Primary Care Directorate
General Practice Policy Division

Scottish Government
Riaghaltas na h-Alba
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Proposed Funding Package Offer to General Practice – 2026/27 to 2028/29

1. The Scottish Government recognises the pressures facing general practice and is committed to long-term, sustainable investment. **This three-year package (2026–29) represents a total investment of £249.36m by 2028/29 on a recurring basis as set out in Table 1.** Funding is contingent on Parliamentary agreement to the Scottish Budget for 2026/27 and any future Spending Review outcomes. As well as core investment in workforce and practice expenses the offer is designed to support key enablers around digital, data and quality which are essential to providing a strong foundation for increasing investment in years two and three.

2. This package is not a pay deal, and this offer does not preclude in year increases to uplift GP earnings and staff pay. The Scottish Government is open to discussion as to how this offer aligns with future expenses uplifts. For example, the historical approach to uplifting expenses may require adjustment to account for any funding put in place for non-staff expenses.

3. The Scottish Government negotiates bilaterally with the BMA Scottish GP Committee on all terms and conditions that apply to GPs in Scotland, this is covered by refreshed Terms of Reference – shared separately to this offer. This offer will require detail to be agreed to support its delivery, that will be done under the agreed bilateral process with BMA and cover any required contract changes including those on the delivery of funding to GP practices. We are committed to working in a collaborative way with SGPC based on joint agreement.

4. If this offer is accepted, BMA Scotland will immediately end their trade dispute with Scottish Government on full funding restoration and cease preparations for a ballot of members on industrial action. Scottish Government understands that BMA Scotland reserves the right to re-enter dispute to protect their members and agreements they have made with Scottish Government

5. Noting dialogue between SGPC and Scottish Government negotiators, funding will be broadly directed into six priorities - workforce, expenses, digital & access, quality & data, premises and inequalities - with the aim of improving sustainability, capacity and patient outcomes. A summary of each priority is included in **Annex A**.

6. Where appropriate elements of this offer may also require engagement with Health Boards and Health and Social Care Partnerships to ensure deliverability at that level and to inform the Scottish Government negotiation position (e.g. how direct reimbursement of expenses can be delivered).

Table 1: Summary of proposed investment

	25/26 (£m)	26/27 (£m)	27/28 (£m) *(additional)*	28/29 (£m) *(additional)*	Total recurring (£m)
Priority					
Workforce		35	31.6	51.7	118.3
Workforce Tranche 1	15				15
Workforce Tranche 2*		15			15
Sickness, Maternity etc. Cover		7.5			7.5
Expenses		10	21.7	8.3	40
Premises			15		15
Inequalities			5	5	10
Digital and access		5.5	8.7		14.2
Quality		2	3		5
Digital prescribing		8.14	0.4	0.82	9.36
Total additional funding	15	83.14	85.4	65.82	249.36
Total (cumulative)	**15**	**98.14**	**183.54**	**249.36**	**249.36**

*to be released on achieving milestones

7. This investment in general practice is designed to strengthen capacity and resilience in the community so that patients can access the right care, at the right time, in the right place. 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). Delivery will be through contractual mechanisms and national governance, with mutually agreed conditions attached to ensure transparency and evidence of additionality.

8. The funding is designed to deliver measurable growth in general practice workforce, modernised digital contact systems, and a refreshed Quality Framework with structured protected learning time.

9. In the **short-term** this aims to deliver more reliable and appropriate access, improved continuity of care, and stronger management of long-term conditions. Practices will experience greater stability through direct reimbursement of expenses and more resilient workforce planning.

10. In turn, this will drive **medium-term** outcomes including fewer avoidable hospital admissions; earlier intervention and prevention of disease progression; reduced unwarranted variation in access and outcomes between deprived and affluent communities; and higher levels of patient and workforce satisfaction.

11. The **long-term impacts** are aligned with the aims of the Service Renewal Framework and the Population Health Framework. The investment will lay the foundations for more care to be delivered closer to home, and for reform to ensure that prevention is embedded as an organising principle of the system.

