

Future of general practice in Wales

March 2026



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Future of general practice in Wales

March 2026



About the Committee

The Committee was established on 23 June 2021. Its remit can be found at:
www.senedd.wales/SeneddHealth

Current Committee membership:



**Committee Chair:
Peter Fox MS**
Welsh Conservatives



Mabon ap Gwynfor MS
Plaid Cymru



James Evans MS
Reform UK



John Griffiths MS
Welsh Labour



Lesley Griffiths MS
Welsh Labour



Joyce Watson MS
Welsh Labour

The following Member attended as a substitute during this inquiry.



Altaf Hussain MS
Welsh Conservatives

The following Members were also members of the Committee during this inquiry.



Russell George MS
Independent Member



Sam Rowlands MS
Welsh Conservatives

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Chair's foreword

No-one would argue with the Welsh Government's vision of delivering care closer to home, but we need action now not words.

Traditional hospital-centred care is becoming unsustainable. Shifting the focus to preventative care will help reduce the burden on secondary care services and improve patient outcomes in the long term. However, this will require a significant shift in the way the NHS in Wales operates, with resources being moved from hospital settings towards primary and preventative care.

While the focus, both politically and in the media, is on waiting times and ambulance response times, the reality is that unless we address the lack of provision in primary care, we will never solve the problems in secondary care.

There is no doubt that funding for secondary care has come at the expense of primary and community care, and this imbalance needs to be addressed. The current funding situation in primary care is critically impacting the sustainability of general practice.

It is also clear that the formula for allocating funding to general practice is outdated and poorly aligned with the healthcare needs of the Welsh population. While formula changes alone will not address the need for greater overall investment, reviewing the formula is long overdue. We therefore welcome the establishment of a working group to look at the allocation formula for GMS funding, and urge that this work happens at pace.

Repeatedly, we have heard general practice described as the cornerstone of the NHS. As such, we must ensure it receives the investment and support it needs to carry out its vital role.



Peter Fox MS

Chair, Health and Social Care Committee

Conclusions and recommendations

Conclusion 1. As the cornerstone of the NHS, general practice plays a vital role in patient care and the future of healthcare delivery. General practice will be key in delivering the prevention agenda and care closer to home, and as such needs to be appropriately resourced to do so..... Page 22

Conclusion 2. Given the vital contribution of general practice to patient care, and its importance to the general public, we believe that the incoming Welsh Government should commit to holding an annual debate in the Senedd on developments within primary care to give Senedd Members the opportunity to scrutinise progress in this area..... Page 22

Conclusion 3. The ‘shift left’ agenda - moving activity out of hospital and into the community - will need to be properly resourced. This will require a serious and sustained financial commitment from the incoming Welsh Government and will need to involve a period of ‘double-funding’ to ensure a smooth and safe transition. Page 22

Conclusion 4. We recognise that any changes to the way that services are delivered can be concerning for people, and this is even more so when those services relate to their health. It is therefore essential that the public are fully engaged in the transition to care being delivered closer to home; that they fully understand what changes are being made, why they are being made and the potential benefits to them..... Page 22

Conclusion 5. Pilot projects play an important role in developing innovative approaches and driving service transformation. However, there are challenges created by the lack of sustainable funding that generally accompanies them, and this can be frustrating, particularly where pilots are proven to be successful. We believe that all pilot projects should, at their outset, be accompanied by a robust implementation plan setting out how the successful project will continue to be funded if the pilot proves to be successful..... Page 22

Conclusion 6. We believe that the formula for allocating funding to general practice (the Carr-Hill formula) is not fit for purpose and should be reviewed. An outdated allocation formula risks exacerbating inequalities in access to general practice and undermining the sustainability of services. We welcome the Welsh Government’s establishment of a working group to take this forward, and

anticipate that our successor committee will expect to see clear proposals for reform emerging from its work..... Page 32

Recommendation 1. The incoming Welsh Government should ensure that all primary care pilot projects are accompanied by a robust implementation plan, which sets out how the successful project will continue to be delivered and funded, once the initial pilot period and funding has come to an end..... Page 22

Recommendation 2. Within 100 days of coming into power, the incoming Welsh Government should write to our successor committee setting out its plans for reprofiling spending and resources between primary and secondary care, and the timescales for doing so..... Page 32

Recommendation 3. Within 100 days of coming into power, the incoming Welsh Government should write to our successor committee to confirm its commitment to reviewing the global sum allocation formula and the timescales for this.
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Recommendation 4. The Welsh Government should further explore options for moving to a multi-year funding arrangement for general practice..... Page 33

Recommendation 5. The incoming Welsh Government should develop a workforce plan for general practice to ensure there is a sufficient supply of new GPs and other clinicians to meet future demand. This should be part of a broader, joined-up approach to consideration of the wider workforce across NHS Wales, and support the transformation agenda of shifting care closer to home..... Page 43

Recommendation 6. The incoming Welsh Government should develop a national strategy to embed effective multi-disciplinary team working within primary care across Wales. This should include standardised service models, sustainable funding, clear referral pathways, and investment in both physical and digital infrastructure. Page 43

Recommendation 7. The Welsh Government, in conjunction with health boards and GP practices, should develop a public awareness campaign to:

- promote greater understanding of the role of the multidisciplinary team and its wider benefits for patient health and experience.
- promote the role of front desk general practice staff in triaging patients to get them to the most appropriate practitioner. Page 43

Recommendation 8. The incoming Welsh Government should confirm its position as regards the Marmot Nation programme and the consistent adoption of the eight Marmot principles across all departments. This should include details of:

- How it plans to continue work in this area;
- Lines of responsibility for delivering health equity actions at national, regional, and local levels; and
- monitoring arrangements, including public reporting on progress and outcomes. Page 50

Recommendation 9. The incoming Welsh Government should look at ways to incentivise GPs to take up opportunities in more disadvantaged or underserved communities. This should include consideration of the possible expansion of existing incentive schemes, such as the partnership premium payment. Page 50

Recommendation 10. The incoming Welsh Government should require health boards to establish formal mechanisms to strengthen relationships and mutual understanding between primary and secondary care. This might include regular joint clinical forums, shared training opportunities, and agreed processes for resolving interface issues. Page 55

Recommendation 11. The Welsh Government should mandate the development of formal agreements between secondary and primary care for any services transferred out of hospitals. These should:

- define the responsibilities of both the hospital teams and GP practices;
- ensure that funding and staffing “follow the patient” into primary care for each transferred service; and
- include clear clinical governance arrangements, including accountability for clinical risk and escalation. Page 55

Recommendation 12. The incoming Welsh Government should promote strongly the need for all health boards to include a dedicated, senior primary care leader within their executive teams. Page 60

Recommendation 13. The incoming Welsh Government should commission an independent evaluation of health board managed practices to assess their cost, quality, patient experience, and continuity outcomes compared to independent

contractor practices. This work should include the consideration of best practice examples for sharing across Wales.....Page 66

Recommendation 14. Within 100 days of coming into power, the incoming Welsh Government should write to our successor committee to confirm its commitment to continuing the work to review arrangements for dispensing doctors and the timescales for this..... Page 67

Recommendation 15. The incoming Welsh Government should commission a comprehensive review of the general practice estate. This work should support the longer-term transformation agenda of moving activity out of secondary care and into the community, and should be part of ensuring the primary care estate is fully prepared for this..... Page 79

Recommendation 16. The incoming Welsh Government should develop a clear timetable and accountability framework for delivering digital improvements and interoperability across NHS Wales, including general practice, secondary care and community services. Page 80

Recommendation 17. The incoming Welsh Government should review outdated administrative and regulatory requirements that impede digital transformation (such as the need for ‘wet signatures’) with a view to simplifying, standardising, and modernising these processes across NHS Wales. Page 80

Recommendation 18. The incoming Welsh Government should set out how it intends to strengthen the existing GP access standards and publish a clear plan for ensuring that all practices meet them. This should include measures to support equitable access for people who cannot use digital systems and to reduce the reliance on time-limited booking windows such as the ‘8am scramble’.
..... Page 92

1. Introduction

1. Described as the ‘cornerstone’ of the NHS, general practice handles a significantly larger patient volume than any other sector. Around 90% of all NHS contacts in Wales take place within primary care, and general practice is the largest part of that activity. In the last year, GPs handled 29 million calls and 18 million attendances for a population of 3.3 million.

2. General practice is widely regarded as a high-value part of the NHS, delivering the majority of patient contacts while operating with a smaller share of the overall NHS budget. With adequate resourcing, it has the potential to take on a greater share of the workload currently falling to secondary care. However, this would require a significant change in the way in which NHS funding is allocated.

3. Unfortunately, evidence submitted to our inquiry paints a picture of decline, with chronic underinvestment in general practice, increasing numbers of practices closing, and a beleaguered workforce. We heard significant concerns about the sustainability of services and general practice’s ability to provide safe, quality care.

Our inquiry

4. Primary care is the first point of contact for health care for most people, and offers comprehensive, community-based services. As the ‘front door’ of the NHS, primary care handles most health issues before any referral to secondary care. Primary care includes general practice, community pharmacy, dental, and optometry services. However, as a result of concerns raised by a number of Senedd Members about the accessibility and quality of general practice and its future sustainability, we have chosen to focus our inquiry on the future of general practice in Wales.

5. An open, public call for written evidence ran from 14 January 2025 to 28 March 2025. 61 written responses were received¹. We also held informal roundtable events to explore some of the key challenges facing general practice and opportunities for improvement with GPs and practice staff.

¹ Inquiry into the future of general practice in Wales: [consultation responses](#)

6. Alongside this, the Senedd's Citizen Engagement Team conducted a series of in-person and online focus groups, as well as a number of individual interviews, with GPs, members of the general practice workforce, and service users.²

7. We would like to thank everyone who took part in our inquiry.

² Inquiry into the future of general practice in Wales: [engagement findings](#) and [case studies](#)

2. The role of general practice

The Welsh Government's vision

8. Primary care in NHS Wales is guided by the Welsh Government's 2018 plan, A Healthier Wales³, which sets out a whole-system approach focused on integration, prevention, and delivering care closer to home. The Primary Care Model for Wales⁴ aims to realise this vision by promoting place-based, multiprofessional teams that provide coordinated care tailored to local population needs.

9. Implementation is overseen by the Strategic Programme for Primary Care, a national, health board-led initiative working with the Welsh Government. The programme consists of six workstreams and seeks to consolidate previous strategies, foster collaboration across health and social care, and scale successful local innovations for national delivery.

10. However, while these frameworks set out an ambitious vision for integrated, person-centred care delivered closer to home, they offer limited clarity on the specific role of general practice within that vision. General practice is acknowledged as part of the wider system, but its strategic significance and future direction are often implied rather than explicitly defined.

11. One stakeholder told us:

"The way in which general practice is guided/managed at a governmental or LHB level is not sensitive to the needs of the population or to the staff delivering that care. There is no effective leadership for primary care in Wales at all, and organisations tend to blame each other."⁵

12. John Williams, a Practice Manager from Wrexham, said:

"General practice doesn't seem to be seen, particularly within health boards, as a possible solution to other problems it's facing. Partly, that might be because the narrative, as I understand it, could be confusing. So, on one side, GP practices are saying, "We're struggling", but we have huge expertise that could be harnessed, and I think possibly because of that

³ [A Healthier Wales: our Plan for Health and Social Care](#)

⁴ [Primary Care Model for Wales](#)

⁵ GP59 Individual 08

narrative that we're struggling, we're not often seen as a potential partner, whereas we could, with proper consideration, resourcing and a contract that enables that.”⁶

Care closer to home

13. According to Public Health Wales:

“Wales is experiencing rising healthcare demand driven by chronic illnesses and an aging population. Traditional hospital-centric care is becoming unsustainable, highlighting an urgent need for care that is community-based and proactive.”⁷

14. The Welsh Government says it is committed to the approach set out in A Healthier Wales⁸, which envisions care closer to home. This will require resources to be moved from hospital settings towards primary and preventative care (also known as “shift left”).

“Delivering care closer to home is a core commitment of the future – not an aspiration. The focus is on moving from reactive services which respond and manage symptoms to proactive, integrated, and person-centred care, with an emphasis on prevention and equity. Barriers between services and sectors must be addressed to enable seamless care, and success will be measured by improved health outcomes, equity, and patient satisfaction.”⁹

15. The Welsh Government’s vision for care closer to home was widely supported. The North Cardiff Medical Centre Patient Participation Group said that to ensure general practice remained fit for the future, a more preventative approach to care was needed:

“This would involve not only addressing the current pressures on services but also ensuring that healthcare resources are directed towards early intervention and disease prevention. Shifting the focus to preventative care would help reduce the

⁶ RoP, 10 July 2025, paragraph 14

⁷ [Public Health Wales. Care Delivered Closer to Home: A Public Health Approach in Primary and Community Care by 2035](#)

⁸ [A Healthier Wales: our Plan for Health and Social Care](#)

⁹ HSC Committee, 12 November 2025, Paper 1

burden on primary care services and improve patient outcomes in the long term.”¹⁰

16. However, while being supportive of the vision, stakeholders questioned the pace and scale of system transformation. Evidence from BMA Cymru Wales stated:

“Despite the rhetoric and stated aims of the Welsh Government’s A Healthier Wales calling for a ‘shift in resources to the community’ to redress the health system’s reliance on traditional hospital services, the proportion of NHS funding provided to general practice has continually declined over the past 20 years.”¹¹

17. Similarly, the Royal College of General Practitioners Cymru Wales said that “much of the narrative of Welsh Government has focused on a shift in resources towards primary and preventive care, however, there appears to be a disparity between what is written and what is occurring in terms of funding”¹².

18. It suggested that acute sector pressures continued to dominate attention and resources, because.

“A queue of ambulances waiting outside a hospital or a publication of eye-wateringly high waiting list numbers are always more likely to drive headlines and thus the political agenda.”¹³

19. Stakeholders talked of the need for a strategic rebalancing of investment toward prevention and community care. Evidence from the Welsh NHS Confederation stated that the current funding situation for primary care is critically impacting general practice sustainability, with numerous practices struggling to provide adequate community care. It said:

“The sector lacks the necessary resources to fully transition to a primary care-focused health system within the current contractual framework. Any significant shift of services to

¹⁰ GP31 North Cardiff Medical Centre Patient Participation Group

¹¹ GP34 BMA Cymru Wales

¹² GP38 Royal College of General Practitioners Cymru Wales

¹³ GP38 Royal College of General Practitioners Cymru Wales

*primary care must be accompanied by commensurate resource allocation.*¹⁴

20. The All Wales Primary Care Lead Nurse Network suggested the current General Medical Services (GMS) contract no longer aligned with the demands of modern healthcare and was actively hampering the 'shift left' agenda. It said, "a comprehensive transformation is essential"¹⁵.

