Transforming Primary Care in Scotland

New Models of Care in General Practice: learning from Scotland, Denmark and England

Report on a meeting held in September 2025 at the Dovecot Studios in Edinburgh.

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Executive summary

A meeting was held on the 1st September 2025 at the Dovecot Studios in Edinburgh to discuss primary care transformation in Scotland and new models of care in general practice. Speakers from Scotland presented recent evaluations of the 2018 Scottish GMS contract, and speakers from Denmark and England presented recent developments in their countries. This was then followed by break-out groups to discuss key learning and next steps.

Summary of speakers talks:

- An international scoping review of primary care transformation in OECD countries and China, presented by Stewart Mercer showed that expansion of the multidisciplinary team (MDT) was the single most common approach to primary care transformation. Patients' views were seldom taken into account. There was limited evidence about primary care transformation and health inequalities or healthy ageing.
- An Audit Scotland report on the new Scottish GMS contract presented by Leigh Johnston showed a falling trend in real-terms direct spending in general practice, which fell by 6% between 2021/22 and 2023/24. Additionally, direct spending on general practices as a proportion of NHS spending decreased from seven per cent to 6.5 per cent between 2017/18 and 2023/24. The report also highlighted a lack of clarity over future investment plans and a lack of robust information at a national level about demand, workload, workforce and the quality of care in general practice. It was also noted that uncertainty remains over the strategic direction of general practice, given that phase two of the contract has not been agreed or implemented.
- The Edinburgh University qualitative evaluation presented by Eddie Donaghy showed that although the expansion of the MDT was broadly welcomed, there were many 'internal' and 'external' challenges. Although most patients were satisfied with the care provided by MDT staff, they tended to regard them as an addition rather than a substitute for a GP and were concerned about poor access to GPs and a lack of relational continuity.
- The Edinburgh University quantitative evaluation presented by Stewart Mercer included a 2023 national GP survey which found that < 50% of GPs reported reduced workload following the expansion of the MDT. Compared with a similar survey in 2018, positive job attributes (e.g., "Changes to my job in the last year have led to better patient care") had increased, whereas job satisfaction and negative job attributes (e.g., "I do not have time to carry out all my work") were unchanged. Work pressure, and intention to reduce hours or leave direct patient care were significantly higher in 2023 than in 2018.
- Recent changes in general practice in England (presented by Kath Checkland) include the Additional Roles Reimbursement scheme (ARRS), introduced in 2019 for additional multidisciplinary staff (which has recently had recently qualified GPs added to the eligible roles). There is no evidence as yet that ARRS staff reduce GP workload. The new NHS England 10 Year Health Plan pledges to train more GPs, reduce GP workload, and incentivise general practice 'at scale' through a 'single neighbourhood contract' and a 'multi-neighbourhood contract', though it remains unclear as to how these two contracts will interact with the GMS contract.
- Recent changes in Denmark (presented by Mogens Vestergaard) include recent cross-party agreement to increase overall direct general practice resources (from 8% to 13% of their healthcare budget), bolster GP numbers (from 3600 to 5000) and GP competencies to enable shifting care into the community. They also plan to 'weight' practice list sizes to account for practices caring for patients with more complex needs or multiple morbidities, and deprivation (calculated at individual rather than postcode level). A number of incentives exist to grow the GP workforce and allocate to areas of highest need. Draft legislation has been submitted for public consultation.

Summary of key themes from discussants:

1. The need for a clear vision for general practice and primary care transformation

The implementation of the new contract in Scotland has been sub-optimal and there is a lack of clarity on the future vision for general practice and primary care transformation. The core values of general practice must be retained and it is essential to include patients' views.

2. The importance of relationships and continuity of care

Discussants emphasised the importance of relational continuity. This is especially important with increasing levels of multimorbidity, related to both the ageing population and health inequalities in deprived areas. The importance of relationships between staff were also considered to be of key importance in the effective implementation of the new GP contract and the extended new MDT.

3. The need for transparency and accountability

The independent contractor model was regarded as the most cost-effective model of general practice. If lost, it would be difficult or impossible to return to it. However, transparency and accountability are important in terms of financial and clinical governance and quality assurance. There is also little or no indication to date of the effectiveness, or cost-effectiveness, of new MDT models, and expanding the MDT without a concomitant expansion of generalist clinicians (GPs, practice nurses, and district nurses) may be costly and inefficient, and loses the value of the generalist model.

4. The need for a long-term strategy and sustainability

There is a need for long-term workforce planning and secure funding to ensure the sustainability of general practice in Scotland. Similar planning is required for social care, including both the statutory and third sector organisations. There is a need for a national **public debate** on the future of general practice, primary care and the NHS as a whole and more honest conversations about what is politically and practically possible, rather than over-promising and under-delivering, which has contributed to cynicism and mistrust among many working in primary care and the public at large.

Transforming primary care in Scotland - Full Report

Background

Primary care transformation is high on the agenda of many countries around the world, given rising healthcare costs and ageing populations.[1] With growing populations of citizens with multimorbidity (multiple long-term conditions), primary care offers a holistic, generalist approach that potentially reduces the fragmentation of care that can occur in specialist driven services, offering greater patient safety as well as cost-efficiency.[2]

Since devolution in 1999, Scotland has had control of its health and social care budget, and thus can implement policies that differ from those of the other three UK nations. In April 2018, Scotland embarked on a radical new General Practice contract – the first specifically Scottish GP contract since the creation of the NHS in 1948. The contract aimed to create a more sustainable and appealing career for General Practitioners (GPs) by reducing workload and business risks, strengthening general practice as a community-based service, and improving the quality of patient care.[3] Key objectives included refocusing the GP as an expert medical generalist to manage undifferentiated and complex care, increasing the number of GPs by 800 by 2027, and expanding the multidisciplinary team (MDT) – which now stands at 5,019.5 WTE staff as of March 2025.[4]

These changes in Scotland took place across a backdrop of major changes in policy and the organisation of services around the integration of health and social care, with the formation of local Integrated Authorities and Health and Social Care Partnerships (HSCPs) in April 2016.[5] At the same time, the Scottish GP contract abolished the pay-for-performance quality improvement scheme that had been in place since 2004 - the Quality and Outcomes Framework (QOF) - and established GP Quality Clusters, which aimed to improve the quality of care for patients in the geographical area covered by the practices in the Cluster ('intrinsic function') and to contribute to the integration agenda of the local HSCPs ('extrinsic function').[6]

