OFFICIAL REPORT
AITHISG OIFIGEIL

Public Audit Committee

Wednesday 14 May 2025

Session 6

The Scottish Parliament
Pàrlamaid na h-Alba

Wednesday 14 May 2025

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PUBLIC AUDIT COMMITTEE
15th 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:

Stephen Boyle (Auditor General for Scotland)
Carol Calder (Audit Scotland)
Stephanie Callaghan (Uddingston and Bellshill) (SNP) (Committee Substitute)
Fiona Lees (Audit Scotland)
Eva Thomas-Tudo (Audit Scotland)

CLERK TO THE COMMITTEE

Katrina Venters

LOCATION

The Sir Alexander Fleming Room (CR3)

Scottish Parliament

Public Audit Committee

Wednesday 14 May 2025

[The Convener opened the meeting at 09:36]

Interests

The Convener (Richard Leonard): Good morning. I welcome everyone to the 15th meeting of the Public Audit Committee in 2025. We have received apologies from Stuart McMillan, so I welcome Stephanie Callaghan, who is substituting for Stuart. She is attending virtually for this, her first Public Audit Committee meeting.

Because it is your first meeting, Stephanie, I ask you to declare any relevant interests.

Stephanie Callaghan (Uddingston and Bellshill) (SNP): Just for the record, I was a councillor in South Lanarkshire Council until 2022.

The Convener: Thanks very much.

Decision on Taking Business in Private

09:37

The Convener: Agenda item 2 is for members of the committee to consider whether to take this morning's agenda items 4, 5 and 6 in private. Are we agreed to take those items in private?

Members *indicated agreement.*

“General practice: Progress since the 2018 General Medical Services contract”

09:37

The Convener: Agenda item 3 is consideration of the report by the Auditor General for Scotland “General practice: Progress since the 2018 General Medical Services contract”. I am pleased to welcome the Auditor General, Stephen Boyle. Alongside the Auditor General we have Carol Calder, audit director at Audit Scotland. Joining us online is Eva Thomas-Tudo, audit manager at Audit Scotland. Also joining us in the committee room, we have Fiona Lees, senior auditor at Audit Scotland. You are all very welcome.

We have a number of questions to put to you on the report that you have produced. However, before we get to those questions, I invite you to give us a short opening presentation, Auditor General.

Stephen Boyle (Auditor General for Scotland): Many thanks, convener. Good morning to you and to the committee.

As you mentioned, I am bringing to the committee my report on general practice, which considered the progress that has been made in implementing the 2018 general medical services contract. My report highlights that pressure on general practice has increased since 2018. The reasons for that include a growing and ageing population and enduring health inequalities, together with longer waits for hospital care. Alongside that, the number of estimated whole-time equivalent general practitioners has fallen, and spending directly on general practices has now started to decrease in real terms as a proportion of overall spending in the national health service. People are reporting that they are now finding it more difficult to access healthcare and are less satisfied with the care with which they are being provided at their general practice.

The 2018 general medical services contract aimed to address financial pressures and growing workloads and to improve patients’ access to care. However, seven years on, several commitments have not been fully implemented, and there is now uncertainty about the strategic direction for general practice in Scotland.

Challenges remain with rolling out multidisciplinary teams across the country, and some proposed changes to the way in which general practices are funded have still to be agreed. The Covid-19 pandemic impacted plans, but there remains a lack of clarity about whether, and when, the remaining contract commitments will be fully implemented; how much that will cost; and whether the changes introduced represent value for money or have improved patient care.

I note last week’s programme for government commitment to an extra 100,000 general practitioner appointments by the end of this year, focusing on preventative measures. However, the Scottish Government still needs to clarify its plans for general practice and to set out the actions, timescales and cost to deliver that.

My report makes a number of recommendations to the Scottish Government, but implementing many of them will require the support of GPs, and collaborative working across the health and social care sector.

As ever, convener, we will do our utmost to answer the committee’s questions on the report.

The Convener: Thank you for that outline. I will go straight to Graham Simpson, who will open the questions.

Graham Simpson (Central Scotland) (Con): Good morning to you, Auditor General, and to your team.

This is a damning report, but for those of us who occasionally have to use GPs, it probably tells us nothing that we did not know already: services are strained, and it is often difficult for people to get a GP appointment.

You mentioned the programme for government and the announcement of 100,000 extra appointments for things such as high blood pressure, high cholesterol and so on. That announcement was made in the context of the First Minister saying that he wanted to end the so-called 8 am rush, which refers to the booking system that many GPs use. People have to phone up at 8 am and that is it—if you cannot phone up at 8 am, quite often you are snookered.

Given that that is the First Minister’s ambition, I turn to the letter from Dr Iain Morrison of the British Medical Association—which I presume that you have seen—in which he says some very strong things. He says:

> “We have called upon the Scottish Government to urgently address the shocking situation that General Practice is in and invest directly in GP practices. The funding practices receive for every patient has been eroded year after year against inflation since 2008. In all, eroded funding streams and new cost pressures have created a shortfall in practice funding of 22.8 per cent, and some £290m will be required to close that gap and deliver full funding restoration.”

Dr Morrison presumably knows what he is talking about, as he represents GPs.

Given the situation that you have outlined in your report, and those damning comments from Dr

Morrison, does the First Minister have any chance of achieving his aims?

Stephen Boyle: There is a lot in your question, and I will try to address all of that through our responses. As ever, if I omit something, please remind me; I will try to cover all the points that you make.

I start with the detail of the announcements in the programme for government, which clearly came after the publication of our report. First, I signpost the committee to paragraph 30 in the report, which identifies the Scottish Government's announcement, in November last year, of additional recurring funding of £13.6 million to "ease ... pressures", together with £10.5 million of funding in 2025-26 to target general practice.

The committee will be familiar with much of the discussion about earlier intervention and preventative spending, and that seems to be the thrust of the commitment to 100,000 additional appointments by the end of this year. In and of itself, that would be a welcome contribution. However, by way of context, if it would be helpful for the committee, I will consider what that means on the relative scale of interactions that take place in general practices across the country.

09:45

Looking at Public Health Scotland data, we can take March 2025 as a helpful example. It is perhaps not an average month, as there were still winter pressures, but it is indicative of the scale overall. In the month of March, there were 2.9 million direct encounters in general practices. If we extrapolate that across the full year, we can say that more than 30 million direct encounters take place every single year.

Of course, 100,000 extra appointments will be welcome. More detail on that is necessary, as we still do not have all the precise information about what those appointments will be used for, but I think that it has been suggested that it will be along the lines of more preventative measures and interventions such as cardiology assessments and general health improvements. I will bring in Eva Thomas-Tudo in a moment, as she has undertaken some analysis of that, but it is not yet clear whether that will actually ease some of the pressures in the system that have been spoken about, and which Dr Morrison outlines.

In going through our report and the evidence that we looked at in arriving at our judgments and recommendations, we considered that there is pressure in the system, and that the GMS contract that was designed to address those pressures has not yet been implemented in full. That led us to the recommendations that we make on pages 6 and 7. There remains a need for a clear delivery plan to implement the refreshed vision for primary care, together with clarity on what the next steps are to implement the outstanding parts of the contract.

I will come back to your point about access to appointments in a moment, but I will bring in Eva Thomas-Tudo to say a bit more about our assessment of the programme for government announcements.

Eva Thomas-Tudo (Audit Scotland): I am happy to provide a bit more information. Our understanding is that the announcement provides more detail—as the Auditor General highlighted—on the £10.5 million that was announced as part of the 2025-26 budget. The Scottish Government has now provided information that the £10.5 million is intended to provide 100,000 extra appointments in areas of preventative work for cardiovascular disease.

We have concerns about the capacity of general practice to deliver that. The Royal College of General Practitioners and the BMA have both said that they are not clear on how much capacity general practice has to deliver it. In addition, given that it is intended to provide an additional enhanced service for cardiovascular disease, it is not clear whether that will have a significant impact on the 8 am rush to access appointments, because it will provide services that were not necessarily happening before.

Stephen Boyle: I am happy to take any follow-up questions, Mr Simpson, but I will address—

Graham Simpson: Okay. Sorry—have you finished?

Stephen Boyle: I am sure that we will cover more of what I was going to say in a moment, so I am happy to pause.

Graham Simpson: It strikes me that, if we want to end the 8 am rush—it is not just the First Minister who is saying that he wants to do that; other political leaders have said the same—we need to know how many GP practices actually operate that system in order to start to tackle it. We do not know that, do we?

