RCGP SCOTLAND

# Public Service Reform: Pre-budget scrutiny 2027-28

## RCGP Scotland consultation response

**The Scottish Government aims to deliver on average £0.5 billion in savings through efficiencies per year for the next three years (2026-27 to 2028-29):**

**a) To what extent are these savings achievable, and how will they shape public service delivery.**

RCGP Scotland welcomes the opportunity to respond to the Public Service Reform Committee's pre-budget scrutiny call for views. As the membership body for general practitioners in Scotland, we exist to promote and maintain the highest standards of patient care.

We note that £0.5 billion represents just 0.7% of the Scottish Government's total budget of £67.9 billion for 2026-27, a relatively small proportion of overall public spending.

RCGP Scotland recognises that the need for meaningful public service reform is now unavoidable. In healthcare, demographic change will continue to drive rising demand, making it essential that finite resources are used in ways that maximise patient outcomes and long-term sustainability. While Scotland's overall population is projected to decline over the next two decades, the country's annual disease burden is forecast to increase by 21% between 2019 and 2043. This growth is largely driven by an ageing population, assuming no significant changes in disease prevalence, risk factors, service access, or advances in prevention and treatment. In this context, it is imperative that healthcare resources are directed towards services that deliver the greatest value and impact.

Recent public polling has consistently shown that access to GP appointments is the public's top priority for the NHS. Growing patient demand has stretched GP capacity beyond sustainable limits, leaving many practices managing significant workload pressures and increasingly complex care. These pressures have had an inevitable impact on frontline staff and patient care. According to our latest GP Voice Survey of members, 71% report that patient care is being compromised by unsustainable workloads. 45% of GP members reported a decline in their mental wellbeing while working as a GP over the previous 12 months.

Despite these challenges, general practice continues to provide exceptional value for patients and taxpayers alike. It delivers around 90% of NHS patient contacts while receiving less than 7% of the NHS budget, making it one of the most cost-effective parts of the health service.

Lord Darzi's independent review of the NHS highlighted GP partnerships as demonstrating some of the strongest financial discipline within the health system. Evidence also shows that investment in primary care improves health outcomes while delivering substantial economic and societal benefits. Research suggests that every additional £1 invested in primary care generates at least £14 in productivity gains within local communities.

It is also important to recognise that the share of NHS funding allocated to general practice in Scotland has fallen from 11% in 2008 to less than 7% today. During the same period, patient demand and clinical complexity have increased significantly, while GPs have shouldered additional responsibilities as pressures elsewhere in the health service have resulted in work being transferred into general practice without corresponding resources. Public service reform must acknowledge this reality. Efforts to drive efficiency should focus on areas of the system that are better placed to absorb further resource constraints, rather than starve those general

practice teams who are already delivering high-value care with a relatively small share of NHS funding.

**b) What progress is being made towards achieving these efficiencies?**

RCGP Scotland's manifesto for the 2026 Scottish Parliament election called on all political parties to commit to an NHS "red tape challenge" aimed at identifying and removing unnecessary barriers that prevent healthcare professionals from delivering the best possible care to patients.

GPs are already leading innovative approaches to improve efficiency and patient outcomes across the NHS. One example is the development of interface working between primary and secondary care. RCGP Scotland has long highlighted the primary-secondary care interface as an area of significant risk for both patients and the wider system. Care delivered across organisational boundaries can often be fragmented and inefficient, resulting in poor patient experiences, duplication of work, delays in treatment and avoidable pressures elsewhere in the health service. These challenges can have a particularly detrimental impact on disadvantaged and vulnerable groups.

An example of how these issues can be addressed is a new way of working that NHS Lothian has trialled in medical paediatrics. By redesigning referral pathways and strengthening collaboration between primary and secondary care clinicians, the model has delivered significant improvements in patient experience, referral management and waiting times.

The need for innovation became increasingly apparent in 2019, when growing pressures on paediatric outpatient services led to rising waiting times and a worsening patient experience. Against a backdrop of increasing demand, siloed ways of working and limited opportunities for collaboration between sectors, a new approach was required.