The introduction of the new GP contract in 2018 was preceded by a £30 million Primary Care Transformation Fund in 2015/2016 that provided funding for up to two years for GP practices to test out new models of care, with an evaluation of over 200 pilot studies conducted by the Scottish School of Primary Care.[7]

A meeting was held on the 1st September 2025 at the Dovecot Studios in Edinburgh to discuss progress on primary care transformation in Scotland and new models of care in general practice. Speakers from Scotland presented recent evaluations of the 2018 Scottish GMS contract, and speakers from Denmark and England presented recent developments in their countries. Attendance was by invitation in order to keep the meeting small and to allow in-depth discussions. A list of those who attended is shown in Appendix 1, the programme for the morning is shown in Appendix 2, and speakers' affiliations and biographies are shown in Appendix 3.

Participants were encouraged to speak openly and freely, with Chatham House rules being observed. Comments or views are not attributed to any individual or organisation, other than the speakers' talks which are summarised below.

Summary of speakers talks:

International evidence of primary care transformation

Stewart Mercer presented the findings of a systematic scoping review on primary care transformation in OECD countries plus China, led by David Henderson who was unable to attend the meeting. Over 4,000 papers were screened of which 107 were included in the review. These included quantitative, qualitative, and mixed-methods publications. The publications came from 14 different countries, with the top five being USA, China, Canada, UK, and Australia. The aspects of primary care transformation included in the studies are shown below, with expansion of the multidisciplinary team (MDT) being the most common approach, followed by alternative payment mechanisms, increased primary care access, financial incentives, and service coordination and integration. The outcomes measured in the studies varied widely, but collected managers views was the most common approach (either by questionnaire or by qualitative interviews), followed by GPs views, and other MDT staff views. Collected patients' views was relatively uncommon (less than 15% of studies). There was a lack of clear evidence regarding the effects of attempts to transform primary care on health inequalities and healthy ageing.

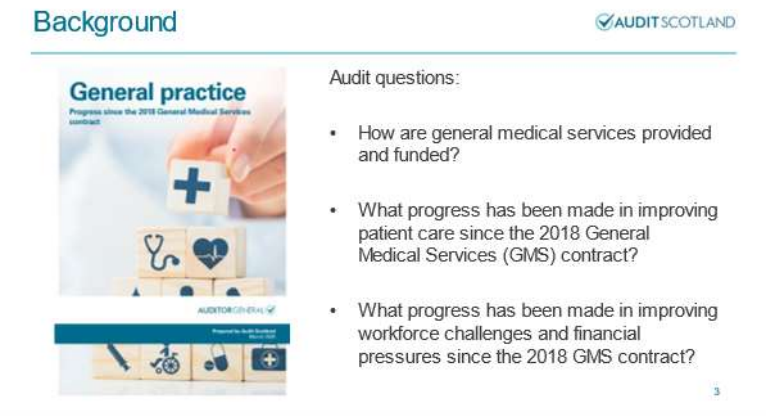
In terms of barriers and facilitators of primary care transformation, four themes were identified:

- Policy, leadership and communication
- Change, culture and relationships
- Resources & Capacity
- Targets, outcomes and measurement

Slides are available here:

Stewart Mercer Review PCT.pdf

Audit Scotland report: General Practice: Progress since the 2018 General Medical Services contract



Leigh Johnston presented findings from the Audit Scotland report on progress of the new GP contract in Scotland. She outlined the growing pressures on general practice in Scotland, including the demographic changes, widening health inequalities, and increasing burden of disease, as well as the long waiting times for secondary care. She also outlined the aims of the new GP contract, including the Scottish Governments' pledge to have 800 more (headcount) GPs by 2027, a target which Audit Scotland found was unlikely to be reached.

She then showed a falling trend in real-terms direct spending in general practice, which fell by 6% between 2021/22 and 2023/24. Additionally, direct spending on general practices as a proportion of NHS spending decreased from seven per cent to 6.5 per cent between 2017/18 and 2023/24. The report also highlighted a lack of clarity over future investment. In terms of data, the Audit Scotland report emphasised a lack of robust information at a national level about demand, workload, workforce and the quality of care in general practice. This limits the Scottish Government's ability to assess the impact of changes introduced by the 2018 GMS contract, and to make well-informed decisions about future plans and investment. She also reported that, in the view of Audit Scotland, the Scottish Government has not been transparent about progress with premises commitments and does not have sufficient oversight of whether general practice premises are fit for purpose. She concluded her talk by pointing out that there is uncertainty over the future strategic direction of general practice, with the original expectation being that phase one of the contract would be fully implemented by April 2019, and phase two would be implemented by April 2021. To date, phase two has not been agreed or implemented.

Slides are available here:

Leigh Johnston Audit Scotland Slides.pdf

Evaluation of the new Scottish GP contract – qualitative findings

Overall conclusions from qualitative evaluation

- Despite initial positive views there are clear internal and external challenges to effective implementation of GP contract
- COVID had a negative impact on primary care transformation
- Greater MDT working has not reduced GP workload or increase time with most complex patients according to accounts by GPs and MDT staff
- GPs in deprived and remote and rural Health Boards report more challenges with GP contract than more affluent areas
- Patients value MDTs but for complex and serious issues want to see a GP
- Patient report ongoing concerns over access and continuity of care with GP, with short or remote GP consultations being most problematic for those in deprived areas and/or with complex multimorbidity