Stephen Boyle: One feature of the report—again, this theme will be familiar to the committee—concerns the adequacy and quality of data in primary care health services in Scotland. Fiona Lees has looked at a lot of that in some of the work that we did, so I will bring her in to develop our position on it.

Many plans and workstreams are in progress across NHS boards, Public Health Scotland, NHS Education for Scotland and NHS National Services Scotland. All those organisations are working to improve the quality of data to allow informed strategic decisions to be made about how primary care services will be delivered. However, the

fundamental issue that remains is that the data that exists on how general practice is being delivered—which is what we are talking about today—is not of good enough quality to allow evaluation and monitoring.

In my opening remarks, I mentioned value for money, which is a core part of our responsibilities and of the interest of the committee. We have survey data and estimated data not only about access—for example, the morning rush—but about patients and GP numbers, which I am sure we will talk about today; however, it is difficult to make those judgments when, fundamentally, that is not yet the good-quality, sustained and empirical information that allows effective decision making and monitoring.

I will bring in Fiona Lees to elaborate on how we approach that as part of our audit.

Fiona Lees (Audit Scotland): To answer your question, Mr Simpson, we do not know exactly how many practices allow online booking. We know that some do, through their websites or external systems such as Patient Access, but we do not have central data that tells us how many practices allow patients to book appointments online.

Graham Simpson: In fact, they are not required to supply that data.

Fiona Lees: We did not ask that question, so I could not say that for sure. However, as far as we are aware, there is no centrally held list that has that information. I am sure that, if you went round all the practices and asked them, they could provide that information, but we did not do that as part of this audit.

Stephen Boyle: I mentioned the work that the national boards are undertaking and the fact that there are plans and aspirations for greater consistency and better data. There are plans for a national GP information technology system by next year, although that project is encountering challenges because the supplier of the system has gone into administration, so there are delays in making it a viable product, as I am sure that you have seen in the report. There is a new web application, too, to better capture some of the workforce data. That is symptomatic of the stark contrast between how data is used and captured in primary care and the extensive volume of data that exists in hospital or acute services across NHS Scotland. I know that the committee is familiar with that point, having taken evidence from Public Health Scotland on it.

Graham Simpson: I will come back to data later. For now, I go back to the pressures that GPs are under, which are due to a lack of GPs and a large number of patients. In paragraph 13 of your report, you say that there are more patients registered than there are people in the country, which is quite staggering.

I was struck by paragraph 15, which shows the difference across the country. It states:

> "The number of patients per WTE GP varies widely, from 721 in NHS Orkney to 2,373 in NHS Lanarkshire."

The latter area is the one that I, the convener and Stephanie Callaghan represent. Last week, the convener and I were at a briefing at North Lanarkshire Council in which health was a big feature. Although North Lanarkshire is doing well in some respects in health terms, people are basically struggling to get healthcare, and that figure shows why. We do not have enough medical practitioners—GPs and others—which, in some parts of the country, is a challenge for the overall health of the population, is it not?

Stephen Boyle: First, you quite rightly draw attention to the difference between the number of people who are registered with a GP and the overall Scottish population, as paragraph 13 sets out. That feels like a curious anomaly. The Scottish Government recognised that and, as we set out in the report, has commissioned a short-life working group to better understand why it exists. As we have already talked about this morning, data is part of the reason, but the difference is also symptomatic of the fact that a more transient population exists. Student population is often cited as part of the reason; people register and then leave the country without deregistering. At the very least, some data cleansing is required to address that issue.

I turn secondly to paragraph 15—I might also touch on paragraph 62 for reference, which potentially links to the points that you made about the regional variation in the number of patients per practice in different parts of the country. It is perhaps not surprising to find that the lowest figure is for Scotland's three island health boards, given the geographies relative to population centres there.

I am not drawing a direct correlation between NHS Lanarkshire's figure and patient satisfaction, but it is noteworthy that people were less satisfied about the care provided by their general practice in 2023-24 than they were six years previously, as shown in exhibit 5 on page 26, which is drawn from the health and care experience survey, and that NHS Lanarkshire is the part of Scotland that is least satisfied with its general practice, as is set out in the final bullet point in paragraph 62. I caveat that by saying that I am not drawing a direct correlation between the number of patients registered per GP practice and satisfaction levels, but the fall in satisfaction levels in NHS Lanarkshire is noteworthy.

Graham Simpson: Yes, I noted that. I live in Lanarkshire and I am happy with my current GP, but that is only after having moved GPs because I could not get an appointment with my previous one. I have gone to a GP practice that does not operate the 8 am system, but not everyone can do that. The ability to switch is not widely known about, and it is not always that easy to do.

You mentioned spending on the six priority areas. Why does the Scottish Government not publish data on that? That limits transparency and public scrutiny. Have you asked it about that?

Stephen Boyle: I will bring in the team to set out some of the engagement that we have had—Carol Calder can speak to that point in a moment. We share the concern that I infer from your question about the need for better disclosure of spend on the priority areas.

Inevitably, some progress has been interrupted. During Covid, the roll-out of the priority areas did not progress as quickly as planned; subsequently, we have seen a focusing on aspects of the six priorities to better deliver progress and implementation. However, we think that there is a gap. There needs to be clearer public reporting of the impact of spend. That goes back to the core of our responsibilities, which is to form an assessment of whether value for money is being delivered from public spending.

10:00

Carol Calder (Audit Scotland): We found in the audit a lack of transparency around the spend and the impact of those six priorities. We do not know what full implementation of those priorities might look like or what costs would be associated with that, but health and social care partnerships have estimated that there is a £125 million shortfall in covering the three prioritised areas within the six and maintaining the other three at current levels.

We noted that the work that has been done to develop the multidisciplinary teams varies across Scotland, but it is not directed or targeted at most need. There is a lack of transparency and insufficient information on spend and impact. We said in our recommendation that although a new plan for primary care reform is due this summer, we would like to see a clear delivery plan and a vision for general practice primary care.

As the Auditor General noted, we would like to see as part of that plan clear actions with timescales that are costed, but we would also like clarity on the current commitments in the general medical services contract—whether or when they will be delivered, what that might look like, how much that will cost, what funding is available and what data will be required for them to monitor and report publicly on the impact and the total spend.

Graham Simpson: Thank you for that. The report says that the Government's most recent annual progress report highlights that 3,540 of the 4,925 whole-time equivalent staff working across the six priority services at March 2024 were funded by the primary care improvement fund. Do you know where the other 1,300 were funded from?

Stephen Boyle: I will ask colleagues to come in on that. You refer to exhibit 4 in the report, which sets out spending through the primary care improvement fund compared with direct spending on general practice. Multidisciplinary teams are, of course, also run by health boards. One of the objectives of the contract was to better balance the wider contribution that health boards, together with the independent contractor model that we have for GPs, will make.

I will ask Fiona Lees to set out the relative spend through the primary care improvement fund compared with direct spending.

Fiona Lees: To answer your question, no, we do not know how the rest of those staff were funded. We know that money is coming through boards. Eva Thomas-Tudo looked at that issue in detail, so she might be able to provide more information, but we do not know where the additional funding came from or exactly how much it is.

Eva, could you add to that?

Eva Thomas-Tudo: Yes, I am happy to. As others have said, there is a lack of transparency about the full amount that is spent on the six priority services. HSCPs are asked to provide details on spending through the primary care improvement fund at least annually to the Scottish Government. However, as you note, there is potentially quite a lot of spending outside of the primary care improvement fund, amounting to that figure of 1,300 whole-time equivalent staff. That is likely to come from a range of other services, including core HSCP funds. There are specific vaccination funds that contribute towards that, and there are specific pots of money for things such as mental health—for instance, action 15 funding goes towards that.

The problem is that that information is not collated or collected consistently anywhere across Scotland, so it is very difficult to get an overall picture of how much is spent on the six priority areas across all the service areas.

Graham Simpson: I have to say that that is all very concerning indeed. That lack of transparency is a feature of your report.

Moving on to a different issue, you say in paragraph 100:

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

It is quite an accusation to make that the Government is being misleading. What lies behind that?

Stephen Boyle: I will ask Carol Calder to set out the detail of paragraph 100 of the report, and the reason why we made such a judgment in relation to the requests for funding from practices, whether that was through loans or eventual board ownership.

To step back for a second, the purpose of including premises in the 2018 GMS contract was to provide part of the sustainability that was sought. It allowed general practices to focus on providing health services, rather than on the additional responsibility and focus required to own and manage properties across the country.