Currently described as a “cluster interface model”, this approach was initially co-designed by NHS Grampian and the Scottish Government. Using clinical expertise and service data, the programme sought to redesign outpatient paediatric pathways around patients' needs while improving efficiency across the system.

Under the model, each GP cluster, comprising groups of five to ten practices within a local area, is linked to both a named consultant specialist and a named GP with an Extended Role (GPwER) in that specialty. These clinicians jointly review all referrals from the cluster, with many cases resolved through specialist advice or telephone consultations. Where face-to-face appointments are required, care is provided closer to patients' homes through community-based clinics.

Following its introduction in NHS Lothian in 2022, the results have been highly encouraging. Evaluation has shown waiting times reduced by up to 80%, DNA (Did Not Attend) rates falling from 15% to 5%, lower referral rates, fewer attendances at A&E, and reduced travel requirements for patients. Satisfaction among both patients and clinicians has also increased significantly, with ratings of the referral pathway rising from around 5 out of 10 to more than 9.5 out of 10. The success of the programme has led to its expansion across multiple paediatric clusters, with other specialties now exploring or adopting the model.

There are also significant opportunities to improve efficiency through the use of artificial intelligence (AI). The Scottish Government's Artificial Intelligence Strategy, published in 2021, set out an ambition for Scotland to become a leading centre for AI innovation, including within healthcare.

While a number of AI initiatives have been piloted across NHS Scotland, these have largely been concentrated in secondary care settings. For example, in May 2024 a national theatre scheduling tool was introduced using more than five years of NHS operating data to optimise theatre utilisation and help reduce waiting times.

RCGP Scotland welcomes the adoption of appropriate AI technologies that can reduce administrative burdens, streamline processes and free up clinicians' time to focus on direct patient care. To date, AI deployment has been far more prevalent in secondary care than in general practice. However, there is significant potential to utilise AI more effectively within primary care to improve productivity and patient access. Any expansion of AI must be implemented carefully, with appropriate safeguards in place to ensure patient safety, maintain public trust and protect clinicians from unintended consequences.

As policymakers consider how to reform public services and improve NHS productivity, there is a clear opportunity to learn from innovations already being delivered on the frontline. Reducing unnecessary bureaucracy, strengthening collaboration across the health service and making better use of technology can all help improve efficiency, patient experience and outcomes without compromising the quality of care.

Not all developments in general practice policy can be viewed through the lens of improving efficiency. RCGP Scotland was therefore disappointed by the Scottish Government's decision to pilot GP walk-in centres despite extensive evidence from England demonstrating that such centres provide a limited range of services at significantly greater cost than traditional general practice.

In July 2026, Public Health Scotland published the first data from the GP walk-in centre pilot programme. The findings largely confirmed RCGP Scotland's longstanding concerns that these centres represent a poor use of scarce NHS resources. The data showed that the six walk-in centres fully operational during June delivered approximately 70 patient contacts per day between them. By comparison, general practice teams across Scotland provide around 136,000 patient contacts every weekday. While the Scottish Government has presented walk-in centres as a means of improving access to GP services, these figures demonstrate that their contribution to addressing the wider capacity challenges facing general practice is minimal.

The financial implications are equally concerning. The Wester Hailes GP walk-in centre in Edinburgh saw 846 patients during June. On that basis, the service would provide approximately 10,152 patient contacts annually. Given the pilot's annual cost of £1.6 million, this equates to an average cost of around £157 per consultation. Even if the centre had operated at its maximum capacity of 60 patients per day throughout the year, the average cost per consultation would still have been approximately £73.

The figures from the GP walk-in centre in Benbecula, which costs £580,000 to operate, saw just 84 patients during June, equivalent to around 1,008 patient contacts annually. This translates to an estimated cost of approximately £575 per consultation.

These costs compare unfavourably with estimates that place the average cost of a GP appointment in England at around £40 to £50. While equivalent Scottish data is not available, there is little reason to believe the average cost of a standard GP consultation in Scotland would be substantially different.