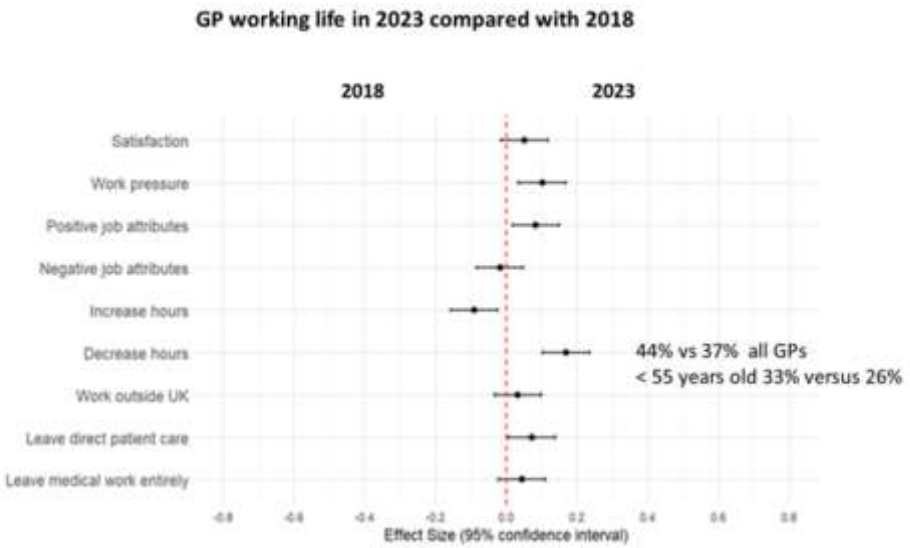
Eddie Donaghy presented the qualitative findings of the evaluation of the new GP contract as part of the ScotCh study, focusing on MDT workforce expansion, GP workload, and Practitioner-Patient experiences. Data were collected between April 2021 - January 2023 by in-depth qualitative semi-structured interviews with key senior Scottish primary care stakeholders (n=18), frontline GPs and new MDT staff in three diverse Scottish Health Boards (HBs) (n=27), and patients in these three HBs (n=30), and analysed thematically.

Although the expansion of the MDT as part of the new contract was broadly welcomed, and many advantages were apparent, there were also concerns expressed by all interviewees. 'Internal' challenges related to new MDTs (many who had moved from secondary care into general practice) finding it hard to adapt to the fast pace of primary care, the need to spend time building new relationships and integrating MDTs into GP practices, line management issues, and the lack of monitoring and evaluation of performance. 'External' challenges related to the ongoing effects post-pandemic demands, low staff morale, and hybrid working. Several interviewees expressed concerns about insufficient public engagement on the contract changes, particularly the practice of reception staff asking patients about their health issue and directing them to a broader range of MDT staff rather than to a GP.

Nearly all GPs (n=23) reported no decrease in workload; most reported increased workload post-pandemic. GPs also needed to spend (unremunerated) time training and supervising MDT staff, and most GPs reported being unable to provide longer consultations to patients with complex needs, which was a core aim of the contract. Patients (n=30) were generally unaware of the new contract, and thought the changes, such as active signposting to wider MDT-based models of care, were due to the pandemic. Some expressed concerns about signposting by reception staff (mainly due to confidentiality concerns) though most were happy with the new MDT staff. However, they often saw them as an addition rather than a substitute for seeing a GP. They were unanimously concerned about poor access to GPs, and those with multimorbidity and complex needs were especially concerned about a lack of relational continuity with their GP. Slides are available here:

Eddie Donaghy
ScotCh Qualitative.pd

Evaluation of the new Scottish GP contract – quantitative findings



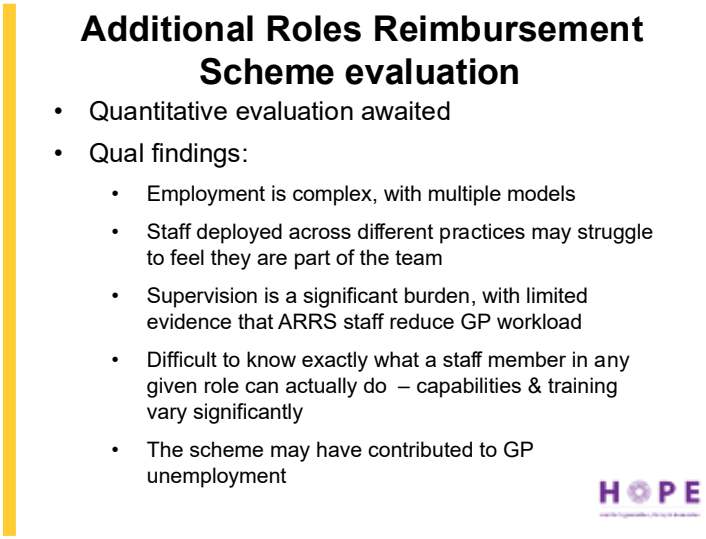
Stewart Mercer then presented the quantitative findings from the ScotCh study, which largely supported the qualitative findings. A patient survey found that most were generally unaware of the new MDT and the fact they might be signposted to see them by reception staff. Most were happy to be signposted, but a significant minority were not, especially in more socio-economically deprived areas (where a third were 'quite' or 'very' unhappy to be signposted).

GPs' views on the new contract were collected by a national survey of all trained GPs in Scotland conducted in late 2023/early 2024. As in the qualitative evaluation, GPs reported many advantages of the new MDTs, but also disadvantages, the most common being a lack of influence over the roles of the new MDT staff in the practice (71%), followed by problems with space (68%), and the time required for training and supervision (61%). Overall, less than 50% reported that the expansion of the MDT had reduced their own workload.

The 2023 survey findings were compared with a similar survey in 2018. Views on Cluster working were largely unchanged with support for Clusters being poor. However, significant improvements between 2018 and 2023 were reported for support for leadership and for quality improvement (QI). In terms of GPs' working lives, 'positive job attributes' (e.g., "Changes to my job in the last year have led to better patient care") were significantly higher in 2023 than in 2018, whereas job satisfaction, negative job attributes (e.g., "I do not have time to carry out all my work"), intention to increase hours or work outside UK or leave medical work entirely stayed the same between 2018 and 2023. Work pressure, and intention to reduce hours or leave direct patient care were significantly higher in 2023 than in 2018. The biggest difference was in intention to reduce hours (44% of GPs in 2023 compared with 37% in 2018). Published paper from the ScotCh programme are listed in appendix 4. Slides are available here:

Stewart Mercer
ScotCh Quantitative.p

What's happening in primary care in England?