What you are asking about might be symptomatic of something that Carol will set out: the implementation of that part of the contract has been very challenging for the NHS and for health boards. It has evolved quite long timescales, which go into the 2030s and 2040s. There is a question mark about whether there is sufficient funding. There is also an interruption factor: it was assumed that much of the funding would come from financial transactions, which, as the committee might be familiar with, were part of the funding stream that the Scottish Government received from the UK Government. However, financial transactions are no longer part of that funding to anything like the extent that they used to be. The Scottish Government and the health boards are operating in a much more challenging fiscal context to take on buildings and loans on premises.

That context is relevant, but it is not a legitimate reason to not be transparent about spending or loans against premises. Carol can share more of that with the committee.

Carol Calder: Originally, £30 million was committed between 2018 and 2021 for sustainability loans. Those GP practices that applied for the loans would get 20 per cent of them each year for five years. In 2019, that £30 million commitment was increased to £50 million. By 2020, no loans had been paid out. We know now that a total of 63 loans have been paid out, equivalent to about £15 million over five years. However, as the Auditor General said, the funding stream that came from the UK Government had been reducing in recent years and, in the 2024-25 budget, no financial transactions capital was available in the health portfolio. There is uncertainty; we advise that the Scottish Government is reviewing its options for the scheme.

On the statement that we have said was misleading, in 2019, the Scottish Government said that 172 loans had been applied for successfully. Actually, 172 applications had been received that expressed interest in the loans and, at that point, no loans had been issued. That is why we said that the statement was misleading. To give context for the scale of it, 63 loans have been issued and a survey in 2019 indicated that just fewer than 400 GP practices were owned by the practitioners; so, 63 out of 400, or roughly 16 per cent, of GP-owned practices received a loan. However at the moment, there is uncertainty about where the funding is coming from.

Individual health boards were required to produce infrastructure plans at the beginning of this year. That was too late for this audit, so we did not see those plans. However, we expect that those plans would include not only the number of GP practices and leases that the board now owns, but detail of the condition and maintenance of those premises. We also anticipate that those plans should include individual boards' plans for taking on more leases and premises, and providing premises for general practice. We would like to see what individual boards are planning to do for their local practices.

Graham Simpson: Sorry—I still have one final question. I know that I have taken up a lot of time, but there is a lot to cover.

Given the state of health boards' finances, which this committee has covered previously, I am struck by a question: why would boards want to take on the responsibility of owning the buildings that GPs work from?

Carol Calder: There was funding available, and committed, back in 2018. With regard to health boards taking on the leases of those premises that are rented rather than owned, we found that there was no funding for that; it was intended to be a cost-neutral exercise.

The NHS National Services Scotland primary care premises group—I hope that I have got the name right; I stumble over it every time—has indicated that some boards are reluctant to pick up leases where there are maintenance costs, because those maintenance costs were not factored into the cost-neutral calculation. That could be one of the reasons why boards are reluctant to pick up the outstanding maintenance costs.

There was a national survey of maintenance in 2018 and, at that point, it was estimated that there was a maintenance backlog of around £60 million in general practices. There has not been a survey

since then, and there is no specific oversight of how fit for purpose those premises are.

Stephen Boyle: To add to that, I direct the committee to the recommendations on page 7, in particular the final recommendation in the report, which is for the Scottish Government to set out, within the next 12 months, how it plans to take forward that part of the contract in respect of the role that NHS Scotland and boards will play regarding the existing infrastructure and any infrastructure planning. Many things in the report are important, but that is fundamental to issues of access and where services will be provided.

The Convener: On that last point, it does not feel as though there is a whole-system approach. We regularly, as the Public Audit Committee, hear the Scottish Government and representatives from health boards say that they have been asked to make recurring and non-recurring savings of 5 per cent every year. Often, when we get into it, the non-recurring savings involve things such as disposal of property or land. Unless this is properly resourced, it is simply not going to work, is it?

Stephen Boyle: There is undoubtedly work to be done, and what is peppered through the report is that the dynamic is different. It is an independent contractor model, and that is always going to be at the heart of the reach of Government and the role of boards in respect of what was a shared contract that was agreed between BMA Scotland, the Scottish Government and boards.

It is clear, however, that there are gaps in implementation, as is reflected in all the recommendations regarding how the service, and the vision for the provision of general practice, will be delivered. There is now a need for clarity, together with a delivery plan to take forward the implementation.

The Convener: I go back to the whole-system perspective. GPs are presumably grappling with the issue of waiting times in secondary care. If people are on long waiting lists to get elective surgery or other procedures, that is presumably leading to an increase in demand on GP services to infill for some of that.

Do you have a view on the necessity of tackling not just the general medical services side of that, but what is going on in secondary care? Presumably, you cannot have success in one area without achieving success in the other.

Stephen Boyle: No, you are quite right—there is a whole-system factor. The report looks only at the progress in implementing the GMS contract from 2018, but—as Mr Simpson mentioned—there are some recurring whole-system features. We have touched on those in our NHS reporting in the round, and we will return to that aspect later this year through our overview of the NHS.

On your point about pressures, convener, exhibit 3 in the report sets out the nature of some of the pressures on general practice. The last point in the table highlights the impact on general practice of more people waiting for treatment in Scotland's hospitals and how that has shifted fundamentally, by way of the statistic that we report from September last year, which shows that just over 38,000 people were waiting for in-patient or day-case treatment in comparison with 1,600 before the pandemic.

10:15

That inevitably has a bearing on the time for which those people need general practice to support them while they are waiting for treatment in hospital. As I said, that is just one of the six themes of pressure that we sought to identify in that part of the report.

The Convener: You have mentioned a couple of times in the past few minutes the need for vision and strategic direction. You begin key message 2 in your report by saying:

> "There is uncertainty about the strategic direction of general practice."

Could you elaborate a little on that? What are the missing ingredients there? Is it about transparency, or does there simply not exist a vision and/or a strategic direction for general practice?

Stephen Boyle: Again, I will bring in colleagues in a moment. We sought, in the report, to do a stock take of the implementation of the contract. A sense has come through from the evidence before us that we are not yet clear on the route through to full implementation of the 2018 contract.

We have touched already on a couple of themes, including data and premises. I am sure that we will discuss further points over the course of the morning, including access and capacity to implement the contract, including the number of GPs; the interrupted progress on rolling out multidisciplinary teams; whether there is sufficient funding in place; and the need for clarity around medium-term funding to implement the remainder of the contract.

That is where we have got to. We have a contract and, not unreasonably, it can be said that the pandemic interrupted progress, which required a stock take to be made. However, that has still led us back, as ever, to looking at how the Government's plans are going to be implemented. There are many plans and strategies under way, and we refer to many of them in the report. The first recommendation that we make in the report

concerns the need for an absolutely clear delivery plan by the end of this year to support the implementation of a vision. The weight of the evidence that we have set out in the report casts doubt on the achievability of the ambitions for the 2018 contract unless there is clarity on the next steps.

The Convener: Okay. I will bring Colin Beattie in shortly, but before I do that, I have one final question, which is about an area that we have not so far discussed but which is in your report. Again, it is a feature that many people have come across in recent years: the creation of GP clusters. I do not know whether they were created to try to address demand and supply and to marry up practices, so that access to a GP does not depend simply on being registered at one GP practice. If someone is registered at a GP practice, that facilitates their getting access to other GP practices in a cluster. Presumably, that is designed to improve levels of access to GP services. Has that been fully funded? Is it being implemented? What is your audit assessment of how that is going?

Stephen Boyle: I will bring in Eva Thomas-Tudo, who did some of the work on GP clusters. Effectively, the intention was to provide both local area support across various GP centres and a mechanism to replace what had been known as the quality and outcomes framework, with quality at its heart, support and clarity around how well GP services were performing.

However, again, with regard to clusters, we have not seen the pace of implementation that was intended, and nor is there a sense that there are the data and evidence to make a rounded assessment of progress or quality. It looks like a welcome idea, on the face of it, but there is still not enough evidence to make a rounded judgment about whether the model is working successfully for GPs or their patients. I will bring Eva Thomas-Tudo in to set that out in more detail.

Eva Thomas-Tudo: The Auditor General is right that the focus of GP clusters was more on quality than on improving access. Their purpose was quality improvement and improvement of the way in which the health and social care system worked. However, we say in the report that the implementation of clusters has not been fully prioritised or fully funded. Research that has been carried out on progress with the clusters has identified a number of barriers, such as a lack of time, a lack of support, a lack of meaningful data and a lack of clarity about the purpose, roles and responsibilities of clusters.