12. **Annex B** sets out the benefits to patients, practices, the wider health system, and how this investment aligns with the Scottish Government's strategic aims**.**

Rural

13. We recognise the distinct challenges of rural and island areas and are committed to supporting and developing rural general practice. We will also undertake a rural impact assessment to inform the implementation of these funding proposals to help ensure it is sensitive to the needs of rural general practice. We will continue to work with SGPC and other stakeholders to improve the attractiveness of careers within remote and rural general practice.

14. We understand that some of the challenges go beyond the scope of this agreement (i.e. housing, transport, etc.), and will continue to work across government to inform the development of the Rural Delivery Plan and National Islands Plan, which are designed to improve the outcomes for rural and island communities.

Governance

15. To ensure effective delivery, oversight of this agreement will be provided nationally by the **General Practice Programme Board**, which brings together Scottish Government, SGPC, NHS Boards and Integration Authorities. This Board will monitor progress, support consistency across the system, and provide strategic leadership on reform.

16. At local level, existing **tripartite arrangements**, involving Integration Authorities, NHS Boards, and GP sub-committees, will continue to lead on implementation. This ensures that changes are grounded in local context and co-produced with clinical leaders. This governance model supports both national alignment and local flexibility, reinforcing our commitment to collective ownership and delivery of the package.

17. It also reflects the **Service Renewal Framework** commitment to whole system accountability and capacity building, and the **Population Health Framework** principle of shared responsibility for prevention and equity. National oversight ensures consistency of standards and outcomes, while local tripartite leadership ensures that services are shaped around the needs of communities. Together, these arrangements make clear how investment in

general practice contributes directly to the wider reform agenda and long-term improvements in population health.

18. Progress will be monitored through agreed national datasets on workforce, access, quality and expenses. Regular reporting to Ministers and the Programme Board will ensure transparency and provide assurance that investment is delivering additional capacity, better patient access, practice sustainability and improved outcomes.

19. Health Boards and practices will be required to provide data that funding is being used in line with these or other agreed objectives.

Annex A: Areas of investment - summary

Year One

Workforce: to expand capacity, improving patient access, sustainability, and wellbeing within general practice with a skill mix that is responsive to patient needs

1. To ensure practices can select options best aligned to their workforce needs, they will be allocated funding through the Global Sum / Income and Expenses Guarantee to increase their capacity in the following areas:

	Workforce Capacity Menu of Options
A	GPs: practices create **new permanent GP** roles (i) GP partners (ii) salaried GPs
B	GPs: practices increase **WTE** of current **GPs** working in practices through extra sessions
C	GPs: practices reduce pressure in short-term through extra **GP locum sessions**
D	GPs: Practices recruit through new Board run fixed-term **GP fellowship** posts. SG would part fund these posts, with practices funding their clinical time in general practice. Fellowships can be used by Practices/Boards to fill posts which are perceived to be more difficult to recruit to (e.g. in rural / deprived areas).
E	Other clinical roles and administrative roles: practices increase WTE and / or create new headcount. Where practices cannot increase GP capacity or the assessed need is for another role they may consider recruiting to **other clinical staff** (e.g. general practice nurses) **or administrative roles**.

2. This phased investment grows year on year and is designed to give practices flexibility to shape their teams according to local need, ensuring additional capacity is realised in ways that are sustainable and patient focused. The expectation is that practices will prioritise GP capacity (a number of GP options are available), assess their requirements, and work through the menu of options as required, adopting a skill mix that is responsive to patient needs, ensuring sufficient levels of GP input per practice population are being planned and provided and fully leveraging the contribution of nursing and wider clinical roles (notably but not exclusively to the multidisciplinary teams (MDTs) developed over recent years).