Kath Checkland presented on recent changes in primary care and general practice in England. In 2019 the UK Government introduced the Primary Care Network Directed Enhanced Service (DES) contract, which was then updated in 2023, 2024 and 2025; this now accounts for approx. 10% of all general practice funding. The underlying principle of this was a desire by government to invest in primary care, but have that investment show demonstrable benefits. It was part of the governments' desire to incentivise more 'at scale' working. It also related to a reluctance of the government to invest in core funding of general practice because of a perceived risk that GP partners would simply increase their personal profits. The DES included, among many other things, the Additional Roles Reimbursement Scheme (ARRS), which accounted for just over 50% of available funding. The ARRS provided 100% reimbursement for a wide variety of additional staff: multidisciplinary staff, employed and deployed in a variety of ways. These were not referred to as being a multidisciplinary team (unlike in Scotland) and instead are described as multidisciplinary 'staff'. Initially this began in 2019 with clinical pharmacists, link workers, first contact physiotherapists, and physician associates, but has since developed into a huge list of over 40 different types of staff, including non-clinical staff (e.g., digital and transformation lead). The target number of staff for 2021-2024 was 26,000 (by comparison there are currently approximately 28,000 FTE GPs in England). Initially GPs were not included as an eligible role within the ARRS, but this was recently changed so that PCNs or practices could employ salaried GPs within two years of qualification. However, the number of practices who have taken up this option appears to be quite low.

Quantitative evaluation of the ARRS is awaited but qualitative evaluations have found that employment is complex, with multiple models. As in the Scottish evaluation, staff deployed across different practices may struggle to feel they are part of the team. The requirement for supervision by GPs is a significant workload burden, with limited evidence that ARRS staff reduce GP workload overall. It can also be difficult to know exactly what a staff member in any given role can do because capabilities and training vary significantly. The scheme may have contributed to GP unemployment. The DES came with several service requirements, but little attention has been specifically paid to health inequalities.

Other changes to the GP contract since 2019 include a wide range of other 'specifications' and 'requirements' focused upon:

- Wider use of risk stratification and proactive care approaches.
- Improving access, via online forms, triage etc.
- Supporting collective approaches to quality improvement (weak incentives).
- Work with community services etc to keep patients out of hospital (weak incentives).

There was a promise of a full renegotiation of the GP contract for implementation in 2027/8. However, since then a new ten-year health plan has been released by the government which focuses upon three 'shifts':

1. Hospital to community – increase proportion of patients treated at home, with corresponding shift in funding.
2. Analogue to digital – significant increase in the use of digital approaches to care, centred around an expansion of the capabilities of the NHS App plus the use of AI.
3. Treatment to prevention – with emphasis on the fact that this will save money.

Plans specific to general practice include pledges to 'revitalise access' by training thousands more GPs so that 'everyone who needs it can get same-day GP access' and to reduce GP workload by introducing AI scribes and by patients accessing health advice via the NHS App, and incentivisation of 'at scale' general practice by introducing two new contracts: a 'single neighbourhood contract' and a 'multi-neighbourhood contract'. Quite how this would work was unclear to the speaker!

Slides are available here:

What's happening in primary care in Denmark?

Mogens Vestergaard spoke on recent changes in Danish healthcare reforms regarding general practice. Mogens pointed out that in many ways Denmark and Scotland are similar. Denmark has six million inhabitants, and five regions (similar to our Health Boards) manage hospitals, private specialists, and GPs. In addition, 98 municipalities (similar to our Councils) that provide home care, nursing homes, and prevention. Private hospitals provide no acute care and use <3% of health costs. There are 1700 clinics and 3500 GPs in Denmark (thus practices are small) and 99% of citizens are registered with a general practice. GPs are the 'gatekeepers' to secondary care. Practices have on average 1650 patients per GP. Contracts are renegotiated every three years in a collective agreement and reimbursement currently is 30% capitation and 70% fee-for-service. There is no co-payment by patients.

There is recognised to be a major imbalance between funding for primary and secondary care, with the number of hospital consultants rising year on year compared to a flat-lining of GP workforce numbers. Care pathways for patients are fragmented between primary and secondary care and within secondary care. The three key challenges for the Danish healthcare system are noted to be:

- Fragmented care pathways.
- Imbalance between primary and secondary care.
- The 'inverse care law' in deprived area (see separate report on inverse care law).

Other challenges include changing disease profiles (with more multimorbidity), shortages of healthcare professionals, and rising patient expectation.

The Health Structure Commission was set up to review eight aspects of healthcare, one of which is the organisation and management of general practice. There are nine members on the committee, and Mogens is the only GP and the only doctor seeing patients on a daily basis.

The commissions' recommendations for general practice are:

1. Expand general practice resources and competences and allocate a higher proportion of the healthcare budget.
2. Increase the number of GPs from 3600 to 5000 GPs by 2035.
3. GP list sizes must reflect patient needs, allowing GPs with many complex or multimorbid patients to care for fewer patients while maintaining the same financial turnover ('weighted' list sizes).

Future recommended work includes:

- Define the services that all GP clinics are expected to deliver.
- Clarify which tasks belong in general practice and which belong in other settings.
- Describe how hospitals, specialists, and other services support general practice.
- Include core values such as first contact, comprehensive care, coordination of care, and continuity.
- Develop a national health plan to guide resource distribution between general practice and hospitals and across regions.
- Develop a new GP remuneration system - the GP fee structure for general practice needs to be simpler.
- Allocate more money for research in primary care in general, and to health services research in particular.

Draft legislation has been submitted for public consultation. The Bill proposes less autonomy and professional influence for general practice, and more Government control. It also introduces weighted list sizes of patients per GP, based on patients' needs, to be financed through internal redistribution. Some GPs would be allowed fewer patients but keep the same income, while others would have to take more patients. The Danish General Practitioners' Union and the Danish Minister of the Interior and Health have now reached an agreement for additional funding to ensure that no general practitioners will experience a loss of income.

Slides are available here:

Key learning and next steps for primary care transformation in Scotland – break-out group discussions

Attendees were divided into four break-out groups for discussion informed by the topics raised in the presentations and from their own knowledge and experiences of primary care. Each group had a facilitator and a scribe. The scribes then feedback the main points raised in the break-out groups to all attendees for further discussion.

Below is a summary of the four key themes that emerged from the discussions.