Some of the key roles of clusters have been fully funded by the Scottish Government. For example, every practice has a practice quality lead. The role is designed to work with other practice quality leads in the cluster and has been funded for roughly one day a month, although the funding has not been uplifted since 2018. Each cluster should also have a cluster quality lead, but that role has not been centrally funded—that is for each area to decide. Therefore, there is now significant variation in the extent to which clusters have the support and funding that they need to work.

The Convener: From the first 50 minutes of evidence that we have taken, what seems to be emerging is that there are lots of announcements and initiatives but that the implementation of those seems to be falling short. As a consequence, as MSPs, we continue to have regular correspondence with constituents who cannot get access to their GP. That remains an outstanding concern that we all share.

Stephen Boyle: That is a fair summary of the discussion that we have had so far. I am sure that the committee will go on to talk about the funding investment that has been made in general practice; we set much of that out in the report. However, the implementation or evidence gap makes it clear that there is not yet sufficient evidence that the approach is making a difference. That might relate to access or to survey data, with patients reporting that they are less satisfied with GP services, or it might be that parts of the contract have not been taken forward. We sought to make an assessment in the audit report, and, based on all the indicators, it remains a system that is under pressure.

Colin Beattie (Midlothian North and Musselburgh) (SNP): On the transfer of services to NHS boards, which is a key element in the GP mix, did you identify any evidence in your audit of where the workload still fell to general practice, despite the responsibility for providing the service having moved to the local NHS board?

Stephen Boyle: To an extent, yes. I refer the committee to paragraph 63 of our report, which addresses the nature of your question in respect of multidisciplinary teams. In effect, those are support teams that are typically employed by the health board to deliver a range of services that, previously, had been delivered under the auspices of GP practices. As we have already touched on, and as you might expect, there is some regional variation with regard to where progress has or has not been made.

Public Health Scotland surveyed GP on how well multidisciplinary teams had been implemented, and it found some quite stark information about the number of multidisciplinary teams, which, as we have already covered, remains short of what had been anticipated. We also reported that GPs are noting that there is inconsistency in some of the work of

multidisciplinary teams. Staff availability was, again, a barrier to effective planning, and there was some variation in skills and experience.

The final bullet point in paragraph 63 is particularly noteworthy: some GPs report that, rather than being of benefit, the implementation of multidisciplinary teams has actually increased their workload, by virtue of the additional supervision and training that they or the health board have had to provide to multidisciplinary teams. We feel that we are at the midpoint of the journey with regard to the transfer of resource and responsibility, but there is not yet clarity about whether the approach is working as it was intended to.

Colin Beattie: How effective the approach has been is a question that has been asked for several years. Is that all about money or is it about will?

Stephen Boyle: It is not exclusively about one or the other. Is your question about the direction of travel for the implementation of the full contract?

Colin Beattie: Yes.

Stephen Boyle: We need clarity about the funding that is necessary, we need a medium-term financial plan and we need a direction of travel for its implementation. We talk about the delivery plan that is necessary with regard to support teams, practice funding and the number of GPs. We need clarity around when that will be implemented. There is a bit of a classic theme of an implementation gap or doubt about where we currently sit.

Colin Beattie: On a similar theme, the Scottish Government made transitionary payments in 2021-2022 and 2022-2023. Is there any explanation for why all practices received transitionary payments, including those that had access to MDTs? That does not seem right.

Stephen Boyle: Eva Thomas-Tudo might be able to give you more detail about the funding arrangements.

Eva Thomas-Tudo: That was a decision that the Scottish Government made. The transitionary payments that were made in 2021-2022 and 2022-2023 were combined with winter support funding, so the money went to all practices rather than there being a process to determine the extent to which MDTs were supporting those practices. In our report, we highlighted the fact that that meant that the support was fairly inequitable.

Since then, the Scottish Government has not provided national transitionary support, despite the fact that MDTs are not yet fully implemented. Instead, it has advised that areas can arrange transitionary payments as appropriate. That enables areas to provide support more equitably, so they will be able to target the support where it is most needed, based on access to MDTs. However, that is expected to come out of their existing budgets. If they have spent their full allocations on multidisciplinary teams, they might not have the extra funding to provide transitionary payments to general practices that do not yet have sufficient MDT support.

Colin Beattie: Do you agree that that does not seem to be a very fair system overall?

Stephen Boyle: I think that that is more a question for the Scottish Government than a question for us; it is a question about the allocation of funding, the Government's interpretation of progress and the implementation of the contract.

In our report, we are clear that the tailoring of the implementation of the contract is a decision for the Government. One of the points that we make throughout the report about that relates to the extent to which health inequalities have or have not been considered. There are a number of variables with regard to how spending could be tailored and the fact that choices have been made not to do that. I just note that that is the case; it is more for the Scottish Government to say why it has made those choices.

Colin Beattie: We can hold that question for the Scottish Government.

I am going to talk to you about data. We always end up talking about data. You have talked about data already. Let us talk about data again.

10:30

I cannot recall for how long I have sat on this committee, but it has been all about data and an inability to validate where money is being spent because you simply do not have the data to know whether there is an outcome at the end. That issue has been raised by you, Auditor General, and by your predecessor, and by this committee and all its predecessors. Why is it that we continue, constantly, to come up against the data gap?

It is difficult to improve primary care when you do not have the basic information as to where you need to put the resources to get the outcome that you are looking for. How do we deal with that? Poor-quality data seems to be endemic.

Stephen Boyle: I absolutely agree with you. As we say on page 21, a lack of data is an issue not just in and of itself but because it makes it difficult for the Scottish Government to make informed decisions or evaluate progress. There are fundamentals here that need to be addressed.

There is a recognition by the Scottish Government, which published its monitoring and evaluation strategy six years ago, with a 10-year approach to improving and assessing the impact

of primary care reform in Scotland. That is welcome, but the Government has to make a judgment about why that work is taking the time that it is taking. Other factors are highlighted in the report, and have been mentioned by GPs, patients and the BMA, but the Government is taking too long to address some of the concerns about data. We do not have a rounded national picture of data to inform and monitor general practice arrangements.

As I mentioned to the convener, the dynamic of the independent contractor model is a factor to be overcome. We have not audited that, but we refer to some of the contrasts with NHS GP practices in England, where steps have been taken more recently to get a more rounded data picture. That contrasts with the situation in Scotland, which I would characterise as being more about local recording and local notes. In GP centres in Scotland, for example, people are not employed to record data.

Finally, I highlight that the situation with GP practices in Scotland is quite a contrast with the picture for acute care, where investment has been made. NHS boards have detailed and robust data arrangements as a consequence of planned investment over many years, and there are centres of excellence for data. It is not a welcome or sustainable position to have such a contrast in Scotland between primary care and secondary care.

Colin Beattie: I was talking partly generally, although with a focus on primary care. Looking at primary care, I am aware of surgeries in my area that decline to provide data, for a number of reasons. Some of them say that they are too busy; others simply say, "We are independent contractors and providing data is not part of what we are contracted to do." How do we deal with that? On that basis, we will never have the data that is needed in order to make the necessary decisions.

Stephen Boyle: Fiona Lees might want to touch on some of that. We have looked at it through the audit. I would say that if the case has not been made with GPs in Scotland for why providing robust data is important, and if GPs feel that they have not been funded or supported in that respect and it has not been made clear how they might best do that, it is inevitable that there will be barriers.

We set out in other parts of the report the extent of the pressures that exist in the system and the demands on Scotland's GPs. If GPs are presented with the need for more data without any clarity as to how they are going to be supported to provide that data, it is perhaps not surprising either that there is incomplete data or that providing it is presented as a voluntary requirement.

Those barriers have to be overcome. Again, it is part of our thinking and our recommendations that the data aspect is central to policy making and the evaluation of primary care, and all the benefits that go with that. We make a clear statement in the report that preventive investment spend on primary care is good value for money. We know that keeping people well and out of hospital delivers better outcomes at lower cost, but getting good data is absolutely part of the route to sustaining that approach.

Fiona Lees can say a bit more on that.

Fiona Lees: There are several reasons why things are all a bit more complicated in primary care than they are in secondary care. For one, there is not a lack of data per se, but a lack of complete and consistent data at national level. GPs actually hold a lot of data in their clinical systems, but much of it is for direct patient care, so it is text based—it is not coded or consistent, and it is not aimed at answering questions on national outcomes. In secondary care, there are teams of people who are dedicated to collecting, validating and submitting data.

There are also more complicated information governance arrangements in primary care, because that involves dealing with nearly 900 private businesses. In addition, not all of the data is held by GPs; some of it is held by boards. If a patient sees a member of one of the multidisciplinary teams, they might see them at board level, so that data will be held on the board's information technology system, not the GP's IT system. As the committee may know, those systems do not talk to each other very well.