The evidence from England also raises wider concerns about the effectiveness of walk-in centres. Evaluations found that they were neither cost-effective nor successful in reducing pressure on either general practice or emergency departments. It suggested that between 10%

and 16% of patients attending walk-in centres would not otherwise have sought healthcare advice, while a further 46% went on to consult their GP within the following two weeks. Rather than reducing demand elsewhere in the system, walk-in centres often generated unnecessary healthcare consumption and duplication.

Concerns were also raised about their impact on health inequalities, and over time many centres were either closed or converted into urgent treatment centres. Against a backdrop of tight public finances and growing demand for healthcare, the pilot of GP walk-in centres is difficult to reconcile with the Scottish Government's stated commitment to public service reform to maximise outcomes. The pilot must be rigorously evaluated at its conclusion.

The original programme comprised 15 pilot sites at a cost of £36 million. Following concerns that the initial rollout would fall significantly short of its ambition to deliver one million additional appointments, the scheme was expanded to 30 pilot sites. To date, no detailed costings have been published for this expansion.

The Scottish Government has confirmed that this programme is time-limited. Once all pilot sites have concluded, it is essential that a robust, transparent and evidence-based evaluation is undertaken. If that evaluation demonstrates, as we expect, that walk-in centres deliver fewer services at a significantly higher cost than existing GP services, the programme should not continue. Resources should instead be redirected towards strengthening in-hours and out-of-hours general practice, where investment can deliver the greatest benefit for patients and the most effective use of NHS resources.

It is regrettable that so much time and attention has been devoted to the issue of GP walk-in centres, when it could have been focused on addressing challenges that would make a more meaningful difference to patients, such as improving GP telephony systems, expanding workforce capacity, and modernising appointment booking systems.

**c) What are the barriers to achieving greater efficiency and how can these be addressed.**

General practice in Scotland is a highly efficient service, responsible for delivering 90% of patient care with less than 7% of the budget. GPs and their teams delivered 33.98 million direct encounters with patients between October 2024 and September 2025 - an increase of 2.4 million on the same 12-month period in 2023-24.

However, there remains barriers to achieving greater efficiency in the service. One of the greatest barriers to delivering increased efficiency in general practice is slow and dated IT hardware and software. RCGP Scotland's most recent GP Voice Survey found that 45% of GP members reported that their PC/laptop hardware was not fit for purpose, and 53% said the same about their software.

The impact of poor IT systems has been recently demonstrated as GP practices move from their current IT systems to a new hosted Vision platform. Many practices reported insufficient training ahead of the migration, leaving staff feeling underprepared and unfamiliar with the new system. As a result, practice teams are reporting a range of interruptions to patient care, including difficulties accessing and interpreting patients' medical histories prior to consultations, problems with locating patient documents that are part of the record, and disruptions to prescribing. This experience makes the case for improved IT hardware and software alongside better change management to prepare for change and reduce inefficiencies.

Another example of where greater efficiency can be achieved is around e-prescribing. RCGP Scotland has long advocated for the development of e-prescribing software and programmes

across primary care. E-prescribing was one of the key asks from the College in our manifesto for the 2021 Scottish Parliament election, and while it is frustrating that paper is still being used for the dispensing of prescriptions – progress is in motion. Currently, electronic messaging software is in place where GP clinical systems send prescription information to community pharmacies.

The development of an end-to-end paperless e-prescribing system spanning across general practice, pharmacy and secondary care would improve patient safety and experience, while also reducing the environmental impact of healthcare. The Digital Prescribing and Dispensing Pathways Programme (DPDP), aims to replace paper-based prescriptions with a digital solution and is now delivered by Public Services Delivery (Scotland), having previously been jointly delivered by a partnership between NHS National Services Scotland and NHS Education for Scotland.