1. The need for a clear vision for general practice and primary care transformation

- There was a perceived **lack of clarity** in Scotland regarding the current and future vision for general practice and primary care transformation, given the evidence presented by the speakers on the **Audit Scotland report** on the new Scottish GMS contract, and the qualitative and quantitative evaluation of the new contract by the **University of Edinburgh**. The evidence presented suggests that the **implementation** of the new contract has been **sub-optimal**. It is as yet unclear what phase two of the contract will deliver given that, at the time of writing it is still under negotiation, with the BMA currently in formal dispute with the Scottish Government.

- It was felt to be essential to retain the **core values of general practice**, and that a values-based approach must be retained for the future. It was also considered essential to include the **patients' voice** in discussion about the future of general practice and primary care. However, the way in which this is done needs careful planning and consideration of what is feasible. The NHS England 10 Year Plan held a public consultation over several months, which essentially generated a long wish list, making it hard to distil into a clear plan with deliverables. This relates to the need for a national debate on the future of general practice, primary care, and the wider NHS (see below under long-term strategy and sustainability).

2. The importance of relationships and continuity of care

- Barbara Starfield's four Cs of primary care were raised as remaining of key importance - contact, comprehensiveness, coordination and continuity – but all four groups emphasised the importance of **relational continuity**. This has been diminished over the last few decades because of a focus by governments in Scotland and England on speed of access. With the increasing evidence-base in support of continuity of care in terms of a range of patient outcomes, relational continuity has risen to the forefront of discussions on primary care transformation. This is especially important with increasing levels of **multimorbidity**, related to both the ageing population and health inequalities in deprived areas. Ways to deliver relational continuity to patients with a largely part-time GP workforce and an MDT model of general practice, how to balance

that with appropriate access, and how best to measure and reward it were issues that need to be resolved going forward.

- The importance of building **relationships between staff** were also considered to be of key importance in the effective implementation of the new GP contract and the extended new MDT. As presented in the talks, there are many positive examples of this working, but also many challenges. The issue of **fragmentation of care** was also discussed, in terms of patients potentially seeing several different members of the MDT without clear join-up and team-working. In England, this appears to be a substantial problem due to the very large number of different new staff (some of whom are not clinical), the wide range of employment models, and the lack of emphasis on 'team' (in England they are referred to as 'additional roles staff 'rather than 'teams').

- It was of interest that the new GP contract in **Denmark** focuses on increasing the number of GPs substantially (including a proportionate universalism approach), without any further planned increase in MDT staff. In Denmark, the number of GPs per practice is also substantially smaller than in Scotland, making relational continuity more achievable.

3. The need for transparency and accountability

- There was discussion on different models of primary care and **different employment models** for GPs. It was suggested that younger GPs were less interested in being partners in a practice, though this can change as they gain experience. In England the larger clinical role list (ARRS) was felt to be intimidating and unworkable and the move towards a more corporate service model (larger practices, fewer partners) in England was not felt to be desirable for Scotland. The **independent contractor model** was regarded as the most cost-effective model of general practice, and it also allows for the more "entrepreneurial" GPs who are willing to innovate and try new ideas. If lost, it was felt that it would be difficult or impossible to return to it. However, the independent contractor model has also potentially led to a **lack of trust** by governments in Scotland and England around GPs profiteering, potentially limiting their willingness to invest directly in general practice.

- This raised the issue of **transparency and accountability**, both in terms of finances, but also in terms of clinical governance and quality assurance. With the abolishment of the QOF in Scotland, a key mechanism for quality assurance was removed, with no clear mechanism to measure quality post-QOF, nor indeed any agreement on what quality in general practice and primary care actually 'looks like'. If quality relates to holistic care – which is highly desirable for a multimorbid population – then single disease indicators may be of little value.

- The issue of transparency and accountability also applied to the **new MDT**, with little or no indication to date through national data of their **effectiveness nor cost-effectiveness**. There was a concern that rapidly expanding the MDT without a concomitant expansion of GP numbers was costly and inefficient, given that most of the MDT were specialists not generalists. **Generalist healthcare** – delivered largely by GPs, general practice nurses, and district nurses, is an obvious strategy to deal with multimorbidity in a cost-effective way and in line with the Scottish Governments ambitions for **Realistic Medicine.**

4. The need for a long-term strategy and sustainability

- All four groups raised the need for **long-term workforce planning and funding** to ensure the sustainability of general practice. This was felt to be lacking in Scotland and in England. Financial insecurity and the 4 yearly cycles of the political system leads to a constant churn of policies and uncertainty for staff and patients alike. Admiration was expressed that **Denmark** had recently achieved **cross-party consensus for a 10-year plan** on healthcare reform, including general practice, and had made a commitment to substantially increasing the proportion of healthcare spend on general practice, as well as promising a large **expansion of the GP workforce** from 3,600 to 5,000 over the next ten years.

- In addition to long-term planning for the healthcare system, similar planning was recognised as being needed for **social care**, including both the statutory and third sector organisations. Without this, the ambition for health and social care integration that meets the needs of all members of the population is unlikely to be realised, and NHS sustainability is threatened.

- As well as a need for a long-term strategy, discussants also raised the need for a national **public debate** on the future of general practice, primary care and the NHS as a whole. This would require political will from across the political parties, and more honest conversations about what is politically and practically possible and desirable from a state-funded healthcare service, rather than over-promising and under-delivering, which has contributed to cynicism and mistrust among many working in primary care and the public at large.

Summaries of the discussions in the four groups is available here:

Key learning and next steps for primary care

Summary and Conclusions

The need to ensure sustainability of primary care is of global concern.[8] With a shortage of GPs in many OECD countries, expansion of multidisciplinary models of care as part of 'primary care transformation' has been a common response.[1] Scotland embarked on a radical new GP contract in 2018 which aimed to improve quality of care and reduce GP workload.[3] The evidence presented at this meeting by the speakers suggests that the implementation of the new contract has been sub-optimal and its effectiveness and cost-effectiveness largely unknown. Clearly, the COVID-19 pandemic significantly disrupted progress and its aftermath is still being felt, although progress was also recognised as slow prior to the pandemic.[9,10]

The rapid expansion of the MDT in Scotland has brought advantages and disadvantages to GPs and patients alike. Similar problems were reported by Professor Checkland in England, where an even larger variety of new staff have been deployed under the Additional Roles and Reimbursement Scheme, with no evidence to date of a reduction in GP workload. A different approach is being taken by Denmark, which has achieved cross-party agreement to expand the GP workforce from 3600 to 5000 GPs by 2035, without any planned increase in MDT staff. There is also a commitment to significantly increase the percentage of healthcare spend to general practice and to move towards weighted list sizes, based on patient complexity and need.