Colin Beattie brought up another important point, which is that the system in primary care relies on GPs providing that data when they are asked to do so. A good example of that is the general practice workforce survey, which is run once a year. That is the best information that we currently have available to work out what whole-time equivalent GP numbers are.

At present, however, only about 85 per cent of practices provide that information. I know that that figure sounds quite high, but it means that around 130 practices are not providing that information. That means that we do not have really good, robust data around the number of GPs and GP capacity. GPs being willing to provide the information is an important element in building national data sets.

Colin Beattie: I come back to what the Auditor General said a few minutes ago about persuading GPs of the need for good data. GPs are intelligent people—they must understand the reasons why data is necessary in order to measure outcomes and ensure that resources are being put in the

right place. I cannot conceive of the notion that they would not appreciate that. Still, however, we have that difficulty.

Stephen Boyle: I am quite sure that GPs understand the value of good data. As Fiona Lees mentioned, they will be using data in their practices to support the delivery of healthcare and the management of their businesses.

We are perhaps drifting into speculation; I am quite sure that GP representatives, or GPs themselves, will be able to give you a much more informed picture than I can. Nonetheless, it is interesting to see that incentivisation was a feature of attempts to improve data in the NHS in England—we set some of that out in paragraph 49 of the report. A contractual model exists in primary care in Scotland, so if other parts of the system require data, perhaps incentivisation needs to be part of the plans to improve data.

Again, I know that the Scottish Government is sighted on those issues and has planned to take forward work on them. We have mentioned the national GP clinical system, which would—as we note in paragraph 50 of the report—look to go some way towards addressing the issues. Unfortunately, however, as we have touched on, that has been interrupted by the financial position of the supplier.

Where I stand on the matter, Mr Beattie, is that a way through those issues has to be found in order to ensure that we have better-quality data, in order, ultimately, to support the good use of public money for patient care.

Colin Beattie: That brings me to the last question on data. Are you satisfied with what the Scottish Government is doing to improve primary care data and provide the infrastructure to support it? The issue has to be resolved.

Stephen Boyle: It does have to be resolved, but I do not think that I could give you a definitive validation of that position at the moment. As you said at the start, it feels as though we have been talking about the need for better-quality data in primary care for too long. The system must move more quickly to arrive at a more robust suite of data than we have at the moment, to inform decision making and policy implementation and evaluation. Although we have strategies, recognition and plans, they must be implemented at pace.

Colin Beattie: My last question is about GP head count. In paragraph 81, you say that there is not enough

"information about the number of hours worked by GPs",

which seems extraordinary. Apparently, there is evidence that

"the average number of sessions worked by GPs"

was measured at 6.4 sessions in 2017 but that

"by March 2024, this had decreased to 6.2."

That does not sound like a huge decrease, but if we multiply it across the country, it is perhaps a lot more significant. Given the pressure that GPs are under, why do we not know how many hours they are putting into the job? Why can we not evaluate that?

Stephen Boyle: I will bring in Fiona Lees again in a moment. It probably builds on the discussion that we have been having—the information that is set out in paragraph 81 is drawn from a workforce survey rather than from specific, reliable, validated system-implemented information. Fiona might want to say a bit more about that and perhaps return to how GP numbers are ultimately affecting the desire for increased capacity in the system, improving access and throughput.

Fiona Lees: Yes, that information is drawn from the general practice workforce survey that is run once a year. As we have said, the figures are estimated, because not everybody responds to the survey. The problem with the survey is that it asks not how many hours GPs are contracted to work but how many sessions, and sessions vary in length—they can be four hours in some places and five hours in others. Without that information, we cannot properly assess how many hours GPs are working.

Anecdotally, a lot of GPs have said to me that they are working more hours per session, but we cannot quantify that, because we do not have the data. We believe that for the next round of the survey in 2025, it will be looking at changing that. Instead of asking only for the number of sessions, it will ask for the number of contracted hours. That would certainly help to give a better indication of the whole-time equivalent figure. If we could get the response rate up further and have more information from all practices, we would have much clearer information about the capacity of GPs in Scotland.

Colin Beattie: Is there any indication that the GP surgeries are prepared to give out that information?

Fiona Lees: We did not come across any indication of that in our audit.

Colin Beattie: The number of hours that people work is a sensitive area but it is important, because there is a public perception that doctors are not putting a lot of hours in. Although I do not believe that to be the case in most cases, we need the evidence to be able to understand.

Fiona Lees: Yes, I absolutely agree that we need the evidence to be able to understand. There

is a difference between how many hours GPs are contracted to work and how many hours they are actually working. Although we do not have national data about that, staff surveys that the RCGP and the BMA run indicate that GPs are routinely working more than the hours that they are contracted to work. Without the evidence, though, I cannot put a figure on that.

Colin Beattie: That goes back to the problem that you do not have the data to prove the point. Do we have accurate figures for doctors who work part time, to understand what part of the mix they are?

10:45

Fiona Lees: That information would come from the survey that I have been talking about, which is based on asking GPs about the number of sessions that they work per week. In the context of the survey, a full-time GP works eight or more sessions per week. Looking at that data, you could say that a GP works part time if they work fewer than eight sessions. The survey chunks it up in that way to tell you how many sessions GPs work. That information is available. I do not have with me a breakdown of exactly how many GPs work part time or fewer than eight sessions a week, but that information is available in the survey. It is estimated, though—with all the caveats around the data that I have mentioned.

Colin Beattie: Estimated?

Fiona Lees: Yes.

Colin Beattie: Did you say that a survey is going out?

Fiona Lees: Yes, it is usually run once per year. Normally, the data is collected in March, so we will have that information by the end of this year.

Colin Beattie: Will the survey be changed this year to ensure that more robust data is being collected?

Fiona Lees: My understanding is that it will be changed, but you could perhaps ask the Scottish Government to confirm that.

Colin Beattie: Okay. Thank you.

The Convener: Before I bring in Stephanie Callaghan, I have two quick questions to put to you. The first question goes back to data. The committee has seen quite a few false dawns when it comes to data collection. I looked back at what was said exactly two years ago—on 4 May 2023—when the director general for health and social care and chief executive of the national health service in Scotland told the committee:

"We have started the roll-out of the next generation of information technology to general practices; we hope that that will help to improve ease of extraction of data from GP systems and that it will give us a chance to start with a clean slate on how data is coded."—[*Official Report*, *Public Audit Committee*, 4 May 2023; c 26-27.]

That is what we have been speaking about this morning, but that was two years ago. Do you get a sense that there is a lack of urgency? Are there legitimate reasons why the delay has been extended in the way that it has?

Stephen Boyle: I accept that the roll-out across nearly 900 GP practices in Scotland with varying IT investment capabilities is complicated. I understand that the programme is complex, and I in no way challenge the ambition that the director general set out. However, it goes back to some of the discussion that we have been having today about the fact that this is taking a long time—and it was taking a long time before that contribution two years ago.

It is for the Government to satisfy itself, through its engagement with GPs and their representatives, that it has a realistic, clear path to implementing better data assumptions and standards so that it can effectively manage, from its side, its investment and patient care in the round.

At this moment, I do not want to say that I have confidence, although there is a recognition and understanding of the issues and their complexity. As I have said a couple of times already, the issue must be overcome at a greater pace than has been shown so far.

The Convener: What we are discussing this morning is described as a contract. Is it a woolly, social contract—a voluntary arrangement—or is it a contract in which parties are involved and remedy can be sought? That could be a remedy whereby the Government could say, "As part of the contract, you promised to provide us with data, which you are not doing. You are in breach of the contract." Or, on the other side, GPs might say, "You promised to give us the resources to have multidisciplinary teams and you haven't done that. You promised to put resources into secondary care to stop the logjam falling back on us and you haven't."

Is it a contract in the sense that people have any access to a remedy if there is a breach of contract?

Stephen Boyle: "No" is the answer to that question. That is not our understanding, and there is debate about that point—about the appropriateness of continuing to refer to this as a contract. Indeed, we had some discussion of that during the course of our audit work. It is not our understanding that there would be remedy, recourse or the potential for legal action if the contract was seen not to be implemented.

Whether you call it a plan, a commitment or a contract, it amounts to the same thing: when the contract was agreed, in 2018, there was an expectation on both parties that these were the steps that would be taken and that they would know when it had been implemented. Seven years later, I am not sure that we know whether there is a clear path to the implementation of the GMS contract. Perhaps expectations need to be revisited. That is our fundamental recommendation to ensure a clear delivery plan and shared assumptions and expectations about where general medical services in Scotland go next.