21. Nia Boughton, RCN Cymru told us:

*"So, it is quite a substantial investment that's required, and often when we talk about 'shift left' and we talk about moving services out of secondary into primary care, there is a perception that you can just switch off the funding stream in secondary care, redivert that money into primary care and then that service will pop up in primary care and everything will be fine, but it isn't as simple as that. You need to have two funding streams to allow that model to be established."*¹⁶

22. Nicholas Prigg, a GP partner near Wrexham, said that if the Welsh Government wanted to move care closer to people's homes, they needed to provide the facilities to enable this:

*"Shifting care out of the hospital is going to mean we need more GPs, nurses etc in the community – they need accommodating. Facilities need to be fit for purpose (some are, some aren't). There needs to be a recognition that requirements in the community will grow as more 'left shift' occurs – so any new build/re-development requires room to grow/future proof."*¹⁷

23. While primary care professionals believe they can play a greater role in delivering care in community settings, they face barriers such as underinvestment in training and limited employment opportunities.

24. Allied Health Professions Federation Cymru raised concerns about the lack of a long-term workforce plan and said that limited routes into the professions were

¹⁴ GP32 Welsh NHS Confederation

¹⁵ GP17 All Wales Primary Care Lead Nurse Network

¹⁶ RoP, 2 October 2025, paragraph 122

¹⁷ GP11 Nicholas Prigg

affecting the full contribution of allied health professionals to the primary care model.¹⁸

25. Evidence from the Royal College of Nurses Wales highlighted the lack of placements in GP surgeries for nursing students in primary care:

“One reason for this is because GPs require payment for allowing a nursing student to have an education placement at the surgery. This is not equitable when other parts of the NHS and independent health and social care do not receive a payment for placements.”¹⁹

Primary care clusters

26. Primary care clusters have been a core part of Welsh health policy since the publication of *Setting the Direction*²⁰, the Welsh Government’s strategic delivery programme for primary and community services in 2010, which introduced geographically based networks to coordinate care closer to home. Each cluster serves 25,000–100,000 people and brings together a range of professionals to plan and deliver services collaboratively. The Strategic Programme for Primary Care²¹, established in 2018, aims to accelerate cluster development.

27. Despite their central role, stakeholders have raised concerns about primary care clusters, particularly around inconsistent performance, unclear accountability, and limited autonomy. Reviews by the Bevan Commission and Royal College of General Practitioners²² and the Fifth Senedd’s Health, Social Care and Sport Committee²³ have called for stronger governance, greater transparency, and clearer guidance on best practice.

28. Dr Ian Harris, a GP in Bridgend and Deputy Chair of the General Practitioners Committee Wales, who gave evidence to the Fifth Senedd’s inquiry, told us he had not seen any improvements since that inquiry:

“[...] if anything, the processes of trying to release funding for initiatives are even more clogged than they were back in the day, and what we’re seeing is there’s probably more health board interference in that. It feels to me that the cluster project

¹⁸ GP43 Allied Health Professions Federation Cymru

¹⁹ GP15 Royal College of Nursing Wales

²⁰ [Setting the Direction](#), Primary & Community Services Strategic Delivery Programme

²¹ [Strategic Programme for Primary Care](#)

²² [Delivering a Prudent Approach to Primary Care in Wales](#), July 2020

²³ [Health, Social Care and Sport Committee. Inquiry into Primary Care: Clusters, October 2017](#)

is completely encased in concrete at the minute and going nowhere. And unless that changes and unless the thinking process and the freedom to innovate and to mainstream successful things are enabled very quickly, I think we're almost at a point where the enthusiasm for engaging with clusters is gone."²⁴

29. The Allied Health Professions Federation Cymru reported there had been some progress in relation to increased leadership and ensuring AHP representation on cluster groups, but said this remained complicated by the large number and complexity of cluster groups.²⁵

30. This was not the case for all professions. The Royal College of Nursing Wales told us:

*"Registered nurses, both those employed in GP practices and indeed those in community nursing services, need to be included in strategic planning undertaken by primary care clusters. To ensure that this is the case, it should be required that there is a registered nurse on every cluster board."*²⁶

31. We also heard concerns from a number of stakeholders about the short-term nature of cluster funding. Calum Higgins, Chartered Society of Physiotherapists, told us:

*"What we've found with funding is that transformation funding has been made available, there have been great pilot projects that have gone forward, and then once that funding comes to an end (...) there's then an argument between health boards and GP clusters as to who carries on that work, because it's been temporary funding."*²⁷

32. Similarly, Dr Tom Kneale, a GP in Ruthin, talked about the difficulty in getting forward funding for successful cluster projects:

"So, your concept is to provide funding for us to create innovative projects and then to get forward funding after that, but what we find is that the forward funding just isn't

²⁴ RoP, 17 September 2025, paragraph 77

²⁵ GP43 Allied Health Professions Federation Cymru

²⁶ GP15 Royal College of Nursing Wales

²⁷ RoP, 2 October 2025, paragraph 30

forthcoming. We've got data and evidence for really good cluster projects, for example, care home advanced nurse practitioners, and we just can't get the forward funding.”²⁸

Evidence from the Welsh Government

33. The Welsh Government says it is “determined to reorientate services away from secondary care and deliver a major transformation programme focused on prevention, support and community-by-design”. Further, it says that

“Having evolved as the main point of access for NHS care, delivering the highest volume of patient contacts, and adapting to the changing needs of our communities, GMS is now poised to play a central role in a new era of transformation.”²⁹

34. The Cabinet Secretary told us:

“So, the current system that we operate can best be summarised by the term ‘hospital by default’, effectively. So, we provide care in the most expensive and least convenient, from a patient part of view, part of our health system. So, the policy consensus has been for a long time—not just in Wales, but practically everywhere—that what we need to do is make sure that services are more readily available in primary care settings and in community settings as well. So, the direction of travel is obviously very clear.”³⁰

35. The Cabinet Secretary said that one of the mechanisms for moving more services out of secondary care into primary care and community settings was the Collaborative Directed Supplementary Service (CDSS), which will require health boards to commission services from primary care clusters, moving activity and funding out of hospitals and strengthening resilience. He confirmed that funding would follow activity as services shifted from secondary to primary care, but the transition would require a period of double funding, creating budget pressures. Support for this would come via GMS funding, cluster-level commissioning under the CDSS, and measures such as lease payments and improvement grants.

“One of the practical challenges that we will face is, unsurprisingly, it's not possible simply to turn off activity in

²⁸ RoP, 17 September 2025, paragraph 75

²⁹ HSC Committee, 12 November 2025, Paper 1

³⁰ RoP, 12 November 2025, paragraph 8

secondary overnight and for it to appear the next morning in primary care, obviously.”³¹

Our view

36. General practice is truly the cornerstone of the NHS, and the first point of contact for health care for the majority of people. As such, it is clear that the current model of delivery, largely centred around secondary care, cannot continue.

37. The Welsh Government’s vision of care closer to home is widely supported. However, if it is truly determined to reorientate services away from secondary care, general practice should be seen as the enabler of that system transformation, not a barrier, and must be supported to deliver this vision. This will require a genuine shift of resources into primary care, not just a re-branding of existing resources. The need to move resources from secondary to primary care is further discussed in Chapter 3.

38. The Welsh Government’s evidence paper explicitly positions general practice as central to the future of NHS Wales. But while the strategic intent is now clearer, questions remain about how this vision will be implemented in practice, particularly in terms of funding, workforce, and service planning. Witnesses also talked of a lack of effective leadership for primary care in Wales.

39. Primary care clusters are ideally positioned to help facilitate the shift from secondary to primary care. However, we heard concerns about inconsistent performance, unclear accountability, and limited autonomy. Perhaps most worrying was the evidence that, not only had things not improved since the report of our predecessor Committee in 2017, but in some respects, they were worse.

40. Transformation funding and the roll-out of pilot projects have been a recurrent theme through much of our work. A common issue with pilot projects is the short term nature of the funding. We have been told of successful, short-term pilots that have not been rolled out more widely once the funding comes to an end, which is not a sustainable position.

41. While the Cabinet Secretary describes how Collaborative Directed Supplementary Services (CDSS) will require health boards to commission services from primary care clusters, moving activity and funding out of hospitals, there is still a lot of uncertainty around how this will work in practice. We have written

³¹ RoP, 12 November 2025, paragraph 39

separately to the Cabinet Secretary to provide further detail on CDSS and how this will help secure adequate investment for general practice.

Conclusion 1. As the cornerstone of the NHS, general practice plays a vital role in patient care and the future of healthcare delivery. General practice will be key in delivering the prevention agenda and care closer to home, and as such needs to be appropriately resourced to do so.

Conclusion 2. Given the vital contribution of general practice to patient care, and its importance to the general public, we believe that the incoming Welsh Government should commit to holding an annual debate in the Senedd on developments within primary care to give Senedd Members the opportunity to scrutinise progress in this area.

Conclusion 3. The 'shift left' agenda - moving activity out of hospital and into the community - will need to be properly resourced. This will require a serious and sustained financial commitment from the incoming Welsh Government and will need to involve a period of 'double-funding' to ensure a smooth and safe transition.

Conclusion 4. We recognise that any changes to the way that services are delivered can be concerning for people, and this is even more so when those services relate to their health. It is therefore essential that the public are fully engaged in the transition to care being delivered closer to home; that they fully understand what changes are being made, why they are being made and the potential benefits to them.

Conclusion 5. Pilot projects play an important role in developing innovative approaches and driving service transformation. However, there are challenges created by the lack of sustainable funding that generally accompanies them, and this can be frustrating, particularly where pilots are proven to be successful. We believe that all pilot projects should, at their outset, be accompanied by a robust implementation plan setting out how the successful project will continue to be funded if the pilot proves to be successful.

Recommendation 1. The incoming Welsh Government should ensure that all primary care pilot projects are accompanied by a robust implementation plan, which sets out how the successful project will continue to be delivered and funded, once the initial pilot period and funding has come to an end.

3. Funding and contracts

42. Much of the NHS care that people receive begins in general practice, most of which is delivered under the General Medical Services (GMS) contract. Most services are delivered by independent contractor GP practices, with health board-managed practices established where needed to support communities lacking independent contractor operations.

43. Health boards receive a ring-fenced amount for GMS, as set out in Welsh Government's allocation letters to Health Boards.

Level of investment

44. Despite managing around 90% of all NHS contacts, primary care receives a disproportionately small share of funding. According to NHS Wales summarised accounts, GMS expenditure in 2024-25 accounted for 5.7% of gross spending, a decrease from 7.1% in 2018-19. BMA Cymru Wales has called for GMS investment to be restored to 2005-06 levels, reported as 8.7% of gross expenditure, within the next three years, with an aspiration to increase this to nearer 11% in the next five years.³²

45. According to the Welsh NHS Confederation:

"The financial landscape for general practice in Wales is under significant strain."³³

46. We were told that rising patient demand post-pandemic, coupled with increasing operational costs, including National Insurance rises, has not been matched by corresponding increases in funding. General practice's declining share of the NHS Wales budget is widely seen as a threat to service sustainability, workforce morale, and the delivery of preventive care. Professor Adrian Edwards told us:

"There has been a real-terms increase in spend across the NHS, but it has disproportionately not gone to primary care. So, primary care has risen by 14 per cent over these last 10 years, but in other areas of the NHS, their real-terms spend has

³² GP34 BMA Cymru Wales

³³ GP32 Welsh NHS Confederation

*increased by 17 per cent to 45 per cent. So, someone's getting a huge slice of the cake."*³⁴

47. One respondent to our consultation told us that in Wales, the balance of investment in primary and secondary care is "so skewed that it would be laughable were it not so worrying", and goes on to say:

*"It appears that actions have not matched the policy rhetoric, and we have prioritised technical efficiency (getting more from the resources invested) over allocative efficiency (allocating resources in such a way as to maximise health). Underinvestment in primary care is, therefore, a systemic problem for the NHS."*³⁵

48. Yet general practice is widely recognised as offering excellent value for money. Evidence from the Partners of Felinheli and Porthaethwy Surgery in North Wales stated:

*"We provide excellent value for money and so much more could be done within a well-staffed General Practice at a considerable saving to the NHS and closer to home that would greatly benefit patients."*³⁶

49. The Royal College of General Practitioners Cymru Wales said:

*"If the role is sustainably funded through the NHS, it will become the public service we need, offering quality care for patients, managing acute and chronic illness, with the essential capacity needed for preventive care."*³⁷

50. Paul Mears, Chief Executive of Cwm Taf Morgannwg University Health Board, acknowledged that the allocation for primary care, when compared to spend on hospital care, was significantly lower, and this had been the case for some time:

"Obviously, with the pressure since COVID to continue to improve waiting times and reduce waiting times in planned care and urgent care in hospitals, that's led to quite a bit of

³⁴ RoP, 6 November 2025, paragraph 20

³⁵ GP56 Individual 07

³⁶ GP55 Partners of Felinheli and Porthaethwy Surgery, North Wales

³⁷ GP38 Royal College of General Practitioners Cymru Wales

extra resource being put into the secondary care part of what we do.”³⁸

51. He went on to say that he believed there was a collective ambition across Wales to rectify this position and bring resources back into primary and community care, in line with ‘A Healthier Wales’, but cautioned that:

“If we’re serious about that, then clearly the resources need to follow the rhetoric and we need to think about how we, as health boards, improve the way in which we allocate resource towards primary care.

But also there’s a conversation, I think, about how, within Government, the resources that get allocated to the agenda around primary care, and GPs in particular, can be reflective of the ambition.”³⁹

Carr-Hill formula

52. Core funding for GP practices in Wales under the GMS contract is calculated using the global sum allocation formula (also known as the Carr-Hill formula). This formula adjusts for factors such as age and sex of the patient population, morbidity and mortality, practice list turnover, and care home populations.

53. Dr Matthew Jones, a GP partner in Cardiff, explained how the Carr-Hill formula was developed by integrating data from both England and Wales, but while the formula applied in both nations was identical; some differences between the two countries had been overlooked:

“England has approximately 6,600 GP surgeries with 62 million patients registered at these facilities. In comparison, Wales has around 384 GP surgeries (as of January 2023) and serves 3.2 million patients. The Carr-Hill formula’s primary purpose is to compare different populations to determine the workload level for GP surgeries.

In England, due to the larger number of data sets available, the formula achieves a higher degree of accuracy. Conversely, in Wales, because there are relatively fewer GP practices, there is

³⁸ RoP, 2 October 2025, paragraph 362

³⁹ RoP, 2 October 2025, paragraph 364

a risk that very similar GP surgeries may receive significantly different levels of funding.