We identified several important themes from this meeting. Firstly, the need for a clear vision of primary care transformation. This should retain the core values of general practice but also include patients' voices. Secondly, the importance of relationships and relational continuity of care for patients, especially those with complex problems and multimorbidity. Creating the conditions for good interprofessional relationships of respect and trust within teams was also considered to be of key importance in the effective implementation of the new GP contract and the extended new MDT. Thirdly, the need for transparency and accountability in terms of financial and clinical governance and quality assurance including the effectiveness, and cost-effectiveness, of new MDT models. Fourthly, the need for a long-term workforce strategy and financial sustainability.

The evaluation of the Primary Care Phased Investment Programme by Healthcare Improvement Scotland, will be important in informing the conditions and enablers required to optimise the contribution of the MDT to general practice. Their preliminary qualitative findings[13] are broadly similar to the University of Edinburgh evaluation, presented by Eddie Donaghy.[12] Their final report will be submitted to the Scottish Government in December 2025.

In conclusion, a strong primary care system is essential for the future sustainability of the health service in Scotland. Although the expansion of the new MDT is largely welcomed by GPs[11,12] and patients,[13] specialist MDT staff are not necessarily a substitute for GPs and general practice nurses, whose generalist expertise is essential in delivering holistic, relational care to an increasingly complex population with multiple long-term conditions.[14]

Moving forward, the challenge and opportunity for Scotland lies in building a model of care that fully integrates multidisciplinary teams within general practice, while protecting the values of continuity, accountability, and the generalist expertise that underpin holistic and sustainable primary care.[14]

Acknowledgements

We would like to thank all speakers and attendees. Thanks also to Lauren Ng, Eddie Donaghy, James Bogie, and John Gillies for capturing the key points raised in the break-out groups and feeding this back to the whole audience. Special thanks to Jayne Richards for her hard work and expertise in helping to organise the event.

Disclaimer

The views expressed in this report from the break-out group discussions were analysed and collated by the authors of this report, and do not necessarily reflect the views of all discussants. It should be noted that the two attendees from the Scottish Government did so as observers and did not contribute to the discussions. It should also be noted that Carey Lunan attended in her role as Honorary Senior Lecturer in General Practice at the University of Edinburgh.

References

1. Henderson DAG, Donaghy E, Dozier M, Guthrie B, Huang H, Pickersgill M, Stewart E, Thompson A, Wang HHX, Mercer SW. Understanding primary care transformation and implications for ageing populations and health inequalities: a systematic scoping review of new models of primary health care in OECD countries and China. BMC Med 21, 319 (2023). https://doi.org/10.1186/s12916-023-03033-z

2. Moffat K, Mercer SW. Challenges of managing people with multimorbidity in today's healthcare systems. BMC Fam Pract. 2015 Oct 14;16:129. doi: 10.1186/s12875-015-0344-4. PMID: 26462820; PMCID: PMC4604728.

3. GP contract Scotland 2018/19. BMA. https://www.bma.org.uk/pay-and-contracts/contracts/gp-contract/gp-contract-scotland-201819

4. Primary care improvement plans - implementation progress summary: March 2025. Scottish Government. https://www.gov.scot/publications/primary-care-improvement-plans-implementation-progress-summary-march-2025/

5. Health and Social Care Integration. Scottish Government. https://www.gov.scot/policies/social-care/health-and-social-care-integration/

6. Improving Together: A National Framework for Quality and GP Clusters in Scotland. Scottish government. https://www.gov.scot/publications/improving-together-national-framework-quality-gp-clusters-scotland/pages/4/

7. National Evaluation of New Models of Primary Care in Scotland. Scottish School of Primary Care, 2019. https://www.sspc.ac.uk/media/Media_645962_smxx.pdf

8. Primary Health Care. WHO. https://www.who.int/health-topics/primary-health-care#tab=tab_1

9. General practice. Progress since the 2018 General Medical Services contract. Audit Scotland 2025. https://audit.scot/uploads/2025-03/nr_250327_general_practice.pdf

10. Mercer S, Gillies J, Fitzpatrick B. Progress of GP clusters 2 years after their introduction in Scotland: findings from the Scottish School of Primary Care national GP survey. BJGP Open. 2020 Dec 15;4(5):bjgpopen20X101112. doi: 10.3399/bjgpopen20X101112. PMID: 33144368; PMCID: PMC7880176.

11. Donaghy E, Sweeney KD, Ng L, Haines H, Thompson A, Henderson D, Wang HH, Thompson A, Guthrie B, Mercer SW. Primary care transformation in Scotland: a comparison of two cross-sectional national surveys of GPs' views in 2018 and 2023. Br J Gen Pract. 2025 Jul 31;75(757):e559-e565. doi: 10.3399/BJGP.2024.0500. PMID: 39778945; PMCID: PMC12159868.

12. Donaghy E, Huang H, Henderson D, Wang HH, Guthrie B, Mercer SW. Primary care transformation in Scotland: a qualitative study of GPs' and multidisciplinary team members' views. Br J Gen Pract. 2023 Dec 28;74(738):e1-e8. doi: 10.3399/BJGP.2023.0086. PMID: 38154939; PMCID: PMC10756001.