The Convener: That is a useful clarification.

Stephanie Callaghan: I am interested in the progress on improving patient care. We have already spoken a bit about the fact that people are finding it more difficult to access healthcare at their general practice. It is no surprise that the Scottish Government has been commissioning some initiatives to help to address the issue. One example is the primary care access programme, which supports general practice teams to use data—we are talking about data again—to identify areas for improvement and then to look at improving an aspect of access over a short period. Do you have any views on the steps that the Scottish Government is taking to address concerns about people's access to healthcare at their general practice? I am interested in any positive examples of areas where progress has been made.

Stephen Boyle: I will bring colleagues in to supplement what I have to say.

When you present a report such as this, there is a risk that it does not necessarily reflect the fact that there are always some excellent examples of public service. Those examples can be squeezed out by an overall picture of challenge, and that could be a feature of today's report.

You mentioned access to healthcare and examples of practice. I might bring in colleagues to talk about one of the case studies in our report that relates to the evolution of some of the services that can be offered in general practice. The role of community link workers is about centring the role that general practice can play in improving people's lives, and there are some terrific examples in the report.

However, a wider feature that we have perhaps not talked about today is the impact on people's perceptions that communication can have. The evidence is that people are not all that familiar with some of the changes in the GMS contract. They are not necessarily clear about the evolving role of multidisciplinary teams or the change in the focus of the work of practice managers or, in particular, of GP receptionists, who are now absolutely at the heart of teams in GP centres. People are not always clear about what they do. There is a perception that that can be an intrusive triage service rather than part of their job. More communication with the public is definitely necessary, although that should not detract from the fact that some people report that they get an excellent service and that they are happy with their GP.

I will bring in Fiona Lees or Carol Calder to say more.

Carol Calder: There is a general misunderstanding among the public about the way in which general practice is changing. One of our recommendations is about ensuring that there is better communication with the public about their expectations of how we all approach and receive care through our local general practice. As the Auditor General mentioned, there is not necessarily acceptance of those changes, of the role of triage in getting an appointment or being directed to the right person, or of the roles of multidisciplinary teams. Perhaps there is still a perception that we just want a GP appointment, so work needs to be done around that.

You and the Auditor General are correct in saying that the report focuses on the delivery of the contract, but we know that general practice plays a critical part in our overall health service. It is the front door through which we all—everyone in this room as well as everyone outside it—access healthcare in the first instance. Therefore, it plays an enormous role in referring people to the right places, managing complex care in the community and treating and diagnosing common medical conditions. It plays a vital part, and we need to take the public with us in the approach to how they access general practice in order to access the wider health and care service.

Stephanie Callaghan: That is really helpful. To a degree, you have pre-empted my next question. I am interested to hear about the case study that the Auditor General mentioned.

Stephen Boyle: Do you want to talk to that, Carol?

Carol Calder: Are you referring to the community link workers case study?

Stephen Boyle: Yes.

Carol Calder: I think that Eva Thomas-Tudo would be better able to talk about that.

Stephen Boyle: Thank you—I apologise. Eva can say more about the vital role that community link workers play. There is a slight caveat in that there is often a degree of insecurity about their position and their vulnerability to the financial pressures in the system.

Eva Thomas-Tudo: Community link workers are one of the six priority services that are being rolled out across Scotland. They are intended to target non-medical support, such as support with financial issues or social issues that you do not necessarily need clinical support for. As the Auditor General touched on, community link workers are often employed by third sector organisations that have short-term funding and contracts, which means that their jobs are fairly insecure. The Scottish Government is carrying out a review of community link workers in order to determine the direction of travel. That is due to conclude next year.

In relation to good practice in some other aspects of access that you have talked about, the report mentions the primary care access programme that Healthcare Improvement Scotland took on for a couple of years, which ended fairly recently. The programme touched on very specific aspects of access in practices, such as access to appointments and the streamlining of processes. It did not necessarily address fundamental access issues such as workforce shortages and that kind of thing, so the impact that it could have was fairly limited. However, it streamlined processes to make them as efficient as they could be in practices, given their current resources. That work has now been incorporated into a wider piece of work in the primary care phased investment programme, which is known as an improvement collaborative, and more practices are getting access to similar resources from Healthcare Improvement Scotland until the end of this year.

Stephanie Callaghan: There is certainly some good stuff to hear about. We need to value the third sector. It will be good to have that report when it is published next year and to have a wee look at it.

I go back to the issues around people's understanding of the changes to GP surgeries. What actions does the Scottish Government need to take to help the public to understand how and why general practice is changing? People are insisting on seeing a GP, waiting in a queue for that and then being referred to the expert nurse anyway, which means that people are ending up waiting longer because they are waiting twice. What can we do to tackle that?

11:00

Stephen Boyle: I absolutely agree. In paragraph 56 of our report, we mention that the Scottish Government initially ran a public awareness campaign in March 2022 to share with the public some of the changes to the roles in general practice and to provide a better understanding of the responsibilities of multidisciplinary teams and the role that receptionists will play in people's access to care. However, I am left wondering whether that was enough. The statistics suggest that either rerunning that campaign or finding additional or alternative ways to inform the public would have a significant bearing on the level of people's satisfaction with the service. I think that Carol Calder is right that people might have had a sense, traditionally, that, when they contact their GP surgery, it is a GP who they want to speak to. I think that people's views change, and they just want to be able to meet or speak to somebody who can help them with the problem that they have, and their satisfaction is not necessarily dependent on speaking to a particular member of the team.

We can reflect on the situation in March 2022 and see that, when we were emerging from Covid, people might have assumed that the changing role of receptionists or multidisciplinary teams was a legacy of Covid. There are probably some misconceptions among the public that need to be addressed by health boards and the Government in order to reset the evolving and changing role of general practice in providing services to patients. Again, the Government is familiar with signposting people to different systems. In our report, we also talk about the role that GPs' websites can play in providing consistency. NHS 24 has done work on that. Again, an acceleration is needed: we need more consistency and more communication with the public to better inform them about the new contract. Ultimately, people do not really care about the contract; they just care about the service that they can expect from their GP.

Stephanie Callaghan: Yes, absolutely, Stephen—you are bang on there. It is a really big and important topic for the people who we represent.

I am also a bit curious about whether it is the role of only the Scottish Government to explain to people what is happening in GP practices, the fact that primary care is changing and about direct routes to see allied health professionals. Is there a role for the Scottish general practice committee to look at the negative public narrative around GPs and GP surgeries, to highlight the strengths that AHPs bring to the table, to do more work on getting that information out to people and to learn from each other's good practice?

Stephen Boyle: That is a fair point, especially given that the nature of the contract is that it is agreed with GPs and their representatives along with the Government and, of course, the health boards. There needs to be shared ownership of providing clarity to the public on how those services are evolving. If that is not the case—if some of the issues about ownership and clarity on the delivery of the contract are not addressed—

there will inevitably be a concern that that communication is either inconsistent or, at worst, undermined. Some of the root issues that we set out in the report, along with the issue of effective communication, need to be addressed in order to manage the public's expectations properly.

Stephanie Callaghan: That is great, because building trust is absolutely critical. At a local level, that can be quite powerful.

I do not know whether you would want to comment on this, but, earlier, we were talking about the drop in levels of satisfaction in NHS Lanarkshire, which might be a symptom of what we have been talking about. Do you have any thoughts on whether the digital front door app, which is due to be piloted in NHS Lanarkshire, might be helpful and might have an impact?

Stephen Boyle: That is a welcome development with regard to improving access and providing clarity. I am perhaps cautious about drawing conclusions until I have seen some of the evaluation or evidence, in the same way as I referred to in my discussion with Mr Simpson earlier. I am equally cautious about making a direct correlation between satisfaction levels and the number of patients per GP, and NHS Lanarkshire features in our report in relation to those figures, too. At the risk of repeating myself, it is about the fact that investment in technology and data needs to be accompanied by good evaluation arrangements, so that decision making by health boards and the Scottish Government about whether they are on the right track or need to change tack is part of the implementation of new approaches, whether that is the contract generally or the digital front door app. However, we are certainly keen to see how that evolves.

The Convener: I turn to the deputy convener, Jamie Greene, for our final round of questions.

Jamie Greene (West Scotland) (LD): Thank you, convener. How long would you like me to go on for? I have lots of questions.

The Convener: Well, until half past 11 at least.