3. Recognising that sums proposed for workforce are of the highest magnitude within the package, practices will be required to set out intentions and subsequently demonstrate the capacity added through quarterly Workforce

Survey returns, to ensure transparency and accountability of spend. There will be a requirement for Boards to take a role in oversight of this process (particularly supporting Workforce Survey returns) with the ability to view practice-level data. Practices can engage with Boards on the use of the funding to deliver sustainable workforce models and the need for continued review of the opportunities from delivery of MDTs. Reporting will also take account of and respond to learning derived from the ongoing approach taken to monitoring the additional £15m allocated for workforce recruitment and retention in 2025/26.

4. In financial year 26/27 as part of workforce funding investment we will revise SFE arrangements to enable locum cover to be provided on day 1 of sickness and revise the sick leave locum reimbursement available to practices. The rate for maternity, study and suspension leave would also be reviewed.

Expenses Reform: to improve sustainability while delivering part of the 2018 contract commitment to Phase Two

5. We will support improved consistency for expenses currently covered by the Premises Directions, and introduce direct reimbursement for agreed non-staff expenses in phases over the years 26/27, 27/28 and 28/29. In Year 1 (26/27) additional investment of £10m will be allocated to address the high degree of variation in local arrangements, ensuring equity, best practice and best value.

6. In Year 1 (26/27) this investment will be allocated to facilitate direct reimbursement, separate from and in addition to the Global Sum. In Years 2 and 3 (27/28 and 28/29) we propose that a proportion of funding will be reallocated from the Global Sum alongside additional investment to directly reimburse expenses.

7. Our expectation is that any funding freed up in the Global Sum as a result of additional investment would be recycled by practices to increase workforce capacity or address other sustainability pressures. This will ensure that these proposals in turn support better services and access to services for patients.

Digital and Access: to improve the digital systems available to general practice, enabling their use to support patient choice in how they engage with their GP, and to generate data that drives continuous improvement

8. We will invest in a national programme to ensure every practice has modern cloud-based telephony. By January 2027, every practice will need to have moved to cloud-based systems, in line with the national Public Switched Telephone Network switch-off. Work begins with a full baseline assessment and agreed national standards, supported by training and change management. The main implementation phase will take place in 2026/27, with full compliance required by 2027/28. Practices will be expected to use a core set of features such as automated call back, call flow, and real-time monitoring. These features are designed to reduce queues, improve safety, and provide the data needed for service planning. We will seek to establish a national programme to oversee this work, with the programme advising on the

best approach to procurement.

9. Alongside telephony, from Year 2 we propose to roll out national **Digital Asynchronous Consulting Systems (DACs),** implementing DACs within all General Practices over the following years. This would be phased nationally and aligned with the Digital Front Door programme, so patients can submit digital requests and access services without always needing a call or an appointment. Implementation would be supported by workflow redesign, coaching, and national standards, ensuring DACs genuinely ease workload rather than add to it. Data from DACs use would also help monitor demand and patient experience.

10. By 2028/29, all **practice websites** will be expected to meet a national minimum standard. This will ensure every site is accessible and provides a reliable entry point for patients, with core functions such as appointment booking, repeat prescription requests, and information on services.

11. From 2027/28, GMS regulations will be amended to require every practice to offer multiple ways to contact and consult and to maintain a mix of urgent, routine, and arrangeable-in-advance appointments. The exact model and appointment mix will be at the discretion of practices. Our intention is to encourage a variety of different routes to meet different patient needs rather than to propose a set proportion of available appointments being reserved for each type of consultation. These requirements will be subject to assurance nationally to ensure consistency and equity across Scotland.

12. The proposed data and digital investments and associated funding allocations require further joint work, including with Digital Health and Care colleagues and National Boards. Reflecting the 24/7 nature of primary care (i.e. delivery both in hours and out of hours), it will be important that practices work with Health Boards and Integrated Joint Boards in enhancing digital access and supports for patients in a consistent manner.