13. Primary Care Phased Investment Programme. Evaluation update: Interim report. Healthcare Improvement Scotland, June 2025: https://www.healthcareimprovementscotland.scot/wp-content/uploads/2025/07/Primary-Care-PIP-Evaluation-Interim-Report-July-2025.pdf

14. Mercer SW, Gillies J, MacRae C. Generalist approaches to healthcare systems: organisation and design of healthcare. In: Generalism in Clinical Education and Practice. Edited by S Parkes and K Leadham-Green. UCL Press, 25 July 2024; DOI: https://doi.org/10.14324/111.9781800085428

Appendices

Appendix 1. Attendees

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Colin Angus	Patient and public Involvement Chair, ScotCh study	colin_angus@hotmail.com
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John Gillies	Honorary Professor of General Practice, University of Edinburgh	John.Gillies@ed.ac.uk
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Sara Redmond	Chief Officer of Development, The Health and Social Care Alliance	Sara.Redmond@alliance-scotland.org.uk
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Marianne McCallum	Deep End GP, Glasgow	marianne.mccallum@glasgow.ac.uk
Nora Murray-Cavanagh	Deep End GP, Edinburgh	nora.murray-cavanagh@nhs.scot
Andrea Williamson	Professor of Inclusion Health, University of Glasgow	andrea.williamson@glasgow.ac.uk
Tejesh Mistry	CEO, Voluntary Health Scotland	tejesh.mistry@vhscotland.org.uk
Sarah Doyle	Chief Executive and Nurse Director, Queen's Nursing Institute Scotland	sarah.doyle@qnis.org.uk
Peter Mclean	Chair of Primary Care Managers, Scotland	peter.maclean@nhs.scot
Katie Gallacher	GP/Co-Director of the Scottish School of Primary Care	Katie.Gallacher@glasgow.ac.uk
John Ford	Public health doctor and Senior Clinical Lecturer in Health Equity, Queen Mary University London	j.a.ford@qmul.ac.uk

Invited but unable to attend:

Iain Morrison	Chair, Scottish General Practice Committee, BMA
Chris Black	Deputy Chair, SGPC, BMA
Alan Miles	Deputy Chair, SPCP, BMA
Chris Proven	Chair, RCGP Scotland
Caroline Hickling	Policy and Public Affairs Manager, RCGP Scotland
Paul Baughan	Clinical Lead Healthcare Improvement Scotland
Dianne Stockton	Director of Public Health for Public Health Scotland
Peter Cawston	Commissioner, Poverty and Inequalities Commission
Irene Oldfather	Director, Health and Social Care Alliance
Mary Hemphill	PPI Member, ScotCh Study
David Henderson	Research Fellow, University of Edinburgh
Margaret McCartney	Senior Lecturer, University of St Andrews
Lindsay Pope	Professor of Medical Education, University of Glasgow
Andrea Williamson	Professor of Inclusion Health, University of Glasgow
Adrian Baker	GP Partner, Nairn Healthcare Group

Appendix 2. Programme

9.15: Welcome – Carey Lunan

9.20: International evidence on primary care transformation – Stewart Mercer

9.30: Progress since the 2018 General Medical Services contract – Leigh Johnston

9.50: Views on the new GP contract in Scotland: qualitative findings – Eddie Donaghy

10.00: Views on the new GP contract in Scotland: quantitative findings – Stewart Mercer

10.10-10.30: Q+A/Discussion

10.30-11.00: Coffee

11.00-11.30: What's happening in primary care in England? – Kath Checkland

11.30 -12.00: What's happening in primary care in Denmark? – Mogens Vestergaard

12.00-12.40: Break-out session 1: Key learning and next steps for primary care transformation in Scotland

12.40-1.00: Feedback and discussion

1.00-2.00: Lunch

Appendix 3. Speakers Biographies

Leigh Johnston

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Leigh is a Senior Manager within the Performance Audit and Best Value team at Audit Scotland. Leigh leads performance audits within the health and care portfolio. Responsible for the annual NHS in Scotland report and the recent audit of general practice which looked at progress since the 2018 General Medical Services contract.

Kath Checkland

Kath is a former rural GP and current Professor of Health Policy & Primary Care at the University of Manchester. Her research focuses upon the impact of policy on the NHS, with a particular focus on primary care. She is passionate about holistic primary care, and leads a team of researchers whose work explores how access and continuity of care can be maintained in an increasingly fragmented system. She works closely with policy makers in England, and is currently researching how local integrated care can best be commissioned and managed. Her work is predominantly qualitative, but she works closely with health economists and leads large scale mixed methods studies.

Mogens Vestergaard

Mogens is a Danish general practitioner and Professor of Clinical Epidemiology at Aarhus University, with research focusing on family medicine, social inequality, multimorbidity, and mental health. As founder and chair of the Danish Deep End group, he has been a leading voice in reducing the impact of the inverse care law and promoting better healthcare in socioeconomically challenged communities in Denmark. Mogens served on Denmark's Health Structure Commission and has advised the government on preparing the healthcare system for future challenges. He now works as an expert ambassador for the Ministry of Health to implement the national health reform and strengthen collaboration between authorities and general practitioners. He was awarded the Honorary Award of the Danish Medical Association in 2025.

John Ford

John is an academic public health doctor and Senior Clinical Lecturer in Health Equity in the Wolfson Institute, Queen Mary University London where he leads the Health Equity Evidence Centre. He is also Honorary Public Health Consultant within the national team of NHS England. He is the Director of the Health Equity Evidence Centre which focuses on building the evidence base of what works to address health and care inequalities and leads a programme of research focused on addressing the structural determinants of health and care inequalities, such as funding, workforce and workload.

Carey Lunan

Carey is a GP and Chair of the Scottish Deep End Group. She is also Honorary Senior Clinical Lecturer at the University of Edinburgh. These are the roles in which she will be chairing the event. Carey also has a role as a senior medical advisor on health inequalities to the Scottish Government.

She is a passionate advocate of the role of general practice in addressing health inequalities. In 2020, when she was Chair of the RCGP in Scotland, she was awarded an MBE for services to healthcare during the Covid19 pandemic.

David Blane

David is a GP and Senior Clinical Lecturer at the University of Glasgow and the Academic Lead for the Scottish Deep End GP Group. He has been involved in research, teaching and advocacy related to the social determinants of health and health inequalities since 2010 and was awarded the RCGP John Fry Award in 2024.

Eddie Donaghy

Eddie is a social scientist and mixed-methods researcher at the University of Edinburgh, with extensive experience in health services research, including mental health services, services for people experiencing homelessness, and primary care inequalities. He led the qualitative evaluation of the ScotCh study (see below) and currently leads a large qualitative evaluation of social prescribing link workers in Scotland and England, which is part of a NIHR mixed-methods programme of work on link workers.