Jamie Greene: That is grand. Good morning, Auditor General and esteemed colleagues. I have a few areas to cover. I will start by going back to an issue that came up earlier in relation to multidisciplinary teams. It sounds like a fairly positive move—the idea that care can be delivered by the person in the GP practice who is best able to offer the care, which goes back to the point about people's perception that they must speak to a GP when, actually, if the care can be delivered by someone else, that is better. However, your report seems to allude to the fact that your researchers uncovered some dissatisfaction among the GP fraternity because some GPs think that the approach might actually be adding to their workload, not reducing it. Can you explain that?

Stephen Boyle: Like you, deputy convener, I thought that it was something of a stand-out comment from GPs in the survey that some of them felt that multidisciplinary teams had increased their workload and that, in some cases, they were needing to spend more time supervising and training multidisciplinary teams. Beyond that, it is difficult to draw any definitive conclusions about the extent to which that is a feature across the country or isolated to particular practices. Again, that is perhaps symptomatic of the impact of the investment in multidisciplinary teams not yet being carried through as was intended. At its heart, the approach was designed to ease some of the pressure on GPs. If that has not yet been implemented, I can well understand why there might be tensions about how successful the approach has been. We probably do not have enough evidence to say whether that is a teething issue, a mid-implementation phase or something more fundamental. However, the fact that that is the case causes a degree of concern for the Government, GPs and their representatives. They need to take stock with regard to where they go next in relation to the full implementation of the remaining parts of the roles that MDTs were to play.

Jamie Greene: Is the tension actually a result of the fact that the Government is putting money into health boards to deliver MDT personnel rather than increasing the money that is going through the GMS contracts directly to GPs? Do GPs just want the money directly in order to do the work that they have got to do rather than see people who are coming in at a more junior level being funded differently? It is the same pot of cash overall. Is that where the tension really lies, given that these are private practices?

Stephen Boyle: That is potentially the case. I refer the committee to exhibit 4 in the report in relation to the totality of spending. Since 2017-18, the investment in GPs has increased by just over £1 billion, which is 33 per cent in cash terms and, taking account of inflation, just below 7 per cent in real terms. There has been a significant investment in GP services. In more recent years, it has been slightly below the rate of inflation.

In the communication from GPs and their representatives that Mr Simpson mentioned earlier, there is an emerging challenge about the relative investment in GP services compared to that in secondary care settings and whether that is sufficient to shift the balance of care towards keeping people healthy and out of hospital, rather than treating them when they become ill.

Alongside that, as we set out in the report, we are not seeing the progress that the Government

had hoped to make in additional GP numbers. That is in contrast to a significant increase in the number of hospital doctors over the same time period. There are contrasting stories in relation to where investment is being made. I understand that the Government needs to do both of those things—there cannot be an immediate transition away from providing secondary services. However, there is undoubtedly a tension, which has been reported and which the committee has heard about in correspondence, about the investment, outcomes and achievement of objectives in primary care relative to those in secondary care.

Jamie Greene: That is interesting. Your exhibit 4 points to an overall increase, albeit under inflation, in the primary care budget. However, the BMA has quite stark views on that. Its letter calls the situation "shocking" and talks about the erosion of funding meaning that there is

"a shortfall in practice funding of 22.8 per cent".

The letter goes on to say that

"£290 million will be required to close that gap".

The BMA's perception that GPs are not properly funded seems not to marry up with what the Government is spending on primary practice. Our job is to audit Government spending in that respect, but the feedback from the front line seems to suggest that they are being massively underfunded. Presumably, those views cannot both be correct.

Stephen Boyle: Like you, deputy convener, we have had very clear feedback from GP representatives about their ambitions and the investment that they consider to be necessary to deliver the intended outcomes of general practice services and perhaps also the GMS contract ambitions from 2018.

I will go back to the recommendations in our report for clarity and transparency about how the Scottish Government wishes to deliver its vision for general practice and the medium-term funding requirements for the sector. Is there to be a fundamental shift in where NHS spending takes place in Scotland? Will it remain largely in secondary care settings or is there a plan to move to a greater ratio of investment in primary care settings? We call for that clarity in the report.

Jamie Greene: We have talked about data and the lack of it, but there are things that we know and that have been made clear to us. I would like to look at two pieces of data: one is the ratio of GPs to population and the other is the number of GP practices in Scotland.

Please correct me if I am wrong, but my understanding is that the number of practices has fallen considerably over the past 10 years. On the patient per whole-time equivalent GP ratio—perhaps we can clarify for the benefit of people watching that that ratio is different from the GP head count; it is the number of patients that a GP has on average—the Scottish Government often claims that WTE GP to patient ratio is smaller in Scotland than elsewhere and that therefore people have easier access to a GP in Scotland than in other parts of the UK. However, your analysis seems to suggest that the WTE GP to patient ratio has decreased over many years, by some margin. It used to be 1,515 patients per WTE GP and it is now 1,735 patients per WTE GP. It is no wonder that people cannot get an appointment at 8 o'clock to see their GP; far more people are registered with GPs.

Stephen Boyle: Those are the statistics that we set out in the report. Fiona Lees might want to comment on that. On the number of GP practices, for example, I think that I am right in saying that we have data up to 2021 in the report, but she might have more up-to-date numbers.

11:15

We saw a decrease from just over 1,000 practices in 2011 to 890 by 2021. I will come back in on the point about correlation with access, but Fiona may want to pick up some of the statistics first.

Fiona Lees: I have had a look at the most recent data. In April 2018, when the contract was just starting, there were around 950 practices. As of April this year, there are 887, so we have 63 fewer than we had at the beginning of the contract.

Jamie Greene: Is that good or bad, though? Is it a consolidation—is it better to have fewer, bigger practices? It is quite hard to tell what that number means. On the face of it, it looks like it is poor, because it means that there are fewer practices, and therefore there is much less local access to a GP.

Fiona Lees: List sizes per practice have got bigger because there are fewer practices, but the reasons why practices close are not recorded centrally, so we do not know whether it is because someone handed back their contract or because practices have merged. We therefore do not have a sense of why those practices closed—we just know that there are fewer practices now than there used to be.

Stephen Boyle: You are probably right, Mr Greene. I do not think that whether a practice is larger or smaller, or indeed the number of patients who are registered there, necessarily matters to the public. They are probably most interested in whether they can access care and services when they want to do so.

One of the core parts of our audit was to look not exclusively at GP numbers, but ultimately—this is why the multidisciplinary team roll-out matters—at capacity in the system to provide services. There are indicators that the system remains under real pressure, and there is a lack of clarity about the route through to easing some of that pressure on patient services and increasing the resultant satisfaction.

Jamie Greene: Did Audit Scotland do any analysis on section 2C practices—in other words, those practices that were private partnerships but which decided, for whatever reason, to hand their licence back to the local health board? It is quite difficult to get numbers on them, but the numbers that we were able to pull out of the BMA suggest that there has been a marked increase in the number of section 2C practices. That is more obvious in certain regions than in others. For example, in the Lothians, Shetland, Tayside and Highland, double, treble or even quadruple the number of practices have been handed back to local health boards. Has any work been undertaken on why that is happening so much and why the frequency and volume are increasing?

Stephen Boyle: As Fiona Lees mentioned, we have not done any dedicated analysis of those factors. Anecdotally, the circumstances that you describe—such as pressure, sustainability, the ability to recruit GPs, some of the funding aspects and, as we mentioned, some of the responsibilities around the premises—are factors in why some practices are being handed back. With regard to whether those factors are common to all of them, however, we have not done that detailed assessment yet.

Jamie Greene: One thing that we have not gone into great detail on is satisfaction. You talked earlier about the health and care experience survey for 2023-24, which is detailed in exhibit 5. I found that to be one of the more shocking graphs in your report. Every single metric on which people were questioned in 2017-18 and again six years later—with the same set of questions—saw a decline in satisfaction, and some of those declines were quite stark. The starkest decline was in people's overall rating of their care experience as good or excellent. It was at 69 per cent in 2023-24, having gone down by 14 percentage points in just six years. Two thirds of people believe that they are getting a good service, but the other third do not. That is pretty shocking.

Did anything that came out of that survey jump out at you as being an area of concern?

Stephen Boyle: As we say, some of the statistics make challenging reading for Government and health boards. It would be interesting to get a sense of whether that is a surprising set of results for them, given what we hear anecdotally of the pressure that exists in the system.

I come back to some of the factors that we have already touched on this morning, which are set out in exhibit 3. There are undoubtedly pressures in the system that might be indicative of people's experience. People who are managing longer-term conditions, for example, may be waiting for hospital treatment. That might be informing their overall view, but it might not necessarily be indicative of the service that they receive directly from a practice.