The Carr-Hill formula financially rewards rural GP practices. However, since Wales has a population density four times lower than that of England, this formula inadvertently disadvantages GP practices in major urban areas of Wales. Unlike England, which has multiple large cities sharing this financial burden, Welsh urban practices are disproportionately affected.”⁴⁰

54. His evidence also contains detailed information on how the Carr-Hill formula is calculated, the ratings of all the GP Practices in Wales, and the impact of that rating on their funding⁴¹.

55. The majority of responses received from those working in general practice raised concerns about the Carr-Hill formula, with witnesses saying it is outdated and poorly aligned with the healthcare needs of the Welsh population, particularly in deprived areas where patient complexity is higher. Because it does not reflect current patterns of need, the formula can result in funding shortfalls for practices serving communities with the greatest health challenges, exacerbating existing inequalities.

56. We discuss issues relating to deprivation and the Carr-Hill formula further in Chapter 5.

57. One witness told us:

“The Carr-Hill formula for GP funding means that our practice sits 4th from bottom of the league table for funding in Wales. Our Carr-Hill weighting is 0.72. This means that each patient registered with our practices attracts only 72% of the expected practice income for a patient. Our list size is 11,526 patients and yet we are only funded to provide a service for 8,281 patients.”⁴²

58. Professor Adrian Edwards talked about the ‘inverse workload law’:

“In the affluent areas of Wales, the average number of patients per GP is 2,100, and in deprived areas, it’s 2,400. And by the way, those practices get 7 per cent less income to provide those

⁴⁰ GP18 Dr Matthew Jones

⁴¹ GP18 Dr Matthew Jones

⁴² GP14 Individual 02

services. When we look at what's actually happening with those patients, the doctor has got more patients to start with in a deprived area, and then those patients are actually presenting more often as well."⁴³

59. There has not been a review of the Carr-Hill formula since its implementation in 2004, and there was strong support from stakeholders for such a review to be undertaken. Dr Gareth Lucucq, a Practice Manager in Cardiff, said the formula needed to be reformed to:

*"reflect the complexity and demand more accurately for services in general practice."*⁴⁴

60. A practising GP who responded to our consultation told us:

*"We know that we have unmet demand and need from our patients. Please give us the resources to meet this demand. Please urgently review the Carr-Hill formula so that funding between Carr-Hill winners and losers does not continue to grow."*⁴⁵

61. The Welsh NHS Confederation called for "a thorough review of the Carr-Hill formula to ensure funding accurately reflects service scope and demand"⁴⁶.

62. While BMA Cymru Wales called for the Welsh Government to commit to a review of the appropriateness of the current funding allocation formula for Welsh general practice, involving specialist population health and financial expertise:

*"This must include extensive modelling of the consequences of any potential adjustments and inclusion of any new factors in the formula. Recommendations of this review would inform the next steps for GP funding allocation in Wales."*⁴⁷

63. However, Dr Gareth Oelmann, a GP in Cwmbran and chair of the General Practitioners Committee Wales, urged caution:

"if we make any changes [...] then it has to be done on an evidenced, modelled, reviewed basis. If we just make simple,

⁴³ RoP, 6 November 2025, paragraph 13

⁴⁴ GP02 Dr Gareth Lucucq

⁴⁵ GP14 Individual 02

⁴⁶ GP32 Welsh NHS Confederation

⁴⁷ GP34 BMA Cymru Wales

quick-fix changes, there will be losers as much as there are winners, and that will equally defund other practices, destabilise other practices, and one thing at a national level that we cannot afford to do is to have unintended consequences.”⁴⁸

64. He also told us that revising the formula alone would not resolve the broader funding challenges in general practice. Regardless of the formula used, the overall funding envelope - the ‘quantum’ - remained inadequate:

“We recognise that the funding formula is only part of the funding question, because we actually need to look at the quantum of the pot.”⁴⁹

65. Dr Ian Harris, a GP in Bridgend and Deputy Chair of the General Practitioners Committee Wales, added:

“There is a lot of clamour around Carr-Hill and around allocation formulas, and it is understandable—the formula is out of date and we would like to review it—but when you start hearing, ‘The formula doesn’t work for me’ in an urban practice with a young population, when you’re hearing that it doesn’t work for you in an ageing population in a retirement seaside town, when you hear it doesn’t work in a rural multi-site practice, what you’re starting to hear is, ‘Well, perhaps it isn’t the formula; perhaps it’s the quantum’.”⁵⁰

Annual contract process

66. We were told that general practices across Wales face significant challenges due to the annual contract negotiation cycle, which creates uncertainty and limits their ability to plan, invest, or expand services strategically. Funding is often confirmed late in the financial year, leaving practices ‘a year behind’ and unable to make informed decisions about staffing or service delivery.

67. John Williams, a practice manager in Wrexham, said:

“leaving aside the actual amount of funding, one of the issues with the contract is that it arrives later and later each year. I

⁴⁸ RoP, 7 September 2025, paragraph 48

⁴⁹ RoP, 7 September 2025, paragraph 44

⁵⁰ RoP, 7 September 2025, paragraph 52

think, in this year, it arrived in month nine, possibly even 10, of the year, which makes it very difficult - nigh on impossible - to plan for any medium- or long-term impactful intervention."

68. Similarly, Dr Ian Harris told us:

"The real problem with annual contracts is the fact that we agreed last year's contract in January 2025 for something that began in April 2024. How can you deliver anything for 2024-25 in that timescale? We would assert that the negotiations should be happening and complete before April each financial year, if they're on an annual basis, and this is something we've pushed for recurrently."⁵¹

69. Dr Richard Stratton, a GP Partner in Powys, described the position as "debilitating" and said that without the ability to plan, everything is in crisis management. He called for:

"a contract that supports the delivery over what I would suggest would be a minimum of five years. And regularly updated over those five years as well, so we would know what years 6, 7 and 8 would look like, and we could plan and deliver to that. It would give us far more confidence."⁵²

70. However, Dr Gareth Oelmann told us that he would not want to see multi-year contractual deals, pointing to a five-year deal in England that had left practices contractually at a 2 per cent increase year on year, which had created its own problems. Instead, he would like to see a multi-year funding strategy, which:

"is a much more nuanced way to address some of the issues, to move the resource restoration argument and shifting left, and resources following the cost."⁵³

71. He also suggested decoupling pay from contract negotiations, as:

"it doesn't do anything for the morale of those who are within our employ to not be seeing a pay award that their peers, equivalents, in the rest of the NHS are already seeing."⁵⁴

⁵¹ RoP, 7 September 2025, paragraph 65

⁵² RoP, 10 July 2025, paragraph 28

⁵³ RoP, 7 September 2025, paragraph 28

⁵⁴ RoP, 7 September 2025, paragraph 67

Evidence from the Welsh Government

72. Evidence from the Welsh Government stated:

“Between 2014–15 and 2023–24, NHS Wales spending increased from £7.4bn to £10.16bn and GMS funding increased from £618m to £649m. However, the share of NHS funding for primary care fell from 24% to 17.2%, and GMS’ share dropped from 8.3% to 6.4%, reflecting faster growth in overall NHS expenditure.”⁵⁵

73. The Cabinet Secretary acknowledged that the proportion of spend on primary care had reduced over the last 15- 20 years and stressed the need to reverse this. However, he went on to say:

“A reducing percentage is not the same as a reducing budget, and actually what, in practice, has happened, because of significant additional investment that we’ve made to the NHS overall, is most of that investment has gone into secondary care and therefore the percentages have changed.”⁵⁶

74. He also confirmed that a review of the Carr-Hill formula was currently being discussed with GPs, but noted it was a complex process that would take time. He cautioned that it would not be a panacea, because, in any review, “there are always people who gain and some people who lose out”⁵⁷.

75. In a subsequent written statement, released on 12 December 2025, the Cabinet Secretary announced the establishment of a series of working groups to drive forward ongoing and future improvements, one of which would look at the allocation formula for GMS funding. He said:

“Of particular significance is the review of the global sum allocation formula, which will be the first comprehensive assessment in more than 20 years. This review presents a major opportunity to ensure funding is distributed fairly and reflects the current needs of practices and communities across Wales.”⁵⁸

⁵⁵ [HSC Committee, 12 November 2025, paper 1](#)

⁵⁶ RoP, 12 November 2025, paragraph 37

⁵⁷ RoP, 12 November 2025, paragraph 44

⁵⁸ [Written Statement: General Medical Services Contract Reform for 2025-26, 12 December 2025](#)

76. The Cabinet Secretary agreed that there were merits in multi-year deals but highlighted that previous attempts had not always been successful:

“So, I think there has been evidence elsewhere in the past of those agreements being a little rigid and not able to respond to changing requirements, and then they’ve been challenging. If you can get a mechanism that provides visibility and some level of flexibility to be able to respond to different circumstances, then I think that will be a good thing to aim for.”⁵⁹

77. He also linked late funding issues to the sequencing of pay and service negotiations inherent in the independent contractor model:

“We have a model that is an independent contractor model, largely, and inherent in that model, I’m afraid, is an element of negotiating around a contract. So, if we didn’t have that arm’s-length independent provider arrangement, then I suppose this might be something, but I think it’s pretty inherent in that arrangement.”⁶⁰

Our view

78. It is clear that increased investment in secondary care has come at the expense of primary care, with the overall funding envelope being insufficient to meet the increasing demands being placed on general practice, in particular. In saying this, however, we recognise the significant pressures that exist in secondary care, not least in dealing with the waiting list backlog post-Covid. Stakeholders suggest that general practice’s declining share of the NHS Wales budget is not only threatening service sustainability and the delivery of preventive care, but having a serious impact on workforce morale.

79. Both the Cabinet Secretary and health board representatives acknowledge that the allocation for primary care, when compared to spend on hospital care, is significantly lower. Witnesses suggested that this is partly because waiting times and ambulance response times have a far higher profile and generate more media attention, but there are, of course, other, much bigger systemic and structural issues at play.

⁵⁹ RoP, 12 November 2025, paragraph 46

⁶⁰ RoP, 12 November 2025, paragraph 48

80. A move to a more preventative agenda will require a shift in money and services, and will require a period of double funding to get there. This will need bold action from the incoming Welsh Government, which will need to make clear how funding and services will shift across from secondary care into the community, and over what period. There will need to be a well-planned transition for this, with a timeline, and a commitment to double funding for a period of time.

Recommendation 2. Within 100 days of coming into power, the incoming Welsh Government should write to our successor committee setting out its plans for reprofiling spending and resources between primary and secondary care, and the timescales for doing so.

81. A clear and consistent message from stakeholders is that the Carr-Hill formula is outdated and poorly aligned with the healthcare needs of the Welsh population. In particular, we heard that the formula fails to reflect the higher complexity and demand in deprived communities, effectively penalising practices that serve sicker and poorer populations. We believe that formula changes alone will not address the need for greater overall investment, however, a review of the formula is long overdue.

Conclusion 6. We believe that the formula for allocating funding to general practice (the Carr-Hill formula) is not fit for purpose and should be reviewed. An outdated allocation formula risks exacerbating inequalities in access to general practice and undermining the sustainability of services. We welcome the Welsh Government's establishment of a working group to take this forward, and anticipate that our successor committee will expect to see clear proposals for reform emerging from its work.

Recommendation 3. Within 100 days of coming into power, the incoming Welsh Government should write to our successor committee to confirm its commitment to reviewing the global sum allocation formula and the timescales for this.

82. We recognise the significant challenges the annual contract negotiation cycle places on general practice, creating uncertainty and limiting ability to plan. While we note the Cabinet Secretary's evidence that previous attempts to move to multi-year funding arrangements had not been successful, we do not believe that should preclude further exploration, particularly with the benefit of past experience. We therefore believe that further consideration should be given to moving to multi-year funding arrangements to improve stability and support long-term planning.

Recommendation 4. The Welsh Government should further explore options for moving to a multi-year funding arrangement for general practice.

4. Workforce and multidisciplinary teams

Recruitment and retention pressures

83. According to the Royal College of General Practitioners Cymru Wales:

“The stark truth is that general practice is in crisis. In 2002, GPs worked across 516 practices in Wales. By the start of the pandemic in 2020, there were 404 practices. Today, just 374 GP practices remain.”

84. Many witnesses talked about burnout and declining morale, driven by long hours, rising demand, and a sense of being undervalued. A recent survey by the BMA found that just over half of GP partners saw themselves remaining in their current position in three years’ time:

“GPs work tirelessly for their communities, but sadly, their efforts to keep up with an ever-increasing workload are detrimental to their mental wellbeing, with many reporting burnout, overwhelm, and fatigue.”⁶¹

85. We heard other allied health professionals were experiencing similar problems. Helen Davies, Royal Pharmaceutical Society Wales, told us:

“Burnout is a real issue. There’s a lot of good will out there, I think, and that comes with our roles. We care for our patients and care for the population, so we will go above and beyond. It can’t carry on like that for ever.”⁶²

86. We also heard that a large proportion of GPs and nurses working in GP settings are nearing retirement age, raising urgent succession planning and retention concerns. Dr Tom Kneale, a GP in Ruthin, told us:

“I joined my practice and all the partners there qualified in the year I was born, so I had a couple of years, which was lovely, and then they gradually all retired. So, we struggled for years trying to recruit in a rural area, so it was exceptionally hard.”⁶³

⁶¹ GP34 BMA Cymru Wales

⁶² RoP, 2 October 2025, paragraph 229

⁶³ RoP, 17 September 2025, paragraph 100

87. A number of witnesses⁶⁴ reported that GPs are struggling to find work as practices cannot afford to employ them. Dr James Pink, a GP Partner in Cardiff, said:

“In Cardiff, we currently have a situation where there are more GPs looking for work than there are available jobs. Our locum colleagues are grateful for any shifts and job adverts for non-clinical GP jobs such as teaching and appraisals are significantly overprescribed. Few practices are recruiting GPs currently as although there is significant patient demand, there is simply no funding to pay for new jobs.”⁶⁵

88. BMA Cymru Wales described this situation as “paradoxical that at a time of immense workforce need, we hear concerning reports of widespread underemployment or unemployment by sessional and newly qualified GPs”.⁶⁶

89. It says this is partly a result of the crippling financial pressures that practices have been facing in recent years:

“Practices are unable to afford to offer substantive salaried roles or rely upon locum GPs in the same way as they used to. There is a ready and trained workforce who are available to relieve some of the immediate pressures and in time facilitate the shift left of services closer to home. However, this can only be unlocked with reprioritisation of investment.”⁶⁷

90. We heard this was also having an impact on the number of GPs leaving Wales to work overseas. Dr Rowena Christmas, a GP in Monmouthshire and Chair of the Royal College of General Practitioners Cymru Wales, told us:

“They are better paid, they have got a much better work-life balance, they have got fewer patients to see. It is understandable that we are losing these absolutely fantastic people, but they do not actually want to go. They want to stay and work in Wales. They are just struggling to find the work.”⁶⁸

⁶⁴ GP13, GP14, GP16, GP21, GP31, GP55, GP58

⁶⁵ GP21 Dr James Pink

⁶⁶ GP34 BMA Cymru Wales

⁶⁷ GP34 BMA Cymru Wales

⁶⁸ RoP, 17 September 2025, paragraph 115

91. We were told that the pressures on the general practice workforce were further being exacerbated by a lack of investment in training and continuing professional development. According to the Royal College of General Practitioners Tracking survey 2023⁶⁹, while 78 per cent of GPs reported having access to continual professional development and training that met their needs, time was a major limiting factor, with 60% of GPs not having enough time to undertake training alongside practice work.