Stewart Mercer

Stewart is a former GP and current Professor of Primary Care and Multimorbidity at the University of Edinburgh. Over the last 25 years he has extensively researched the needs of patients with complex multimorbidity, and how health and social care systems need to adapt and respond to ageing populations and health inequalities. As Director of Scottish School of Primary Care from 2014 to 2020) he led the New Models Evaluation of Primary Care in Scotland (2016-2018). He led the ScotCh study - an independent evaluation of the new GP contract in Scotland funded by the Economic and Social Research Council (2020-2024).

Appendix 4. Publications form the Edinburgh University evaluation of primary care transformation in Scotland

1. Mercer SW, Gillies J, Rhian Noble-Jones R, Fitzpatrick B. National evaluation of new models of primary care in Scotland. Scottish School of Primary Care. Jan 2019: https://www.sspc.ac.uk/media/Media_645962_smxx.pdf

2. Mercer S, Gillies J, Fitzpatrick B. Progress of GP clusters 2 years after their introduction in Scotland: findings from the Scottish School of Primary Care national GP survey. BJGP Open. 2020 Dec 15;4(5):bjgpopen20X101112. doi: 10.3399/bjgpopen20X101112. PMID: 33144368; PMCID: PMC7880176.

3. Huang H, Jefferson ER, Gotink M, Sinclair C, Mercer SW, Guthrie B. Collaborative improvement in Scottish GP clusters after the Quality and Outcomes Framework: a qualitative study. Br J Gen Pract. 2021 Aug 26;71(710):e719-e727. doi: 10.3399/BJGP.2020.1101. PMID: 33798092; PMCID: PMC8321438.

4. Stewart E, Donaghy E, Guthrie B, Henderson D, Huang H, Pickersgill M, Wang HHX, Stewart Mercer SW. Transforming Primary Care in Scotland: A critical analysis of policy. BJGP 2022; 72 (719): 292-294. DOI: https://doi.org/10.3399/bjgp22X719765

5. Huang H, Wang HHX, Donaghy E, Henderson D, Mercer SW. Using self-determination theory in research and evaluation in primary care. Health Expect. 2022 Dec;25(6):2700-2708. doi: 10.1111/hex.13620. Epub 2022 Oct 1. PMID: 36181716; PMCID: PMC9700158.

6. Donaghy E, Huang H, Henderson D, Wang HH, Guthrie B, Thompson A, Mercer SW. Primary care transformation in Scotland: qualitative evaluation of the views of national senior stakeholders and cluster quality leads. Br J Gen Pract. 2023 Feb 23;73(728):e231-e241. doi: 10.3399/BJGP.2022.0186. PMID: 36127153; PMCID: PMC9512407.

7. McSwiggan E, Ng L, Donaghy E, Huang H, Gillies J, Henderson D, Thompson A, Wang HHX, Mercer SW. Evaluating primary care transformation: synthesis of findings across UK pilot projects. BJGP Open 3 March 2023; BJGPO.2022.0154. DOI: https://doi.org/10.3399/BJGPO.2022.0154

8. Kidd C, Donaghy E, Huang H, Noble-Jones R, Ogilvie S, McGregor J, Gillies J, Henderson D, Wang HHX, Mercer SW. Challenges in implementing GP Clusters in Scotland: a comparison of the views of senior primary care stakeholders in 2016 and 2021. BJGPOpen 3 March 2023; BJGPO.2022.0152. DOI: https://doi.org/10.3399/BJGPO.2022.0152

9. Donaghy E, Huang H, Henderson D, Wang HHX, Guthrie B, Mercer SW. Primary care transformation in Scotland: qualitative evaluation of the views of general practitioners and multidisciplinary team staff members. BJGP 18 August 2023; BJGP.2023.0086. DOI: 10.3399/BJGP.2023.0086

10. Donaghy E, Sweeney K, Henderson D, Angus C, Cullen M, Hemphill M, Wang HHX, Guthrie B, Mercer SW. Primary care transformation in Scotland: qualitative evaluation of the views of patients. BJGP 16 January 2024; BJGP.2023.0437. DOI: 10.3399/BJGP.2023.043

11. Sweeney K, Donaghy, Henderson D, Huayi H, Wang HHX, Thompson A, Guthrie B, Mercer SW. Patients' experiences of GP consultations following the introduction of the new GP contract in Scotland: cross-sectional survey. BJGP 2024; 74 (738): e1-e8. DOI: 10.3399/BJGP.2023.0086

12. Henderson DAG, Donaghy E, Dozier M, Guthrie B, Huang H, Pickersgill M, Stewart E, Thompson A, Wang HHX, Mercer SW. Understanding primary care transformation and implications for ageing populations and health inequalities: a systematic scoping review of new models of primary health care in high income countries and China. BMC Med 21, 319 (2023). https://doi.org/10.1186/s12916-023-03033-z

13. Sweeney K, Donaghy E, Henderson D, Wang HHX, Thompson A, Guthrie B, Mercer SW. A mixed-methods evaluation of patient's views on primary care multi-disciplinary teams in Scotland. BJGP Open 2024 Apr 25:BJGPO.2023.0200. doi: 10.3399/BJGPO.2023.0200. Epub ahead of print. PMID: 38663983.

14. Donaghy E, Sweeney KD, Ng L, Haines H, Thompson A, Henderson D, Wang HHX2, Thompson A, Guthrie B, Mercer SW. Primary care transformation in Scotland: a comparison two cross-sectional national surveys of general practitioners' views in 2018 and 2023. Br J Gen Pract. 2025; 75 (757): e559-e565. DOI: 10.3399/BJGP.2024.0500

15. Henderson D, Donaghy E, Sweeney K, Guthrie B, Thompson AGH, Wang HHX, Mercer SW. Patient satisfaction with general practice in Scotland 2011/12 to 2021/22. PLoS One. 2025 Apr 30;20(4):e0322095. doi: 10.1371/journal.pone.0322095. PMID: 40305548; PMCID: PMC12043161.

16. Ho L, Mercer SW, Henderson D, Donaghy E, Guthrie B. Effect of UK Quality and Outcomes Framework pay-for-performance programme on quality of primary care: systematic review with quantitative synthesis. BMJ. 2025 Jun 25;389:e083424. doi: 10.1136/bmj-2024-083424. PMID: 40562441; PMCID: PMC12188983.