RCGP Scotland welcomes the fact that the business case for DPDP was approved, and that work is ongoing to deliver e-prescribing (albeit as a minimum viable product, which fails to provide a solution for dispensing practices). We recognise that GP IT reprovisioning must be completed to ensure compatibility between new GP IT systems and the e prescribing software.

We recognise the delays and setbacks introduced by INPS being placed into administration and the process of the novation of a new contract and we hope that DPDP will be sufficiently resourced to be rolled out in the near future, allowing for the substantial productivity benefits to be realised.

**2. How should the Scottish Government best present the extent of any realised efficiencies in the annual budget publication, including providing clarity on whether these are expected to be recurring savings?**

NA.

**3. The Fiscal Sustainability Delivery Plan aims to achieve an average reduction of the public sector workforce of 0.5% per year over five years.**

**a) To what extent is this target achievable and how will it shape public service delivery?**

RCGP Scotland has no specific comment on the Fiscal Sustainability Delivery Plan's proposal to achieve an average annual reduction of 0.5% in the public sector workforce over the next five years.

However, workforce planning within the NHS must reflect the Scottish Government's wider ambitions for public service reform and the shift towards prevention and community-based care.

As of August 2025, Scotland had 3,591 whole-time equivalent (WTE) GPs. While this represented the first increase in GP numbers for several years and is a welcome development, it follows a sustained period of decline. The GP workforce remains smaller than it was before the COVID-19 pandemic.

The longer-term trend is particularly concerning. Since 2013, the WTE GP workforce has fallen by 2.3%, while the number of WTE medical and dental consultants has increased by 35.6%. If the Scottish Government is serious about shifting care closer to home, strengthening

prevention, and reducing pressure on hospitals, a clear workforce strategy is needed to grow the GP workforce and support a rebalancing of resources towards primary and community care.

It is also important that workforce planning is based on meaningful measures. Headcount figures alone can present a misleading picture, as they do not account for the diverse working patterns of modern general practice. Similarly, GP registrars should not be counted as part of the established workforce, as there is no guarantee they will ultimately enter or remain in general practice in Scotland. Whole-time equivalent GP numbers provide the most accurate reflection of frontline capacity and should therefore be the principal metric used for workforce planning and public reporting. We highlight that the published numbers do not include GPs working only in the Out of Hours service or only in locum roles.

Against this backdrop, it is increasingly clear that the Scottish Government's commitment to increase GP numbers by 800 by 2027 will not be achieved, a conclusion also reached by Audit Scotland. By 2025, the workforce had increased by only 197 GPs on a headcount basis, leaving the target a considerable distance from being met. This underlines the need for a realistic, long-term workforce strategy that focuses not only on recruitment, but also on retention, workload sustainability and making general practice an attractive career for future generations of doctors.

RCGP Scotland continues to call on the Scottish Government to deliver a long-term GP workforce plan that seeks to build the capacity of general practice to match the population's healthcare needs.

**b) What progress is being made towards achieving this target?**

NA.

**4. What actions can the Scottish Government take to ensure these workforce reductions are delivered in a managed way which best supports effective government and public service delivery?**

NA.

**5. The PSR strategy states that it will protect frontline services. To what extent is there sufficient clarity about how frontline roles are defined and how efficiencies in back-office functions can be delivered in a way that minimises impact on the delivery of public services?**

NA.

**6. Beyond the financial benefits that the Public Sector Reform (PSR) Strategy aims to achieve, what are the key outcomes that reform should be aiming for.**

All reform efforts must achieve:

- Improved outcomes.
- Testing of digital technologies, with adoption of those that demonstrate benefits.
- Better alignment with the future population's needs.

**7. The PSR Strategy includes 18 different workstreams which aim to remove barriers to reform.**

**One workstream focuses on "simplification", recognising that "complexity of processes, structures and reporting requirements is a key barrier to effective and efficient service delivery".**

**"Prevention" is one of three pillars providing structure to the Strategy.**

**a) What should the Scottish Government's priorities be under its simplification workstream and what level of savings can be achieved through this approach.**

Please refer to answer 1 b as it relates to GP walk-in centres and work to improve communication across the primary secondary care interface.