92. Evidence from the Welsh NHS Confederation stated:

"(...) a critical issue is the limited opportunity for professional development within general practice. This creates a workforce that is stagnant in skill and an unattractive environment for younger professionals.

*Employers of practice staff must prioritise the development of progression and development opportunities, supported by Health Education and Improvement Wales (HEIW), health boards, and Primary Care Academies."*⁷⁰

Use of the multi-disciplinary team (MDT)

93. While the benefits of multi-disciplinary working are widely recognised, we were told that implementation of MDTs remains inconsistent, with many practices lacking the infrastructure, funding, or digital systems to support them effectively. Successful integration of allied health professionals (AHPs), nurses, and pharmacists requires long-term funding, joined-up workforce planning, and investment in digital systems and estates. However, evidence from the Royal College of Occupational Therapists stated that current systems do not always facilitate a true MDT:

*"More thought is needed about systems that support MDT working and better understanding the benefits of an MDT approach to care."*⁷¹

94. Similarly, Dr Gareth Lucocq, a Practice Manager in Cardiff, said:

"The multidisciplinary team model, which has been identified as an important strategy for alleviating pressure on GPs, is not

⁶⁹69 RCGP Tracking Survey 2023

⁷⁰70 GP32 Welsh NHS Confederation

⁷¹71 GP39 Royal College of Occupational Therapists

yet universally implemented or sufficiently supported in all areas. While a more diverse team can improve patient care and reduce individual workload, it requires investment in training, recruitment, and infrastructure.”⁷²

95. Nursing, pharmacy, and allied health professionals highlighted the need for a more balanced and inclusive approach to primary care reform. They stressed that current models remain overly medicalised and reactive, with funding structures (particularly the GMS contract) limiting innovation and the integration of wider professional roles. Witnesses emphasised that these funding arrangements disincentivised workforce diversification and hindered the development of multidisciplinary teams. Nia Boughton, Royal College of Nursing Wales, told us:

“The way that primary care is constructed, and has historically been constructed, is that it is an illness system—that we wait for the onset of symptoms before we try to intervene, [...] then we manage symptoms rather than the root cause of illness.

The general medical services contract that configures and covers about 97 per cent of primary care operation in Wales is based upon a funding system that promotes that model of work, so it’s very difficult for us to make the change for workforce diversification.”⁷³

96. Recruitment of different professionals is further hampered by better terms and conditions in secondary care, limited training opportunities, and short-term funding. This affects the ability to embed roles such as physiotherapists, occupational therapists, and pharmacists in general practice.

97. Dr Rebecca Towner, a GP in Cardiff, told us:

“We have invested in our workforce and trained up several members of staff hoping to provide better services for our patients. As we are unable to compete with the salary structure and contracts offered by the hospital we are at a disadvantage so they leave us for better conditions.”⁷⁴

⁷² GP02 Dr Gareth Lucucq

⁷³ RoP, 2 October 2025, paragraph 9

⁷⁴ GP03 Dr Rebecca Towner

98. Similarly, the Royal Pharmaceutical Society Wales said that many pharmacists cited a lack of alignment with the Agenda for Change pay scales, which are offered to hospital colleagues, as a deterrent. It also said:

“The lack of training, professional supervision, and career development opportunities was highlighted as a barrier. Pharmacists in general practice often lack access to protected learning time and the ability to develop into advanced clinical practitioners, which limits their long-term professional satisfaction and career growth.”⁷⁵

99. Evidence from the Welsh NHS Confederation highlighted work being undertaken by Health Education and Improvement Wales (HEIW) to prioritise the development of robust multidisciplinary teams within general practice:

“This involves the strategic integration of various healthcare professionals, including nurses, pharmacists, and allied health professionals, to deliver comprehensive patient care. To facilitate this integration, HEIW has established supportive frameworks and training programs designed to optimise team functionality.”⁷⁶

100. While MDTs can reduce GP workload and improve care, witnesses highlighted that professionals such as pharmacists, physician associates and advanced nurse practitioners are complementary to GPs rather than substitutes. Dr James Pink told us:

“Employing other health professionals to work in primary care has an important role as long as this is considered an addition rather than a substitute for a qualified GP.”⁷⁷

101. These roles often require supervision from a GP, who retains overall clinical responsibility for the practice. In understaffed settings, this can add to GP workload. GPs expressed strong support for MDT working, but stressed the need for realistic expectations, sufficient supervision capacity, and long-term planning to embed these roles effectively. Dr James Pink told us:

“I love the idea of the MDT model, particularly when it’s based in primary care. I guess the only thing we need to consider is the

⁷⁵ GP60 Royal Pharmaceutical Society Wales

⁷⁶ GP32 Welsh NHS Confederation

⁷⁷ GP21 Dr James Pink

governance. Most of the models that I know, we still as the GP will take ultimate responsibility for when there's a problem. [...] I think it's a very exciting role, but it's certainly not one that we're all familiar with at the moment. So, if you're supervising a team of other professionals, whether they be doctors or otherwise, it's a different skill set to just managing your own list and seeing who's in front of you.”⁷⁸

102. Similarly, a GP Partner and Cluster lead in North Wales, said that while multi-disciplinary team working was good, anyone who was not a GP required supervision of their work:

“this has not been factored into their productivity of costing – they cannot work without support in many cases and are neither trained to a high enough level or willing to see the full remit a GP can review – they are NOT a replacement for GP.”⁷⁹

103. Dr Rowena Christmas, Royal College of General Practitioners Wales, told us that it would not make financial sense to employ a physician assistant because they would need to be supervised by a GP, and, “if money were no object”, she would “probably employ a practice nurse or a nurse practitioner or a practice-based pharmacist or another GP”⁸⁰.

104. We also heard of a lack of public awareness about the roles and benefits of MDT members, with patients often viewing these roles as inferior substitutes for GPs. One participant in our engagement activity said:

“No disrespect to the nurse, she's wonderful, but she's not a doctor and they don't delve deeper into other issues.”⁸¹

105. This not only undermines service transformation but reinforces perceptions that non-GP professionals are second-best.

106. The Welsh NHS Confederation told us:

“[...] public trust in general practice is facing significant challenges, stemming from misconceptions and evolving service delivery models. The transition to a multi-disciplinary

⁷⁸ RoP, 10 July 2025, paragraph 91

⁷⁹ GPO6 *Individual 01*

⁸⁰ RoP, 17 September 2025, paragraph 180

⁸¹ Inquiry into the future of general practice in Wales: [engagement findings](#)

team approach, while essential for prudent healthcare, is often misunderstood, leading to a perception that care from non-GP specialists is inferior.”⁸²

107. It went on to say that managing patient expectations was paramount, and would necessitate improved patient information and education:

“Clarity regarding the scope of services provided by GPs and other healthcare professionals is vital, as is a consistent national narrative on self-care and service utilisation, tailored with localised information.”⁸³

108. To maximise the contribution of multidisciplinary professionals, witnesses, including the Chartered Society of Physiotherapy⁸⁴ and Royal College of Nursing Wales⁸⁵ called for a national strategy to embed effective MDT working across Wales. This should include standardised service models, sustainable funding, clear referral pathways, and investment in both physical and digital infrastructure.

Evidence from the Welsh Government

109. Evidence from the Welsh Government stated:

“Workforce sustainability is a priority for GMS in Wales. The number of fully qualified GPs is relatively stable - the number of salaried GPs has increased and there has been a reduction in GP partners.

While the wider practice workforce has also stabilised following earlier expansion, ongoing investment in multidisciplinary teams and staff wellbeing is helping practices adapt to changing demands. Despite persistent challenges such as workload pressures and recruitment in rural areas, these efforts are laying the foundation for a more resilient and sustainable GMS workforce.”⁸⁶

110. We asked the Cabinet Secretary why there were GPs coming through the system who were then unable to find work. He told us:

⁸² GP32 Welsh NHS Confederation

⁸³ GP32 Welsh NHS Confederation

⁸⁴ RoP, 2 October 2025, paragraph 48

⁸⁵ RoP, 2 October 2025, paragraph 49

⁸⁶ [HSC Committee, 12 November 2025, paper 1](#)

“We have a workforce planning system that works on a level with the health boards, with Health Education and Improvement Wales, in order for us to be able to have better alignment between the provision and the opportunities that are available.”⁸⁷

111. He stressed the need for a well-resourced GMS contract to make general practice attractive and highlighted a number of recruitment and retention measures, which included bursaries for hard-to-recruit areas, a GP retainer scheme which encouraged people already in practice to continue to do so, and partnership premiums to encourage people to create partnerships with other professions.

“So, there is work happening to ensure that this does improve. GP numbers have been relatively consistent over the past few years. But, as you say, there are pockets, of course, where this is a challenge.”⁸⁸

112. Evidence from the Welsh Government stated:

“Ongoing investment in multidisciplinary teams and staff wellbeing is laying the groundwork for a more sustainable and positive future for GMS. The expansion of the multidisciplinary team has enabled practices to safely move some workload from GPs to other clinical professionals, enhancing patient care and supporting wider team resilience.”⁸⁹

113. The Cabinet Secretary agreed that recruitment levels of Allied Health Professions (AHPs) had been consistent over the past few years, “despite the pressure on the system”⁹⁰.

114. We asked the Cabinet Secretary what work was being undertaken to change the public perception of seeing an AHP rather than a GP.

115. He said that he believed there was generally a better understanding of the MDT system, and its benefits, than was sometimes assumed. He highlighted initiatives like the common ailments scheme, which encouraged accessing a pharmacist as a first point of contact, and said this was starting to make a

⁸⁷ RoP, 12 November 2025, paragraph 60

⁸⁸ RoP, 12 November 2025, paragraph 60

⁸⁹ [HSC Committee, 12 November 2025, paper.1](#)

⁹⁰ RoP, 12 November 2025, paragraph 66

significant difference. He also noted that all pharmacists will soon qualify as independent prescribers⁹¹, which would provide further opportunities to enhance the role of the MDT:

“These advances mean the public has multiple choices about how and where to access free treatment for a wide range of common illnesses from appropriately-trained professionals, without the need for a GP appointment. These services are helping to manage demand for primary care and enabling GPs to focus their time and expertise on more complex care and continuity for those who need it.”⁹²

Our view

116. According to the Royal College of General Practitioners, general practice is “in crisis”, with the number of GP practices having fallen from 516 in 2002 to 374 in 2023. Many of its members are reporting unsustainable workloads, long hours, and rising patient demand, leading to stress and burnout. This is further exacerbated by difficulties with recruitment and retention, especially in deprived areas.

117. Over half of GP partners say they are doubtful they will remain in post in three years, and many senior GPs are nearing retirement age, risking a wave of departures. Paradoxically, we have been told that newly qualified GPs and locums are struggling to find permanent work because practices say they cannot afford to hire them due to financial constraints.

118. We believe a comprehensive workforce plan is needed for general practice to ensure there is a sufficient supply of new GPs and other clinicians to meet future demand. This should be part of a broader, joined-up approach to consideration of the wider workforce across NHS Wales, and support the transformation agenda of shifting care closer to home.

119. While the value of the multi-disciplinary team is recognised and supported, in many cases it just places further pressure on GPs in terms of supervising the team. We agree with witnesses that a national strategy is needed to embed effective MDT working across Wales. This should include standardised service

⁹¹ RoP, 12 November 2025, paragraph 73

⁹² [HSC Committee, 12 November 2025, paper 1](#)

models, sustainable funding, clear referral pathways, and investment in both physical and digital infrastructure.

Recommendation 5. The incoming Welsh Government should develop a workforce plan for general practice to ensure there is a sufficient supply of new GPs and other clinicians to meet future demand. This should be part of a broader, joined-up approach to consideration of the wider workforce across NHS Wales, and support the transformation agenda of shifting care closer to home.

Recommendation 6. The incoming Welsh Government should develop a national strategy to embed effective multi-disciplinary team working within primary care across Wales. This should include standardised service models, sustainable funding, clear referral pathways, and investment in both physical and digital infrastructure.

120. The multi-disciplinary team can offer more appropriately tailored care depending on the patient's condition, and the public need to be made more aware of the wider benefits they can offer. There is, therefore, a body of work that needs to be undertaken to explain the roles of MDT members and promote their services, helping patients to understand that nurses, pharmacists, physiotherapists, and other allied health professionals can safely address many needs, without having to see a GP.

Recommendation 7. The Welsh Government, in conjunction with health boards and GP practices, should develop a public awareness campaign to:

- promote greater understanding of the role of the multidisciplinary team and its wider benefits for patient health and experience.
- promote the role of front desk general practice staff in triaging patients to get them to the most appropriate practitioner.

5. Health inequalities and the inverse care law

121. The inverse care law states that the availability of good medical care tends to vary inversely with the need for it in the population. Put simply, those who need healthcare the most, typically in deprived areas, are the least likely to receive it.

122. Evidence from Deep End Cymru stated:

“People are getting sick too young and are dying too young, because of the circumstances they are born into. Poverty makes people physically and mentally unwell. In mitigating the impact of these determinants of health, we trust the NHS at least to be fair and effective and efficient in dealing with everyone.

However, we have been disinvesting in the services that add most value to life (primary care and social care) and we have been distributing our investment inequitably (those who need the care the most, are least likely to receive it).”⁹³

123. According to Doctors in Unite Cymru, the burden of ill health is not equally spread across Wales with significance gradients evident by socio-economic disadvantage, gender, ethnicity and underlying health status, for example patients with serious mental health problems also have disproportionately more physical ill health:

“Women in our most socially disadvantaged areas have 17 years less healthy life expectancy and 10 more years of poor health compared to those in the most advantaged areas. And these are problems that are getting worse and inequalities increasing.”⁹⁴

124. While GP practices in Wales’ most deprived communities face disproportionately high levels of chronic illness, lower health literacy, and later presentation of disease, they often operate with fewer resources than practices in more affluent areas.