Quality: to strengthen the use of high-quality data in general practice to support better clinical care, service planning, and continuous improvement

13. We will introduce a new **Quality Framework** (name to be confirmed) to support consistently high-quality care in general practice. The Framework will complement reforms to data, digital systems, and access, embedding quality, consistency, and transparency across general practice.

14. To support improvement activity, we will strengthen access to structured **Protected Learning Time** (PLT) from 2026/27. National funding will provide reliable clinical cover for PLT, enabling every practice team to dedicate time to structured learning, reflection, and service improvement.

15. We are refreshing the **cluster model** to provide clearer strategic direction, national support and more consistent delivery. In addition, we intend to further invest in the cluster quality lead and practice quality lead roles from 2027/28 onwards.

16. We will invest in **improving interface working** by ensuring there are Interface Groups in every Health Board to provide leadership, accountability, and system-wide collaboration. The funding allocation includes resource to facilitate GP attendance at Interface Groups in each Health Board. This will require work with Health Boards and GP sub-committees to support these improvements ensuring cross system buy in. We will also develop a National Policy Framework on Interface Working to clarify purpose, principles, and priorities, as well as an approach to evaluation to assess impact.

17. To support the development of the quality framework, we will strengthen our use of data by developing a **mandatory minimum dataset** and seek a shared commitment to establishing clear expectations and promoting consistent good practice across practices**.**

18. All practices will be required to ensure availability of a practice level dataset at least annually, with some items being required more frequently. This will support whole system planning, transparency, capacity planning, and service improvement. This data will be published and developed iteratively in consultation with territorial and national boards based on feasibility, available funding and capacity. Data completeness which is of a useable quality will form a condition of funding and will be published at practice level.

Year Two

Inequalities: to narrow health gaps, ensuring fairer access and outcomes across all communities

19. Supporting tackling healthcare inequalities is a core aim of this package to better address the needs of populations facing the greatest barriers to care. Priorities will include tackling missingness including through new outreach work (a preventative approach whereby GPs proactively approach registered patients whom they feel are 'missing' and have unmet need, on the basis of their records), improving access to healthcare to make it equitable for priority populations and enabling new Continuity of Care and GIRFE approaches for those who need them most. This has been done successfully as part of the Scottish Government's Inclusion Health Action in General Practice (IHAGP) project currently in its third year in Greater Glasgow and Clyde with a socio-economic deprivation focus, and as a key element in the Cardiovascular Disease Directed Enhanced Service (CVD DES), which was targeted at missingness as well as deprivation.

20. SG proposes a joint and fully collaborative approach with SGPC to design and implement this new assistance for practices with patients in greatest need who are experiencing the effects of socio-economic deprivation. In 2026/27 we will explore and agree with the profession the most suitable approach for establishing and allocating the new healthcare inequalities funding that is indicated for Years 2 and 3 of this offer to ensure this new investment is directed where it will have the greatest impact. The intention is in relation to areas of socio-economic deprivation where healthy life expectancy and life

expectancy are lowest, linked to poverty. With limited funding to date work like the IHAGP project has been constrained to Greater Glasgow and Clyde locales. With greater funding, and opportunity to explore alternative and additional approaches, it would be useful to look beyond ‘deep end’ practices and learn from international work (e.g. Denmark) to look at rural and other pockets of socio-economic deprivation. Scottish Government at this stage intends to continue to fund the IHAGP initiative subject to budget confirmations each Parliamentary cycle.

21. Noting that the targeted, additional inequalities investment is scheduled for Years 2 and 3, practices should nevertheless consider how investment could be deployed in ways that support practice population cohorts that experience healthcare inequalities and need support and assistance to effectively access primary care.

Premises: to improve the sustainability of general practice by reducing financial risk from premises ownership and liability, creating greater confidence for new and existing partners

22. The Scottish Government has identified a budget to complete Tranche 1 of the GP Sustainability Loan scheme in 2025/26 and 2026/27. The funding for that is not part of this offer.