**b) What progress has been made to date with preventative budgeting?**

General practice plays a vital role in delivering preventive care across the population. GPs are often the first point of contact for patients and are key to providing preventative health advice, identifying and managing risk factors, and supporting people to stay well within their communities. This not only improves health outcomes but also helps reduce pressure on other parts of the NHS, as preventing illness is often more effective and cost-efficient than treating it once it develops.

GPs have long been trained to provide this type of care and routinely use consultations as opportunities to deliver targeted patient education and discuss lifestyle changes. Research indicates that most patients are receptive to behaviour change interventions delivered by their GP during routine appointments, particularly in relation to alcohol consumption and smoking. This receptiveness is further strengthened by continuity of care and the ongoing patient-GP relationship.

As noted previously, the proportion of the NHS budget allocated to general practice has fallen from 11% to less than 7%, despite rising demand, increasing population need, and growing clinical complexity. To maximise the contribution of GPs and their teams to prevention, resource must be shifted towards general practice and the wider primary care system. This would enable the recruitment of additional staff, increase capacity, and allow clinicians to spend more time with patients. Effective prevention relies on building relationships, understanding individual circumstances, and having meaningful conversations about health. There is no substitute for an unhurried consultation with a GP.

We note that the Christie Commission in 2011 recommended prioritising prevention and that this was well-evidenced. The case for preventive approaches was understood to be a cost-effective use of taxpayers' money. RCGP Scotland does not believe that public service organisations have achieved this to date.

**c) How should the forthcoming Budget support greater progress towards preventative budgeting across the devolved public sector? Please set out any barriers and how these can be addressed.**

The next Scottish Government Budget must deliver on the historic deal between the BMA's Scottish General Practitioners' Committee and Scottish Government that delivers a total

investment of £249.36 million into general practice on a recurring basis by 2028/2029. This funding will help stabilise general practice, grow GP capacity and deliver a better service for patients. We recognise the historical significance of this deal which states, "Targeted funding – redirected from other current funding sources across the Health and Social Care Portfolio, including the wider NHS – for workforce, expenses, digital systems, and quality improvement is designed to support practices to modernise service delivery, collaborate meaningfully across the system, and actively support the ambitions of the Service Renewal Framework (SRF) and the Population Health Framework (PHF)." This deal cannot be seen as the end point, but rather the beginning of efforts to shift more resource into primary and community settings where it can make the greatest difference - in line with the Scottish Government's Service Renewal Framework and Population Health Framework, and alleviate pressures across the whole healthcare system.

RCGP Scotland notes that the above deal will see general practice's share of the NHS budget restored to approximately 7% of the total budget - well below the 11% received in 2008. In order to deliver on the Scottish Government's stated aims of healthcare reform this shift in resources must accelerate. Inspiration should be taken from Denmark where broad cross-party support for strengthening general practice has been in place since the 15 November 2025 'Health Close to You' agreement. This includes increasing the share of the national health budget spent on general practice from 8% to 12% and expanding the GP workforce from the current workforce of approximately 3,500 to 5,000.

We note Audit Scotland's 2025 report 'General practice: Progress since the 2018 General Medical Services contract', called on Scottish Government to set out a medium-term funding trajectory for general practice to provide certainty and enable better informed decision making and workforce planning. We would welcome movement from Scottish Government on this issue, and it is our hope that the upcoming Primary Care Route Map will set out clearly a longer-term funding pathway as we seek to deliver more care in primary and community settings.

**d) What changes to the Scottish Government's approach to budget-setting are needed to effectively deliver public service reform?**

See previous answer.

**8. The Scottish Government included an upfront Invest to Save Fund of around £30 million in the 2025-26 and 2026-27 Scottish Budgets for reform projects that will deliver ongoing savings and support the delivery of the PSR strategy.**

**a) To what extent is the Invest to Save Fund delivering projects that achieve ongoing savings?**

NA.

**b) How are successful outcomes from this Fund being shared more widely across the public sector?**

NA.