⁹³ GP52 Deep End Cymru

⁹⁴ GP22 Doctors in Unite Cymru

125. Evidence from Deep End Cymru⁹⁵ stated:

“Welsh GP practices with more patients from most deprived areas receive less funding, with practices in most deprived areas receiving around 5% less funds (£50-60k a year).”⁹⁶

126. It went on to point out that people have much greater non-medical needs in more deprived areas, which impact on their physical and mental health and the workload of general practice:

“We know that many individuals and families come to their GP Practice with problems that cannot be solved by the NHS alone. We know that what keeps people well is much more about their circumstances, such as their financial security, their housing, their social connections.

It is estimated that 1 in 5 GP appointments are for non-medical issues such as housing, loneliness, relationships or debt. The personal experience of our Deep End GPs is these are factors in at least a third of the consultations that we have with patients in the most deprived communities and vulnerable groups.”⁹⁷

127. Current funding models, including the Carr-Hill formula, fail to reflect the complexity and socio-economic challenges faced by these populations.

128. Dr Neil James, Chair, Deep End Cymru, told us:

“The Carr-Hill formula seems to favour age over deprivation. So, if you want a needs-based formula, it needs to favour deprivation as much, equally, or perhaps greater than age. So, at the moment, practices with high elderly populations benefit from the Carr-Hill formula, even though those elderly populations may be in very affluent areas. And it doesn't take account of the fact that younger deprived communities can outstrip the demand of elderly populations in affluent areas. So, it needs to recognise deprivation.”⁹⁸

⁹⁵ Deep End Cymru is a network of the GP practices serving the most deprived communities in Wales

⁹⁶ GP52 Deep End Cymru

⁹⁷ GP52 Deep End Cymru

⁹⁸ RoP, 6 November 2025, paragraph 47

129. We heard that practices in deprived areas were also at greater risk of closure or merger than those in more affluent areas. Professor Adrian Edwards told us:

“So, in the Deep End practices that we’re talking about, in this poorest quintile, 10 per cent of the practices closed or merged in the last three years, compared to 2.8 per cent elsewhere.”⁹⁹

130. While Deep End Cymru said that GP practices in the more deprived areas were “quietly drowning”:

“There are many more general practices that have closed or merged in deprived communities than in more rural areas. Since January 2022, 18 GP practices have closed or merged:

- 10 of top 100 Deep End practices = 10%;
- 8 of remaining 290 practices = 2.8%.¹⁰⁰

131. Dr Neil James, added:

“So, once you’ve lost the practice, you’ve lost goodwill, but more importantly, it’s disastrous for patient health. Because in deprived areas, in Deep End, continuity is important; it’s far more important than access.”¹⁰¹

132. We heard that general practice has the potential to address health inequalities through its community reach and preventative focus. However, practices, particularly in deprived areas, are under growing pressure. Stakeholders argue that long-term investment and system-wide reform are needed to enable general practice to play a central role in tackling inequality through a community-focused approach. BMA Cymru Wales told us:

“GPs are uniquely positioned to address health inequalities as the first point of contact for most patients. To address health inequalities in Wales, investing in general practice must be a priority.”¹⁰²

133. While Nia Boughton, Royal College of Nursing Cymru, said:

⁹⁹ RoP, 6 November 2025, paragraph 41

¹⁰⁰ GP52 Deep End Cymru

¹⁰¹ RoP, 6 November 2025, paragraph 36

¹⁰² GP34 BMA Cymru Wales

“There needs to be an absolute refocus on this urgently. If we are to significantly impact on the health inequalities in Wales, if we are really committed to working towards a prevention and population health-focused service, then we’ve got to stop directing all the attention and all the monies into secondary care.”¹⁰³

134. Doctors in Unite Cymru highlighted the 2015-16 Annual Report of the Chief Medical Officer for Wales¹⁰⁴, which made the argument for a move towards “proportionate universalism” to address the health inequalities in Wales. Their evidence stated:

“He [the Chief Medical Officer for Wales] said a one size fits all health and care service will not allocate resources in line with need and could end up exacerbating rather than alleviating health inequalities. Almost a decade on this still true.”¹⁰⁵

135. Deep End Cymru raised concerns that recruitment and retention policies for NHS staff did not sufficiently address health equity. It said that policies do not sufficiently prioritise primary care and do not encourage take-up of roles serving more deprived communities and vulnerable groups:

“In general practice, people tend to work where they train, and many young health workers are highly motivated and keen to be supported into such roles, if they only got the opportunity. We strongly believe that there should be more training on health equity for all healthcare students, and for all staff working in the NHS.”¹⁰⁶

136. Similarly, Doctors in Unite Cymru raised the importance of doctors in training having opportunities to learn in practices in socially disadvantaged areas. It said that research had shown that working and training as a GP in areas of socio-economic deprivation was challenging, and practices in such areas were less likely to offer training to prospective GPs. It highlighted the GP trainee incentive scheme, already benefitting parts of Wales, and said this should be reviewed to

¹⁰³ RoP, 2 October 2025, paragraph 32

¹⁰⁴ [Rebalancing healthcare. Chief Medical Officer for Wales Annual Report 2015-16](#)

¹⁰⁵ GP22 Doctors in Unite Cymru

¹⁰⁶ GP52 Deep End Cymru

assess if more can be done to provide training opportunities in the most disadvantaged and under-doctored communities.¹⁰⁷

137. Dr James Pink, a GP Partner in Cardiff, also suggested incentivising doctors to work in less popular areas of Wales.

“One way that we could do this is with the scheme we’ve already got, which is the partnership premium payment. There’s no reason at all why, with some clever maths, we couldn’t weight that so that you get £1,000 per session to be a GP in Cardiff, let’s say, or a GP partner in Cardiff, but you get £3,000 a session to be a GP somewhere less popular.

That would be a very small investment on the bigger picture, to get people to commit to surgeries outside of the popular areas, and within our schemes already.”¹⁰⁸

Evidence from Welsh Government

138. As previously noted, the Cabinet Secretary has already committed to a review of the global sum allocation formula (Carr-Hill), which should help address the funding disparities that disadvantage practices in areas of higher need.

139. In June 2025, the Welsh Government announced a new package of measures to reduce preventable illness and improve long-term health outcomes. In a written statement, the Cabinet Secretary committed to working with Sir Michael Marmot’s Institute of Health Equity to become a “Marmot Nation”:

“In practice this will mean working with a number of communities across Wales to reduce health inequalities using the Marmot principles, in the same way Torfaen has so successfully done since Gwent became a Marmot region.”¹⁰⁹

140. He went on to say that he would be laying regulations to mandate the use of health impact assessments in certain circumstances by public bodies, to strengthen the health-in-all policies approach:

¹⁰⁷ GP22 Doctors in Unite Cymru

¹⁰⁸ RoP, 10 July 2025, paragraph 71

¹⁰⁹ [Written Statement: Preventing ill health. June 2025](#)

“Preventing ill health is not just the job of the NHS. It must be at the heart of all our services.”¹¹⁰

Our view

141. It is concerning to hear that the Inverse Care Law is still very apparent in Wales, with evidence of deprived communities receiving less care than more affluent communities. We already know from our inquiry into supporting people with chronic conditions¹¹¹, that those living in disadvantaged areas are more likely to be living with multiple chronic conditions, and those who live in the most deprived areas have a shorter life expectancy and spend less of their life in good health. Therefore, tackling health inequalities must be a priority in all general practice reforms, ensuring the most vulnerable communities receive *more* support, not less.

142. We have been told that GPs are uniquely positioned to address health inequalities as the first point of contact for most patients. As such, we agree with witnesses that, if the Welsh Government is truly committed to tackling health inequalities in Wales, there needs to be a real shift in emphasis from secondary care to prevention and population health-focused services.

143. The Welsh Government has committed to making Wales a ‘Marmot Nation’ as part of its strategy to reduce health inequalities, and will provide national support and funding for two years for several local authorities to be ‘trailblazers’ and early adopters in implementing the Marmot principles. The incoming Welsh Government should set out its position on the Marmot principles, including how it plans to continue the existing work in this area and further embed and expand the programme.

Recommendation 8. The incoming Welsh Government should confirm its position as regards the Marmot Nation programme and the consistent adoption of the eight Marmot principles across all departments. This should include details of:

- How it plans to continue work in this area;
- Lines of responsibility for delivering health equity actions at national, regional, and local levels; and

¹¹⁰ [Written Statement: Preventing ill health, June 2025](#)

¹¹¹ [Supporting people with chronic conditions, January 2025](#)

- monitoring arrangements, including public reporting on progress and outcomes.

144. We have already talked about the Carr-Hill formula in Chapter 3, and the resulting disparities in funding for practices in deprived areas, and welcome the Welsh Government's commitment to review the formula. However, Welsh GP practices with more patients from the most deprived areas are receiving less funding and this needs to be addressed as a matter of urgency.

145. Wider societal determinants, such as education, housing and employment can all have an impact on people's physical and mental health. While we welcome the Welsh Government's commitment to greater cross-governmental collaboration, including the introduction of the Health Impact Assessment (Wales) Regulations 2025, we believe more needs to be done to address these wider determinants that have an impact on health and well-being.

146. We heard that GPs are more likely to take up posts where they train but recruitment and retention policies do not sufficiently address health equity or encourage take-up of roles serving more deprived communities. We therefore agree with witnesses that the Welsh Government needs to look at ways to incentivise GPs to take up opportunities in more disadvantaged or underserved communities, including the possible expansion of existing incentive schemes.

Recommendation 9. The incoming Welsh Government should look at ways to incentivise GPs to take up opportunities in more disadvantaged or underserved communities. This should include consideration of the possible expansion of existing incentive schemes, such as the partnership premium payment.

6. Interface between primary and secondary care

147. GPs reported a growing, often unacknowledged shift of responsibilities from secondary care to general practice. This included initiating medications, managing hospital discharge follow-ups, and responding to NHS 111 calls, including those from the urgent mental health support line. The unstructured nature of this transfer has led to a mismatch between responsibilities and resources, and raised ethical concerns about clinical safety and accountability.

148. Dr Richard Stratton, a GP Partner in Powys, told us that there was work (such as routine follow-ups with consultants) currently being undertaken in secondary care that could move into a primary care setting:

“So, there is a real scope for a planned shift of care closer to home. But what we’ve seen is an unplanned shift, which is a request on the discharge form, ‘Please follow up the blood tests.’ The responsibility for following up on tests that you’ve organised remains with that clinician. There is an ethical and professional boundary here that is constantly being breached at the moment.”¹¹²

149. Paul Mears, Chief Executive, Cwm Taf Morgannwg University Health Board, said that there could be tension between primary and secondary care, particularly when a patient was discharged but needed further tests or monitoring, which was then handed over to the GP:

“I do think there is an opportunity for us to join up a lot more those relationships and get those conversations going more actively so that the needs of general practice, and their role in that pathway of care, are understood by hospital clinicians as much as GPs understand the hospital doctors’ perspective.”¹¹³

150. Dr Tom Kneale, a GP in Ruthin, suggested that the interface between primary and secondary care had become more difficult in the post-pandemic era, and went on to say:

¹¹² RoP, 10 July 2025, paragraph 111

¹¹³ RoP, 2 October 2025, paragraph 397

“I think that understanding has slightly drifted as well between what general practice can do and should do and what’s going on in secondary care. I think if we can improve that understanding between the two, I hope that things would get better for patient outcome.”¹¹⁴

151. Dr Johnny Currie, Deep End Cymru policy lead and a GP partner in Newport, told us:

“We don’t have time to build relationships with our teams, never mind with the local services, never mind with that lack of any interface and relationship with hospital consultants, which has made it very adversarial.”¹¹⁵

152. The Royal College of Paediatrics and Child Health (Wales) said that while the Primary Care Model for Wales promoted seamless working across primary and secondary care services, more needed to be done to improve this interface. It said:

“An RCPCH Wales survey (2024) found that nearly half of members (48%) wanting the Welsh Government to prioritise the interface between community, primary, secondary and tertiary care.”¹¹⁶

153. While the Royal College of Nursing Wales suggested that the lack of communication between primary and secondary care services often left patients having to re-explain their symptoms, conditions or needs to each service they encountered.¹¹⁷

154. Dr James Pink, a GP Partner in Cardiff, said that practices had seen an increased shift of work from secondary to primary care. Chronic diseases which used to be managed in hospital outpatient clinics were now being managed in primary care, almost always without the transfer of funding.¹¹⁸

155. Similarly, Dr Virginia Iles, a GP in Cardiff, told us:

“Furthermore the shift of workload from secondary to primary care, for example complex diabetes, severe mental illness, and

¹¹⁴ RoP, 7 July 2025, paragraph 176

¹¹⁵ RoP, 6 November 2025, paragraph 64

¹¹⁶ GP46 Royal College of Paediatrics and Child Health (Wales)

¹¹⁷ GP15 Royal College of Nursing Wales

¹¹⁸ GP21 Dr James Pink

*cardiac failure, while positive, has not been accompanied by commensurate funding.*¹¹⁹

156. Other stakeholders reported mixed experiences of transfers of care. Some services like anticoagulant monitoring and diabetes care had transitioned effectively when adequately funded, while areas such as heart failure clinics suffered from unclear boundaries and accountability.

157. Dr Elin McCarthy, a GP Partner in Swansea, told us there was real ambiguity as to who should be funding the heart failure clinics:

*“These clinics are, essentially, worked by specialist nurses, with secondary care consultants overseeing it. But any tests that are done are put in the name of the GP and by default those patients in those clinics are very elderly, complex and more susceptible to really serious illness. So, often, these blood tests come back abnormal, and it’s the GP who has to read it, the GP who has to action it, and the GP who has to ensure the patient’s safety.”*¹²⁰

158. She went on to say that if things could be more clear cut, or money provided specifically for the interface where primary and secondary care were working together, that would not only benefit the patients but the clinicians as well.

Evidence from the Welsh Government

159. The Cabinet Secretary told us that CDSS (collaborative directed supplementary service) would provide longer term visibility about the resources being made available to primary care:

*“it provides confidence that, as well as shifting funding (...) from secondary into primary (...) it also means that activity.”*¹²¹

160. We asked the Cabinet Secretary what support would be provided during this process of transition, given that general practices are already struggling with the unstructured shift of responsibilities from secondary care to general practice.