People's experience can also be affected by a combination of other elements, such as age or whether they are living with a disability. People are more dissatisfied with GP services in some of Scotland's more deprived areas than they are in the more affluent parts of the country. There is a lot of variation.

It feels as if we are at the mid-point of the implementation of the contract so, in our report, we try not to draw conclusions yet to say that that is how it will be, or indeed that the contract will resolve the situation. Nonetheless, there is a need for clarity on where the contract is going, along with the overall intent for primary care general practice.

Jamie Greene: I will ask a question that may be more controversial. Do you think that there should be a top-down complete change to the system—in other words, to the GMS contract? BMA Scotland and those who represent GP practitioners believe that GPs are not getting paid enough for the work that they do. Their workload is increasing and they are having to take on ever more patients. On the other side of the phone, patient satisfaction is decreasing, and the public are not happy with the output. Is the whole system broken? Is the private practice model actually working in Scotland?

Stephen Boyle: I will address your question, but what we need is a clear plan for how to deliver and provide primary care services—GP services, I should say, rather than primary care—and we make that clear recommendation in the report.

The independent contractor model has existed since the start of the NHS, dating back to the 1940s. It was tested again in the middle of the 2010s, and there remained a clear preference from GPs that that was the model to deliver health services. People's views change, but I have no insight as to whether that has happened in this case; GPs themselves will be better placed to tell you about that. There is enough evidence to suggest that there is pressure in the system, but to make a judgment about that without the contract having been fully implemented might feel premature.

Jamie Greene: We might equally look at what is happening in the dental sector. That is effectively a private sector, albeit that the NHS is free at the point of use, so we do not have a privatised health service in Scotland—I am sure that the Government would be quite keen to stress that. The reality is that a lot of the services are provided through private contracts so, in other words, they are privatised in some way, shape or form.

Do you think that there is just no political appetite for any sort of sweeping reforms? If we sought to bring the whole of primary care into NHS boards under a single budget, do you think that there would be so much pushback from GPs that the change would never be able to happen? If the Government could not introduce such a sweeping change, does it mean that the system will never change? All that will happen is that GPs will ask for more money to deal with the increased demand.

Stephen Boyle: I would probably risk straying into policy areas in commenting on that. It is for the Government, together with GPs and their representatives, to decide how GP services will be delivered in Scotland.

The report says that the contract that was agreed has not been implemented as planned. There are significant gaps, and significant steps are needed to get to a system that can be implemented, monitored and evaluated, which involves addressing some of the need for clarity on data for long-term funding. We also need a real view on the ratio of investment in primary care relative to secondary care. Those things are all part of the complex system-wide issues that need to be considered, over and above the specifics of how the model might operate.

Jamie Greene: Will you talk me through the areas of your report where you look at the Government's plans for recruitment and the increase in GP numbers? A commitment has been made to increase the number of GPs by 800, but the RCGP's initial feedback was that that is nowhere near what is required. It said that having 800 more GPs would still leave a deficit of 700 GPs by 2027. Was the 800 figure plucked out of thin air or does some form of analysis inform it? Is that how many we think that we need, or is it just how many we can afford? Those are two very different things.

Stephen Boyle: I will share that question with Fiona Lees. First, I note that 800 is the number of GPs that was intended to be implemented when the contract was agreed. We set out in exhibit 6 the rate of change since 2017, and you will see from the key messages in the report that we do not believe that the Scottish Government is on track to meet its target of 800 additional GPs.

It is a question of capacity. There is a risk that some of the discussion around the 800 target focuses on head count as opposed to whole-time equivalents. As we have talked about, the impact of head count can vary depending on whether a GP is working full time or part time. As Fiona mentioned, looking at the number of activity sessions that take place is a more fundamental route to increasing capacity, rather than just increasing the head count, which risks obscuring the intended impact. Fiona might also want to talk about whether trainees are included in the number.

In March 2024, Scotland is estimated to have had—again, this is drawn from survey information, so I will not repeat the discussion that we have had on that—3,453 whole-time equivalent GPs, which was a reduction of 67 whole-time equivalents from seven years before. The progress looks constrained, but it is symptomatic of the wider position of the contract roll-out. Capacity will come from an increasing number of GPs, from trainees and from the implementation of the multidisciplinary teams, and there will be a wider system of practice provision. At its heart, however, from the evidence that we have seen, we do not think that the 800 target is on track, and it is now unlikely to be met.

Fiona Lees: On Jamie Greene's question about whether the 800 figure was plucked out of the air, a useful letter from 2019 from the then cabinet secretary to the Health and Sport Committee laid out how the figure was arrived at. The Scottish Government looked at the number of GPs at the time, at the churn—that is, how many GPs were likely to join or leave—and at demographics. It concluded that, if nothing was done, GP numbers would probably stay broadly stable in terms of head count and whole-time equivalents until 2027, and it realised that it would need to increase those because of population change.

The Scottish Government estimated that it would need to increase the number of GPs by around 1 per cent every year to meet the demand, which gave a figure of around 450 more GPs being required. It then looked at the vacancy rate and thought that we were below capacity by another 250, which gave a total of 700. It said very clearly in that letter that the issue was about increasing capacity and not just about head count. In fact, it thought that the 700 figure would equate to an extra 570 whole-time equivalent GPs. It took the 700 figure and, as a stretch target, made it a head count target of 800.

The Scottish Government said that the increase would need to be constantly monitored and reviewed to make sure that it was having the desired effect. That was part of what was supposed to happen. However, no formal review

points were put in place. We have now arrived at a point where, although head count has gone up, it has not gone up as much as was expected, while the estimated—I stress that it is estimated—whole-time equivalent figure has gone down, so the goal of the commitment to increase capacity does not look to have been achieved.

In relation to head count, to touch on what Stephen Boyle said about trainees, I note that we have set out how many of those GPs are fully qualified and how many are trainees. We tend not to always include trainees in our headline figures, because they do not spend all their time in general practice—they spend about 18 months there and 18 months in hospital posts. What we see in the figures is a snapshot of who was there at the time. There is also no guarantee that those trainees will go on to work as fully qualified GPs.

11:30

Jamie Greene: A good example of that is the ScotGEM project to try to recruit rural GPs—that was when the Government had a strategy. I read a news report about that recently. In one year, there were 52 graduates, of whom only 10 went on to become GPs, and only two of those went to the north of Scotland to fulfil GP vacancies in rural areas. That is a drop in the ocean compared with what is required in rural and island communities, where there are generally huge issues in recruiting, retaining and attracting GPs. Despite the incentives to get GPs into rural areas—such as golden handshakes, fast-track schemes and specialist four-year programmes with specific rural medical training—we still cannot fill those gaps, as a result of which those regional inequalities are surely exacerbated.

Stephen Boyle: That probably illustrates the point that you made earlier about GP contractors considering the sustainability of practices if they are unable to recruit to deliver safe clinical practice, notwithstanding the financial issues that have been touched on already.

Jamie Greene: We do not have a huge amount of time left to consider this issue, but I have a final question on the fact that there is no specific target or commitment to increase the number of GP nurses. We are looking at a multidisciplinary team-type model or one in which primary care can be provided by nurses rather than GPs to ensure that it is easier and quicker for people to get an appointment, and there are some good examples of where that is working well. That requires an increase in the number of GP nurses, but my understanding is that the number has decreased in recent years. I think that your report says that it has flatlined, but I will check that. In any case, there is no clear target to increase the number.

If we cannot increase GP numbers by 800—the Royal College of General Practitioners and the British Medical Association say that there should be an increase of 1,500, but we are going in the wrong direction—that is a worry, and the lack of an increase in GP nurse numbers is another worry. Who on earth will deliver for all the increased demand?

Stephen Boyle: There should indeed be clarity on the role that wider members of the GP team play with respect to the roll-out of multidisciplinary teams.

On your point about GP nurses, it is worth noting the demographic factors and the age profile of those members of the team, many of whom are in the latter stages of their careers. Much of that is set out in the report. All of that will have to be factored into training, recruitment and sustainability. As you mentioned, there is no commitment to increasing GP nurse numbers but, stepping back, a clear sense is needed of who will provide those services, through a clear delivery plan, to give that clarity to GPs and the public.

The Convener: On that note, I will draw the public part of this morning's session to a close. Before I do so, I thank our witnesses this morning—Eva Thomas-Tudo, who joined us online, Fiona Lees, Carol Calder and the Auditor General. You have given us quite a lot of food for thought and we will need to consider whether we would like to quiz other people about some of the recommendations and outcomes of the very important report that we have been discussing.

11:34

Meeting continued in private until 12:05.

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