a synergy might lead to fewer people being employed in the organisation or to the services being delivered in a different way. Is that part of your thinking?

Caroline Lamb: Absolutely. Part of our thinking is about whether there are opportunities to remove any duplication and to rationalise. However, a big part of our thinking is also about what that organisation can do on behalf of NHS Scotland that will lead to efficiencies in other parts of the system. So yes, efficiencies and being able to deliver services on a once for Scotland basis are absolutely at the heart of our thinking in all that.

The Convener: Director general, we must leave it there. Thank you very much for that final answer.

I thank all our witnesses for the evidence that they have given us. Thank you, Andrew Chapman, Tim McDonnell, Susan Gallacher and director general Caroline Lamb for giving us your time and insight. We might want to follow up on some areas; I think that you, in turn, undertook to give us more information, which we would very much value, as always.

With that, we move into private session.

12:33

Meeting continued in private until 12:49.

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