¹¹⁹ GP58 Dr Virginia Iles

¹²⁰ RoP, 7 July 2025, paragraph 115

¹²¹ RoP, 12 November 2025, paragraph 10

161. He told us that it was a common challenge for ministers that a strategy or policy would push in one direction, while the funding pressures were pushing in the opposite direction:

“This feels to me like one of those areas where, actually, those two things are pushing in the same direction, because what we want to see from a policy point of view is more of these services delivered locally to people. And also what we want to see is more funding being moved into primary care, because we know (...) that there are incredible pressures there. So, I think this is a golden opportunity, if you like, to align those, and we’ve got to make sure we deliver it.”¹²²

162. He went on to say that in addition to what was happening at a local level, there would also be a national programme to drive this forward, which would engage health boards and practitioners directly:

“And there’ll be clear metrics, clear performance indicators, in the way that committees often press us to put in place, and we’ll be publishing those as well. So, it’ll be a transparent process as well, which I think is really important.”¹²³

Our view

163. GPs told us that there is work currently being undertaken in secondary care that can move into a primary care setting, relieving some of the pressure on hospitals. However, what they are currently seeing is an unstructured shift of tasks without matching resources or clear accountability, and this is leading to some tension between the two sectors.

164. We also heard that relationships between primary and secondary care have become more difficult following the pandemic, possibly as a result of a lack of understanding about the different roles of the two sectors. Health board representatives acknowledge that there can be some tensions between primary and secondary care, and suggest that conversations need to be opened up to create a better understanding between the two.

165. We recognise that where services are transitioned into primary care with the appropriate level of planning and resource, this can be very effective. We therefore

¹²² RoP, 12 November 2025, paragraph 13

¹²³ RoP, 12 November 2025, paragraph 14

believe that structured agreements and accountability at the primary/secondary care interface are needed to ensure that any transfer of responsibilities is planned, resourced, and supported by clear clinical governance.

Recommendation 10. The incoming Welsh Government should require health boards to establish formal mechanisms to strengthen relationships and mutual understanding between primary and secondary care. This might include regular joint clinical forums, shared training opportunities, and agreed processes for resolving interface issues.

Recommendation 11. The Welsh Government should mandate the development of formal agreements between secondary and primary care for any services transferred out of hospitals. These should:

- define the responsibilities of both the hospital teams and GP practices;
- ensure that funding and staffing “follow the patient” into primary care for each transferred service; and
- include clear clinical governance arrangements, including accountability for clinical risk and escalation.

7. GP voice

166. We heard from stakeholders that general practice, and primary care more broadly, remains underrepresented at strategic levels across NHS Wales. Most health boards lack an executive director for primary care, a gap that reinforces perceptions of the sector being undervalued.

167. GPs reported limited involvement in service planning and strategic decision making, despite their frontline expertise and deep understanding of patient needs. They said that decisions were often made without consultation, leading to frustration and disengagement among practitioners. John Williams, a Practice Manager from Wrexham, told us:

“It often feels as if there’s an imposition of ideas on primary care, rather than asking us what would work best for our areas”¹²⁴.

168. Deep End Cymru suggested that NHS Wales leadership undervalued primary care expertise and value in contributing to strategic decisions for transformation:

“These voices with solutions are not heard while there is disconnection between government, Health Boards and primary care. That dissonance means that there is no clear understanding of the structural problems that face general practice, particularly in areas of high deprivation, and hence the structural problems persist down the generations.”¹²⁵

169. Similar concerns were expressed by other professional groups. Steve Simmonds, Community Pharmacy Wales, told us:

“the problem that pharmacy has traditionally faced, and still faces, to some extent, is that it’s almost like an ancillary profession [...] I’m not convinced it’s part of board conversations at health board level. It always seems to be that the conversation is always on a lower level within a health board”¹²⁶.

¹²⁴ RoP, 10 July 2025, paragraph 43

¹²⁵ GP52 Deep End Cymru

¹²⁶ RoP, 2 October 2025, paragraph 265

170. Witnesses stressed that stronger representation was essential to reverse the long-term decline in funding, ensure services reflected real-world practice, and supported integrated, sustainable models of care.

171. Dr Ian Harris, General Practitioners Committee, Wales, called for changes in policy direction at a governmental level:

“It’s a policy decision that the focus is on the shiny bit of the healthcare service, if you like—the hospital end—and that isn’t just at health board level; I believe it’s a policy decision at governmental level currently that needs to change. We’re making that argument, but it’s trying to turn around a supertanker, because the direction of travel with funding and policy over the years has been to relatively de-fund general practice and primary care in favour of other sectors.”¹²⁷

172. While agreeing there was a need for stronger representation, Dr Neil James, Chair, Deep End Cymru, also called for those representatives to be well versed in matters of health inequality:

“Because if you think about it, in Wales over 50 per cent of our households are said to be deprived. It’s a huge proportion of the population.”¹²⁸

173. Health board representatives acknowledged the need to elevate GP voices within health boards. Paul Mears, Chief Executive, Cwm Taf Morgannwg UHB, drew attention to a piece of work being undertaken by the Chief Medical Officer to develop a programme of support in primary care:

“She [the Chief Medical Officer], as part of that, is wanting to talk about, from a professional perspective, how she as the CMO gets more of the GP voice into the bigger strategic conversations in Government as well, because I think it’s about that at every level, in clusters, in health boards and in Government, we need to be making sure that the perspectives and views of GPs are being listened to and shaped, and that we’re able to work with them on that agenda.”¹²⁹

¹²⁷ RoP, 17 September 2025, paragraph 32

¹²⁸ RoP, 6 November 2025, paragraph 72

¹²⁹ RoP, 2 October 2025, paragraph 428

174. However, concerns were raised about GPs capacity to do this. Elaine Lorton, Powys Teaching Health Board, told us:

“When we’re talking about releasing clinician time to do that, that means that they’re then not available to deliver direct patient care, and, if we don’t feel there’s enough capacity to deliver direct patient care, how do we engage and how do we ensure that we are getting that voice, that perspective, those views, at each point that we need it?”¹³⁰

Evidence from the Welsh Government

175. The Cabinet Secretary reiterated the point made by health boards that GPs may lack the time to engage with, for example, the transformation programme.

176. He acknowledged the need to ensure that the voice of GPs, and primary care practitioners more broadly, were heard but noted that structures were already in place:

“So, we already have mechanisms for cluster-level leadership to feed into the health board planning cycle in their integrated medium-term plan planning cycle.”¹³¹

177. We asked the Cabinet Secretary if health boards should be required to appoint a dedicated Executive Director for primary care to strengthen representation and embed primary care perspectives in decision-making.

178. He responded that regulations were already in place which required every health board to appoint a voting member who was responsible for primary care, mental health and community services and that all health boards were complying with this. He further noted that vice-chairs were particularly tasked with representing the voice of primary and community services in board deliberation:

“So, bluntly speaking, if there isn’t sufficient focus at a health board level in board discussions on primary and community care, the first port of call is to engage with vice-chairs and say,

¹³⁰ RoP, 2 October 2025, paragraph 430

¹³¹ RoP, 12 November 2025, paragraph 23

*'Well, what are you doing to make sure that the voice of primary is being heard more completely at that level?'*¹³²

179. The Cabinet Secretary said that he believed that a shift was required in the way health boards prioritised their focus:

"Perhaps understandably, a huge amount of focus goes on secondary care because we know what happens in hospitals, we know how critical it is that they function well and we understand the pressures that are very real. And often health board executives have more experience of a secondary care setting, bluntly.

But really, in a rational system, you would say that since most people's experience of the NHS is, in fact, in the primary care space most of the time, that is where you should start your planning."¹³³

Our view

180. Despite having a wealth of expertise and understanding of their patients' needs, GPs note a lack of representation at strategic levels across NHS Wales. Very few health boards have an Executive Director for Primary Care, and this gap is reinforcing perceptions of the sector being undervalued.

181. GPs report limited involvement in service planning and strategic decision making, saying decisions are often made without consultation, leading to frustration and disengagement among practitioners.

182. Stakeholders talk about a disconnect between government, health boards and primary care, leading to a lack of understanding of the structural problems facing general practice. They say that stronger representation is essential to reverse the long-term decline in funding, ensure services reflect real-world practice, and support integrated, sustainable models of care, and call for changes in policy direction at a governmental level.

183. Evidence to our inquiry highlighted that health boards currently lack an Executive Director for Primary Care, and that assigning primary care to an existing

¹³² RoP, 12 November 2025, paragraph 23

¹³³ RoP, 12 November 2025, paragraph 24

board member is insufficient. We therefore believe that all health boards should include a dedicated, senior primary care leader within their executive teams.

Recommendation 12. The incoming Welsh Government should promote strongly the need for all health boards to include a dedicated, senior primary care leader within their executive teams.

8. Models of practice

Independent contractor model

184. The dominant model for general practice in Wales remains the independent contractor model, where GPs operate as self-employed partners under contract with the NHS. Among GPs and their professional bodies, the independent contractor model remains the preferred structure for general practice in Wales, as it enables GPs to have autonomy to make decisions that best meet the needs of their patients, provides stronger continuity of care, and offers flexibility to innovate.

185. However, the independent contractor model is not without risk. Independent contractors personally bear all financial liabilities and risks associated with running a practice. We heard that these financial and operational risks associated with partnership roles may be deterring younger doctors, many of whom now favour salaried roles for greater stability. According to the Welsh NHS Confederation:

“The traditional model of partnership in general practice is facing a decline in appeal. The financial rewards are often less attractive compared to opportunities in secondary care or salaried positions. Moreover, the substantial financial commitment required for partnership, encompassing mortgages, staffing costs, and business responsibilities, poses a significant barrier for younger professionals. This lack of new partners creates a detrimental cycle, increasing the workload on existing partners and further diminishing the attractiveness of the independent contractor model.”¹³⁴

186. Similarly, Doctors in Unite Cymru suggested the increasing number of salaried GPs and the failure of many existing contractor partnerships was bringing the future of the small business model of general practice into question. It said:

“Very many organisations including a House of Lords Select Committee, NHS Confederation Wales, the Kings Fund, Nuffield Trust and the IPPR have called into question its long term viability with newly qualified doctors expressing concerns about

¹³⁴ GP32 Welsh NHS Confederation

workload, business bureaucracy and financial commitments.”¹³⁵

Health board-managed practices

187. The managed practice model involves GP practices being directly managed by health boards in order to continue to provide primary medical services in that practice area. Health boards will operate the practice with directly employed salaried GPs and/or sessional locum GPs, alongside the wider practice team. This usually occurs when GP partners have handed their GMS contracts back, often as a result of recruitment or financial pressures.

188. As of June 2025, there were 24 health board-managed practices across Wales, with 12 located in Betsi Cadwaladr University Health Board, six in Hywel Dda, five in Aneurin Bevan, and one in Cwm Taf Morgannwg.

189. According to the Welsh NHS Confederation:

“Directly managed practices by health boards provides an element of financial stability, access to wider support and resources, and greater opportunity to integrate services. However, the model reduces autonomy at a practice level and is not cost effective with current funding model.”¹³⁶

190. Health board-managed practices are generally viewed as less cost-effective, largely due to increased management costs and the need to incur sessional locum GPs. BMA Cymru Wales said:

“We acknowledge that the model is necessary in some areas to ensure the continued provision of primary medical services for patients that would otherwise have no access to healthcare. However, it is not a preferred long-term solution due to its higher costs and inefficiencies.”¹³⁷

191. Dr Ian Harris, General Practitioners Committee Wales, told us:

“The reports that we get back are that the services tend not to be as all-encompassing as they are in a GMS contracted practice. The continuity isn’t as real, because clearly what

¹³⁵ GP22 Doctors in Unite Cymru

¹³⁶ GP32 Welsh NHS Confederation

¹³⁷ GP34 BMA Cymru Wales

*you've got is health boards bringing in staff, and generally you will find salaried and locum staff will be more mobile, so you're unlikely to have the same GP in a managed practice as you would.*¹³⁸

192. Dr Tom Kneale, a GP in Ruthin, said he felt there could sometimes be a lack of ownership with managed practices:

*"[...] because within the GMS contract they're my patients, I live in the same area as them, I have to get it right and if I don't, I'll hear about it at the school gates. I don't necessarily think that happens within that managed environment. You see your patients, you leave the building, job done, really, so that value is lost."*¹³⁹

193. He questioned why there had been no evaluation of managed practices and called for strategic support to prevent contracts being handed back:

*"Because once the contract's gone back—and it costs 30 per cent more for a health board to run—returning that practice then to GMS is incredibly difficult, because you have services that are up and running with existing staffing that the health board may have augmented, and, then, when a practice comes in, it has to TUPE those people across and has increased running costs. The key to this has to be stopping that practice getting to managed status in the first place."*¹⁴⁰

Dispensing GP practices

194. A dispensing GP practice is a general medical practice with "outline consent" to both prescribe and supply medicines directly to its patients, rather than issuing prescriptions for a pharmacy to fill. This model primarily serves rural or remote populations where patients live more than 1.6km from a pharmacy, often in areas with limited public transport and long travel distances. Dispensing practices exist in areas where commercial pharmacies are not financially viable.

¹³⁸ RoP, 17 September 2025, paragraph 86

¹³⁹ RoP, 17 September 2025, paragraph 88

¹⁴⁰ RoP, 17 September 2025, paragraph 98

195. Evidence from the Dispensing Doctors' Association Wales¹⁴¹ raised serious concerns about the sustainability of dispensing GP practices in rural Wales, and about systemic inequities in how they are funded and supported.

196. It says that dispensing fees have not kept pace with rising costs, which include increases to the National Living Wales, Employer National Insurance contributions and energy costs.

197. The Dispensing Doctors' Association Wales points out that there is no Welsh-specific contract; dispensing practices in Wales operate under a model entirely tied to English contract negotiations:

“Despite their importance, dispensing practices are tied to a contractual framework set in England, leaving them without a direct voice in Welsh policy decisions.”

198. It calls for “the creation of an independent Welsh dispensing contract and funding envelope, enabling Welsh negotiation, oversight, and review”.

199. It says that while community pharmacies across Wales have benefited from digital innovation funding, dispensing GP practices had been excluded from this funding:

“Despite providing the same NHS medicines supply service, they must rely on manual processes with no access to capital for automation or infrastructure support.”

200. Further, it notes that some practices are facing significant financial strain, with some considering staffing reductions, reduced services, or even handing back dispensing rights.