23. We intend to launch Tranche 2 of the GP Sustainability Loans scheme in 2027/28 with delivery over two years.

Enhanced Services and Seniority

24. We will undertake a review of current enhanced services commencing in 2026. Recognising the potential to grow the general practice contribution to care in the community we will work to agree a revised process for the introduction of future enhanced services including consideration of how they could eventually transition to essential or additional services with associated funding/resource and bilaterally agreed arrangements with SGPC.

25. We do not have the data to model the potential costs of changes to the Seniority Payments structure particularly with a view to supporting retention of GPs and sustainability of general practice. We will gather data with a view to reviewing the Seniority Payment scheme over the course of this agreement.

Annex B

Benefits of the investment for patients

- **Faster, more reliable access:** Minimum contact standards, multiple ways to contact a practice, and improved digital and telephony solutions will make it easier for patients to reach their practice and be seen at the right time.
- **More appointments available:** Investment in workforce growth will deliver capacity for additional GP appointments as well as across the broader general practice workforce, helping to meet the demands of Scotland's growing disease burden and ageing population.
- **Clearer expectations:** Patients will know what to expect from their practice in terms of access routes, giving greater confidence and consistency across Scotland.
- **Better prevention:** Greater workforce capacity and a refreshed quality framework will strengthen preventative care.
- **Improved management of long-term conditions**: particularly risk, complexity and multi-morbidity, will give patients confidence in the quality of care wherever they live.

Benefits of the investment for general practice teams

- **Resilient workforce:** Targeted recruitment and investment in practice staff will expand capacity, strengthen resilience, and improve wellbeing, retention, and continuity of care.
- **Financial sustainability:** Phased direct reimbursement of practice expenses by 2028/29 will reduce volatility and support stable business planning.
- **Protected learning and quality improvement**: Support for protected learning time and refreshed cluster arrangements will enable regular team development and service improvement, providing the conditions to enable GPs to thrive as clinical leaders within communities.

Benefits of the investment for the wider health system

- **Stability in primary care capacity:** A more sustainable and resilient general practice sector reduces pressure on acute and unscheduled care. Beyond reducing acute pressures, strong primary care delivers better outcomes for the majority of patients managed wholly within community settings.
- **Improved planning and assurance:** Direct reimbursement and clearer workforce data provide greater transparency and accountability, supporting better resource allocation and system oversight.
- **Alignment with wider system reform:** More consistent access standards and a quality framework to help Boards to deliver on SRF ambitions for integrated, community-focused care.
- **Improved access to practice level data**: to allow clearer understanding of population health needs and help develop tailored workforce plans with the right skills mix rather than relying on one-off role creation and support delivery of PHF/SRF in local systems.

Alignment with the Scottish Government's strategic aims

- This investment aligns with the ambitions of the **Service Renewal Framework** and the **Population Health Framework** by shifting resources to prevention, supporting care closer to home, and ensuring equity across communities. It also builds on the MDT model established in the 2018 contract, with a focus on supporting the wellbeing of GPs and staff through sustainable, team-based models of care. Through the work of the General Practice Programme Board, we will ensure programme discipline which will allow us to continue to consult colleagues with an interest in general practice across the system to ensure our substantial planned investment in core general practice aligns with and is considered in the context of the Primary Care Phased Investment Programme, associated evidence and developing business case.

The package reflects the five core SRF principles:

- **Prevention Principle**: Investing in workforce capacity and enhanced service delivery to support prevention across the continuum of care, enabling earlier intervention and reducing reliance on acute services.

- **People Principle**: Prioritising care designed around people's needs, with flexible access, improved consultation modes, and co-designed quality frameworks.

- **Community Principle**: Targeting most of the investment towards strengthening community-based care, moving away from hospital-centric models.

- **Population Principle**: Taking a population health approach, enabling practices to respond to local needs and strengthen quality at a population level.

- **Digital Principle**: Introducing phased digital access standards and a quality framework to support patient choice, responsiveness, efficiency, and digital inclusion.