Evidence from the Welsh Government

201. The Cabinet Secretary confirmed that, while the independent contractor model was not the only viable model, it would continue to be the predominate model in Wales as it was cost-effective, flexible, and encouraged innovation:

“I think that those are all good things that we want to encourage. So, I really want to make sure that the model is

¹⁴¹ GP62 Dispensing Doctors' Association Wales

*accessible and effective from a patient point of view, but also attractive from the point of view of GPs.*¹⁴²

202. He said that despite financial pressures and workforce challenges, the Welsh Government was working to improve sustainability of the independent contractor model. This included increased GMS funding, cluster-level commissioning, estate improvements, and regulatory flexibility:

*“The fundamental point is, in an independent contractor model, there is an element of risk that is inevitable and inherent. We need to make sure that the rewards of practice are also in balance with the risks.”*¹⁴³

203. When asked if he saw health board-managed practices as a temporary solution to problems with the independent contractor model, the Cabinet Secretary told us he saw it more as a ‘mixed economy’:

*“I don’t think I would say it’s a temporary element. Some will be, obviously. Some will be using it as a means of stabilising a practice and reintroducing it to an independent contractor model, but others will recognise, perhaps, the challenge in recruitment to particular geographic areas.”*¹⁴⁴

204. The Cabinet Secretary said that, following the eHarley Street experience, work was being undertaken to review the contract guidance and assurance frameworks, and he would be open to contract changes if that review suggested improvements were needed.

205. In relation to dispensing GP practices, the Cabinet Secretary acknowledged that they faced particular challenges in rural areas due to frozen payment rates and reduced income as prescription intervals lengthened.

206. In his written statement, released on 12 December 2025, the Cabinet Secretary announced that the arrangements for dispensing doctors would also be included in the work being undertaken to drive forward ongoing and future improvements. This, he said:

¹⁴² RoP, 12 November 2025, paragraph 78

¹⁴³ RoP, 12 November 2025, paragraph 81

¹⁴⁴ RoP, 12 November 2025, paragraph 83

“further demonstrates the commitment to ensuring all aspects of general practice are responsive to local needs.”¹⁴⁵

Our view

207. While the independent contractor model continues to be the predominate model of practice in Wales, we are concerned that the financial and operational risks associated with becoming a GP partner are deterring younger doctors, who prefer the stability and work life balance offered by a salaried role. This trend, coupled with an ageing GP workforce, raise concerns about the long-term sustainability of the independent contractor model. While we welcome the work being done by the Welsh Government to improve sustainability, we believe this also needs to look at the issues that are deterring younger doctors from taking up partnership roles and how those partnership roles can be made more appealing.

208. There is a role for health board managed practices in certain circumstances, to ensure health care services are maintained. However, we heard concerns about the over-reliance on locums and increased costs associated with managed practices, as well as concerns about patient experience and continuity of care.

209. It is clear that once a GP contract has been handed back to the health board, it is very difficult for it to then return to independent contractor status. Every effort should be made to support struggling practices to retain their independent contractor status. Where that is not possible, clear guidance and evaluation criteria are needed to ensure health board managed practices maintain quality, continuity of care, and community engagement, and to support their return to independent contractor status where appropriate.

210. Whilst there are examples of good practice in health board managed practices, we believe that work is needed in this area to better assess their cost, quality, patient experience, and continuity outcomes, and to identify examples of good practice with a view to rolling them out across Wales.

Recommendation 13. The incoming Welsh Government should commission an independent evaluation of health board managed practices to assess their cost, quality, patient experience, and continuity outcomes compared to independent contractor practices. This work should include the consideration of best practice examples for sharing across Wales.

¹⁴⁵ [Written Statement: General Medical Services Contract Reform for 2025-26, 12 December 2025](#)

211. Dispensing doctors have a vital role to play in rural communities. It is therefore concerning to note the issues raised by the Dispensing Doctors' Association Wales regarding the sustainability of dispensing GP practices in rural Wales, and inequities in the way in which they are funded and supported. We welcome the establishment of a working group to look at the arrangements for dispensing doctors, and urge that this work happens at pace. We believe this work should include consideration of a Wales-specific dispensing contract or funding mechanism that reflects the costs and needs of rural dispensing practices in Wales rather than tying them to a contractual framework set in England.

212. We also believe there needs to be greater investment in digital solutions for dispensing GP practices to address rural digital exclusion and support modernisation, and put them on an equal footing with community pharmacies.

Recommendation 14. Within 100 days of coming into power, the incoming Welsh Government should write to our successor committee to confirm its commitment to continuing the work to review arrangements for dispensing doctors and the timescales for this.

9. Infrastructure and digital transformation

Infrastructure and estates

213. Modernising the general practice estate is an important enabler of the Welsh Government's ambition to deliver more care closer to home. A 2021 report¹⁴⁶ to inform the development of the future primary care estate in Wales, commissioned by the Welsh Government, proposed a national roadmap for improving primary care premises. It highlighted the need for coordinated investment, clearer ownership models, and better data on estate condition.

Condition of the general practice estate

214. Witnesses told us that the condition of general practice estates across Wales was variable. While some premises were modern and fit for purpose, many were outdated, poorly maintained, and lacked the space needed to support multidisciplinary teams, training, and service expansion. This limited the ability to shift care closer to home.

215. Dr Virginia Iles, a GP in Cardiff, said that many buildings were getting old and required considerable investment. Indeed, her own practice had leaking windows, broken and old clinical units, cracked flooring and stained seating:

"Partnerships do not have additional funding to repair these buildings, and rent reimbursement does not keep up with the inflated cost of maintenance. There are no significant grants or funding available to help with this. Most older buildings have insufficient space to take on further primary care employees or trainees."¹⁴⁷

216. Similarly, Dr Elin McCarthy, a GP Partner in Swansea, told us:

"[...] when we can see that there's some funding available, you really have to fight and fight your cause. There are so many obstacles and it's really restrictive."

¹⁴⁶ [Future Approach to Planning Primary Care Premises in Wales, September 2021](#)

¹⁴⁷ GP58 Dr Virginia Iles

217. She went on to say that she was aware of GPs who had not had a boiler for 12 months, so had had no hot water, and had to sit in consultations in a coat or bring in their own heaters.

“You need new couches, you need to have hot running water. But that is the state of affairs, and it’s heartbreaking. And you haven’t got space then to train your students or your registrars, so it’s a vicious circle. You lose that opportunity to attract people into general practice.”¹⁴⁸

218. A survey carried out by the Royal Pharmaceutical Society (RPS) Wales reported difficulties posed by working in older buildings, with issues like dampness, cramped spaces, poor temperature control, and the challenge of maintaining cleanliness.¹⁴⁹

219. Dr Neil James, Chair, Deep End Cymru, described it as ‘a small issue, but it’s also a big issue’. He said:

“Primary care estates are incredibly variable. I know that’s not an easy solution because it involves capital investment, but estates make a big difference. The quality of the estate, the premises, makes a big difference on the working environment. I know there aren’t many terraced houses out there that also serve as GP surgeries anymore, but still, many of them are dated and not particularly aesthetically nice places or professional places to work.”¹⁵⁰

220. The Welsh NHS Confederation said the lack of adequate general practice estate was a significant barrier to the delivery of services, innovation, workforce wellbeing and patient experience, which was further exacerbated by:

“The scarcity of capital funding and the limited availability of alternative funding sources. Even when funding is accessible, the capital development process is complex.”¹⁵¹

¹⁴⁸ RoP, 10 July 2025, paragraph 142

¹⁴⁹ GP60 Royal Pharmaceutical Society Wales

¹⁵⁰ RoP, 6 November 2025, paragraph 105

¹⁵¹ GP32 Welsh NHS Confederation

Multi-disciplinary team working

221. A number of witnesses raised concerns about the impact of the general practice estate on multi-disciplinary team working.

222. The RPS Wales survey highlighted physical space as a major concern for many respondents:

“A common issue is the lack of clinical rooms, which can result in pharmacists having to share spaces with other healthcare professionals or deliver consultations in less-than-ideal environments. In some cases, pharmacists are forced to work from home or use non-clinical spaces, such as meeting or tea rooms, for telephone consultations.”¹⁵²

223. Liz Hallett from the RPS told us:

“[...] there are lots of antiquated buildings with limited space, not enough patient access, or difficult patient access. So, even with the best will in the world, if you wanted to employ a pharmacist, where are you going to put that pharmacist into that building? You do want them to have the opportunity to be part of that multidisciplinary team, to be able to go and knock on that doctor’s door, to have that query about a patient.”¹⁵³

224. While Calum Higgins, Chartered Society of Physiotherapy, called it ‘a parity of esteem issue’. He said:

“If you haven’t got the same facilities as the GP in the practice, the same sort of room set-up, as an AHP practicing there, you’re seen as an afterthought by the patients as well. You need to be integrated into the structure of the building, the plan of how your patients will come into the GP surgery and see you as a professional equal to the others there.”¹⁵⁴

225. Steve Simmonds, Community Pharmacy Wales, also raised issues around parity:

¹⁵² GP60 Royal Pharmaceutical Society Wales

¹⁵³ RoP, 2 October 2025, paragraph 295

¹⁵⁴ RoP, 2 October 2025, paragraph 133

“So, if we’re part of primary care, then we really need access to the estates funding that the rest of primary care has, and to get rid of some of the crazy anomalies there. For instance, a GP practice will pay business rates, a pharmacy practice will pay business rates. The GP practice sends the bill to [...] the health board, to pay it; the pharmacy practice puts its hand in its pocket and writes a cheque. Either we’re part of primary care or we’re not, and if we are part, then ‘Please treat us as equals in primary care’ is the plea.”¹⁵⁵

226. Paul Mears, Chief Executive of Cwm Taf Morgannwg UHB, agreed there was a wide variation of estates across his health board area, with some brand-new, purpose-built facilities, and others that were substandard and not fit for purpose:

“As always with these things, there is a process by which you prioritise investment in those practices. We’ve done quite a lot of investment in CTM over the years on the primary care estate, but I’d also say there’s something (...) about how we get better at using the collective estate. Actually, if you look across the public sector estate, or even just the NHS estate in locations, we often have quite a bit of capacity. It’s just that it’s not always in the right place or being used for the right purposes.”¹⁵⁶

227. He added that it needed to be recognised that some practices owned their own buildings:

“(...) and there is that tension about how much of that we as a health board can control and how much of it sits with the practices.”¹⁵⁷

Financial risk

228. GPs typically occupy their premises in one of two main ways: outright ownership or rental. Dr Richard Stratton, a GP Partner from Powys, told us:

“In general practice, we’re expected to provide our own premises. That can be through our own funding, we might own it, we might lease it off somebody else and, in some cases, the health board own and lease the premises. So, there are various

¹⁵⁵ RoP, 2 October 2025, paragraph 301

¹⁵⁶ RoP, 2 October 2025, paragraph 485

¹⁵⁷ RoP, 2 October 2025, paragraph 486

*states of general practice property, premises, depending on the motivations of the partners or the occupants within that.*¹⁵⁸

229. GP partners often bear personal liability for leases or mortgages, creating a financial risk that deters new recruits from entering partnerships. Evidence from the Royal College of General Practitioners Cymru Wales stated that premises were a considerable cost and concern to GPs, as a lease or mortgage was funded indirectly by the NHS, but it was the partner who was liable:

*“This can create a significant financial challenge if their practice becomes unviable, a particular stress faced by partners in the ‘last person standing’ scenario where they are the final GP after others have left the partnership. In addition, a potential new partner could be discouraged by having to take out a loan to buy in to the practice.”*¹⁵⁹

230. Dai Williams, Community Pharmacy Wales, described his experience:

*“I’ve been lucky enough to get a grant this year to put an extension on the back of my pharmacy to try and increase the number of consulting rooms to a proper standard. I’ve still got to find £150,000 of my own money to do that. That’s a massive investment at my age, where I’m thinking, ‘I’m not sure where the future of primary care is.’”*¹⁶⁰

231. He added:

*“(…) it’s not just the investment, it’s the confidence of the people working in it to think that the risk is worthwhile of putting that investment in. So, unless you can get the assurance of a plan for primary care and confidence that it’s worth investing in, then the key players won’t invest in those improvements.”*¹⁶¹

Digital transformation

232. Digital transformation is a key pillar of the Welsh Government’s long-term vision for health and care, as outlined in A Healthier Wales¹⁶² and the Digital and

¹⁵⁸ RoP, 10 July 2025, paragraph 137

¹⁵⁹ GP38 Royal College of General Practitioners Cymru Wales

¹⁶⁰ RoP, 2 October 2025, paragraph 298

¹⁶¹ RoP, 2 October 2025, paragraph 298

¹⁶² [A Healthier Wales: our Plan for Health and Social Care](#)

Data Strategy for Health and Social Care in Wales (2023)¹⁶³. The strategy promotes a ‘digital-first’ approach to improve outcomes, accessibility, and efficiency through better use of data and technology, emphasising real-time access to patient information, improved interoperability, and tools like the NHS Wales App.

233. To support this, Digital Health and Care Wales (DHCW) developed a Primary Care Digital Strategy (2024–2027)¹⁶⁴, which focuses on equipping general practice and other services with the infrastructure, tools, and training needed to deliver safe, efficient, and patient-centred care. It highlights the importance of digital literacy, interoperable systems, and practice-led innovation.

Lack of integration / system incompatibility

234. We were told that digital infrastructure in general practice is lagging behind, with outdated systems and poor integration across NHS Wales. GPs reported frustration with slow progress and limited collaboration from Digital Health and Care Wales (DHCW), and the continued absence of basic tools like e-prescribing.

235. Dr James Pink, a GP Partner in Cardiff, said there was the potential to have a truly joined-up health service in Wales if the IT systems and information governance were to be co-ordinated:

“Sadly, the reality is that GPs, district nurses, community pharmacists, opticians, dentists and hospital doctors all use different IT systems, with often only limited access to the patient’s medical record if at all. This is as frustrating as it is dangerous.”¹⁶⁵

236. John Williams, a Practice Manager from Wrexham, told us:

“Wales uses a slightly old fashioned IT coding system for its medical records. Whereas in England particularly, and in lots of them in the other Western world, they use a code called SNOMED. Changing to SNOMED coding has been part of the Welsh Government route-map for seven years, but it still hasn’t happened in primary care. What that means in practical terms is that there are lots of off-the-shelf solutions, particularly in AI,

¹⁶³ [Digital and data strategy for health and social care in Wales July 2023](#)

¹⁶⁴ [Digital Health and Care Wales Primary Care Strategy 2024-2027. February 2024](#)

¹⁶⁵ GP21 Dr James Pink

which could really transform our sustainability overnight, but they depend upon that coding to operate.”¹⁶⁶

237. According to the Royal College of General Practitioners Cymru Wales, Wales has been behind the curve on the adoption of technology in general practice and the wider NHS:

“Work on the NHS Wales app only seemed to begin after a similar product had been available in England for a couple of years. There remain outstanding questions about how usable it will really be for patients from a general practice perspective. There was a similar late-adopter approach to e-prescribing, the progress of which has been welcome but now seems to be dragging, and also digital shared patient records.”¹⁶⁷

238. Similarly, Dr Virginia Iles, a GP in Cardiff, said digital technology in Wales lagged significantly:

“We still do not have electronic prescribing, over a decade after England. We are awaiting transfer to EMIS from Vision, and have been for over a year. We have disjointed clunky systems such a non-integrated Radiology request system, non-integrated Consultant advice messaging system. Letters from secondary care can take months to reach us, we still have paper letters which then have to be scanned into our computer system.”¹⁶⁸

239. She went on to say that digital technology and AI could revolutionise the NHS, and the cost savings if hospitals, primary care, district nurses and pharmacies all used the same systems would be immense.

240. Similarly, Dai Williams, a community pharmacist in the Rhondda, told us:

“I can access the summary care record, so I can get access into the GP record and see a summary of where they are, but I don’t get to see everything. I don’t get to see pathology laboratory results or letters from hospitals. I don’t get read-and-write access to the GP’s records. So, there’s a danger that the information that I’m getting isn’t complete to allow me to

¹⁶⁶ RoP, 10 July 2025, paragraph 10

¹⁶⁷ GP38 Royal College of General Practitioners Cymru Wales

¹⁶⁸ GP58 Dr Virginia Iles

*make a decision, and I can't then write directly back into that GP record, so there's a chance that, when I communicate that back, it gets lost in the wad of documents that they have sitting there.*¹⁶⁹

Barriers

241. While digital solutions such as electronic health records and telemedicine hold great potential to enhance patient care, many practices lack the resources or infrastructure to implement these solutions effectively. Evidence from the Welsh NHS Confederation stated:

*"[...] primary care contractors have limited connectivity to wider systems, poor IT infrastructure, and variable integration, hindering the efficient delivery of care and effectiveness of any digital health solutions."*¹⁷⁰

242. We also heard that practices were hampered by outdated and bureaucratic hurdles, such as the continued use of 'wet' signatures¹⁷¹ in Wales. John Williams told us:

*"I was approached by a start-up company in London who did digital patient registrations, so if a patient wanted to register online with a practice, they could do it. They would fill in the form, they would code it, it would send them health information, it was saving the notes. It would take what takes a person half an hour, maybe 30 seconds, and they wanted to charge us 50p for a patient. I thought, 'That's fine. It will save so much money, that's great.' They were willing to work in Wales, and the barrier was that, in Wales, we still need a wet signature on a patient registration form."*¹⁷²

243. Information governance issues could also potentially pose a challenge when sharing data with community services. Under the UK General Data Protection Regulation (GDPR) and the Data Protection Act 2018, GP practices are data controllers for the personal, confidential, and health data they hold about their patients. John Williams told us:

¹⁶⁹ RoP, 2 October 2025, paragraph 169

¹⁷⁰ GP32 Welsh NHS Confederation

¹⁷¹ A wet signature is a traditional, physical signature made by hand with ink on paper

¹⁷² RoP, 10 July 2025, paragraph 149

“We’re often asked to share data or give access to our systems, and completely unredacted access to other normally health board-run community services, which is a huge risk, because you’re granting access to departments, and people are very anxious, justifiably, about that.”¹⁷³

244. . However, he went on to suggest that potential solutions did exist:

“Now that Wales is all moving to a single supplier for primary care data systems, EMIS, there’s a version of EMIS called EMIS Community where we could grant limited access to district nursing, for example, so they could only see what they needed to see, and that would probably satisfy the information governance requirements better.”¹⁷⁴

245. Although he cautioned that there would be a significant cost involved that would need to be funded centrally, but “it’s quite a basic thing to sort out, and it would probably transform a lot of MDT working in the community overnight”.

Digital literacy

246. The issue of digital literacy was raised by a number of witnesses. According to Doctors in Unite Cymru, since the Covid pandemic around 1.751 million appointments per month were available in Wales, with a substantial proportion of these consultations being on-line. It said that while many users appreciated the convenience of digital consultations, many others found it a barrier. A Public Health Wales survey on digital health use in Wales¹⁷⁵ found that only 20% felt that technology provided a better patient experience compared to 50% who disagreed. This was more likely to be the case with older people with poor health.¹⁷⁶

247. Evidence from Llais Cymru stated:

“With a move to more services being available online, or via text/other messaging formats this presents a continued challenge as some older people, and many people with a learning disability, are still digitally excluded. In certain rural

¹⁷³ RoP, 10 July 2025, paragraph 96

¹⁷⁴ RoP, 10 July 2025, paragraph 97

¹⁷⁵ [Use of the internet and digital technology to manage health in Wales: past, current, and future preferences](#)

¹⁷⁶ GP22 Doctors in Unite Cymru

*parts of Wales there remains a problem with digital access generally. Whilst tools such as the NHS App can be useful to book appointments (for example), this still requires connectivity access to be available and for people to be able to use such tools.*¹⁷⁷

248. The Older People’s Commissioner for Wales said that, while digital technology offered opportunities to improve GP practice systems, it was essential that non-digital ways to engage with GP practices were retained and operated in a way that did not disadvantage older people and others who were not online.¹⁷⁸

Leadership

249. Witnesses called for stronger leadership, long-term planning, and practice-led digital solutions. In terms of leadership, Dr James Pink, a GP Partner in Cardiff, said that what was needed was:

*“someone who is really IT literate who can also make decisions. Because we’ve got loads of people who are really keen on IT, and none of them seem to find themselves in positions where they can actually influence policy and make it happen.”*¹⁷⁹

250. Kirsty Brookes, a Pharmacist from Anglesey, agreed, telling us:

*“I think having somebody who is actually in charge can make decisions happen a lot quicker, because it feels like any progress with technology in the Welsh NHS takes years and years and years to get in place.”*¹⁸⁰

Evidence from the Welsh Government

251. The Cabinet Secretary confirmed that a task-and-finish review of estate support for general practice was underway, with publication expected before the next financial year.

252. He also highlighted the £70 million annual Integration and Rebalancing Capital Fund (IRCF) which supported new estate projects, and prioritised models

¹⁷⁷ GP54 Llais Cymru

¹⁷⁸ GP10 Older People’s Commissioner for Wales

¹⁷⁹ RoP, 10 July 2025, paragraph 153

¹⁸⁰ RoP, 10 July 2025, paragraph 157

that moved away from single-partner GMS, separated urgent care, and promoted multi-disciplinary working and equity of access.

253. We asked the Cabinet Secretary if he had given any consideration to transferring lease responsibilities from GP partners to health boards, as a way of encouraging more GPs to enter into partnerships. He told us that he did not support transferring lease responsibilities to health boards except in rare cases because:

“there are some very complex accounting implications to that, and there are some complex operational implications to it as well, which mean that it’s not a realistic alternative to the current arrangements.”¹⁸¹

254. The new Digital, Data and Technology Board, established by the Minister for Mental Health and Wellbeing, was overseeing progress in digital transformation. The Cabinet Secretary confirmed that, by May 2026, all GP practices would move to a single IT supplier and be on a common system:

“it has much more functionality than some parts of the existing infrastructure, which will help us with those things that we want to do around access to records, the NHS app, and all those good things that we want to see.”¹⁸²

255. Further, he said that it was not intended that the NHS Wales app would allow unrestricted booking of GP appointments. Clinical triage would remain essential:

“So, we’re never going to get to a position where people can simply book for whatever they like to see a GP, because the GP may not be the best person for them to see.”¹⁸³

256. In relation to data ownership, the Cabinet Secretary told us that this was governed by legal frameworks. He said there was a lot of work going on in this area and ultimately he would like to see a system that gave confidence to the patient that their data was safeguarded and protected but also enabled appropriate use of that data, in the best interest of the patient. The Cabinet Secretary acknowledged that, while current systems allowed read access and

¹⁸¹ RoP, 12 November 2025, paragraph 109

¹⁸² RoP, 12 November 2025, paragraph 116

¹⁸³ RoP, 12 November 2025, paragraph 126

non-digital sharing between pharmacies and GPs, read-write access for pharmacists and MDT members would improve service integration.

Our view

General practice estate

257. Stakeholders describe a mixed picture of the general practice estate across Wales. While some premises are modern and fit for purpose, many are older and in need of urgent modernisation, with limited accessibility and lacking the space needed to support multi-disciplinary team working. We heard of GPs who were having to work with no heat or hot water. This is completely unacceptable in 2026.

258. We also heard about problems with accessing grant funding for maintenance or improvements, with limited availability of capital funding, and where it is available, a very complicated application process.

259. The Cabinet Secretary told us that a task-and-finish review of estate support for general practice was underway but it is not clear what actions will follow this review and who will be responsible for delivering them. We agree with witnesses that a clear, long-term strategy for modernising the primary care estate is needed. However, before this can be taken forward, a comprehensive review of the general practice estate is needed to assess the scale of the problem. Work in this area should support the longer-term transformation agenda of moving activity out of secondary care and into the community, and should be part of ensuring the primary care estate is fully prepared for this.

Recommendation 15. The incoming Welsh Government should commission a comprehensive review of the general practice estate. This work should support the longer-term transformation agenda of moving activity out of secondary care and into the community, and should be part of ensuring the primary care estate is fully prepared for this.

260. The value of the multi-disciplinary team has already been acknowledged but witnesses told us about the impact the general practice estate is having on their ability to work in this way. Allied health professionals talked about having to carry out consultations in non-clinical spaces, such as meeting or tea rooms. If we are to change public perception and encourage greater use of the MDT, then there needs to be parity of access for everyone delivering services in a practice.

Digital transformation

261. Technology has the potential to transform the way in which healthcare is delivered in Wales but our digital infrastructure is lacking, with fragmented ICT systems, poor interoperability, and inconsistent read/write access undermining teamwork, data sharing, and patient safety. We are also behind England in terms of electronic prescribing and the rollout of the NHS App. We agree with stakeholders that there is the potential to have a truly joined up health service in Wales if the IT systems and information governance were to be co-ordinated.

262. We believe that a clear timetable and accountability framework for delivering digital improvements and interoperability across the system is needed. We also agree that there is a need for stronger leadership to drive the digital transformation agenda at greater pace.

Recommendation 16. The incoming Welsh Government should develop a clear timetable and accountability framework for delivering digital improvements and interoperability across NHS Wales, including general practice, secondary care and community services.

263. In addition to outdated ICT systems, we heard that outdated, overly bureaucratic processes, such as the requirement for ‘wet signatures’ were further hampering digital transformation in Wales. We believe the incoming Welsh Government should review these practices, with a view to simplifying and modernising them.

Recommendation 17. The incoming Welsh Government should review outdated administrative and regulatory requirements that impede digital transformation (such as the need for ‘wet signatures’) with a view to simplifying, standardising, and modernising these processes across NHS Wales.

264. Further, we believe that steps should be taken to enable pharmacists and allied professionals to have full read/write access to patient records, which will help improve safety and service integration.

265. Digital exclusion remains a significant issue in Wales. While many people appreciate the convenience of digital consultations, many others find it a barrier. Some older people, and people with a learning disability, are still digitally excluded, and in certain rural parts of Wales there remains a problem with digital access. We must, therefore, be mindful in taking forward the digital agenda, that non-digital ways to engage with GP practices are retained and operate in a way

that does not disadvantage people who were not willing or able to access services online.

10. Patient experience

Access to general practice

266. Access to general practice remains a significant challenge across Wales, with demand continuing to outstrip supply. Patients face longer waiting times and limited appointment availability, particularly in deprived communities and among those with complex needs.

267. Cllr Lister, Cllr Thorne and Cllr Abdul-Sattar, from Grangetown in Cardiff, highlighted the challenges facing patients in their area when trying to book appointments:

“Many report long wait times on the phone, often resulting in no available appointments once they finally get through. Routine appointments are difficult to secure, leading to a rush for emergency slots, which exacerbates the problem.”¹⁸⁴

268. While the First Minister has been quoted as saying that people should no longer be waiting on hold at 8am every day to get GP appointments¹⁸⁵, the ‘8am phone rush’ remains a common frustration. One individual who submitted written evidence to our inquiry said:

“Why can’t the people of Brecon get an appointment to see a GP, after ringing up and getting through at 8am I was number 49 in the queue.”¹⁸⁶

269. Age Cymru told us:

“Through our annual surveys we have repeatedly heard of blockages in GP access through ‘call at 8am to book an appointment’ systems where despite numerous attempts to get through, all appointments have gone leaving older people without access to care at the time they need it.”¹⁸⁷

270. Power Up, a young people’s wellbeing and social action project led by the mental health and social change charity, Platform, said that timing was a barrier,

¹⁸⁴ GP57 Cllr Lister, Cllr Thorne and Cllr Abdul-Sattar, Grangetown, Cardiff

¹⁸⁵ Wales Online, Eluned Morgan says no-one should be on hold at 8am waiting for a GP appointment, August 2024

¹⁸⁶ GP24 An individual

¹⁸⁷ GP42 Age Cymru

with many young people commenting on how the only method to get a GP appointment was by calling the surgery within a set hour, which also varied depending on the surgery:

“They felt that this made obtaining an appointment inaccessible for people with commitments. They felt that the wait and uncertainty between appointments was also inaccessible for some people, especially neurodivergent people.”¹⁸⁸

271. Action for Children also raised concerns about young people who have had adverse childhood experiences or are neurodivergent having to sit in a surgery waiting area:

“This can be an extremely triggering process for them. Being asked to wait in an unfamiliar environment with lots of other people, numerous conversations taking place at once and movement, can cause sensory overload for those young people who are neurodiverse.”¹⁸⁹

272. Dr Rebecca Towner, a GP in Cardiff, told us:

“We do offer as many routine bookable appointments that we can, but I ask you how are we supposed to offer capacity for all of our patients when the daily demand on top of this is so unpredictable and we are not funded to provide care for all of our patients? I can confirm there is still an 8 am rush in our practice which could be avoided if we were funded properly to recruit more staff.”¹⁹⁰

273. Fair Treatment for the Women of Wales believed that it had become harder to make appointments since the pandemic.

274. Cllr Lister, Cllr Thorne and Cllr Abdul-Sattar suggested a range of measures to enhance appointment systems, including online booking, extended phone line hours and a callback system. They also said that offering flexible time slots,

¹⁸⁸ GP41 Power Up, Platform

¹⁸⁹ GP45 Action for Children

¹⁹⁰ GP03 Dr Rebecca Towner

including evenings and weekends, would accommodate working individuals and reduce the pressure on the 8am rush for appointments.¹⁹¹

Public perception of general practice

275. We heard that public dissatisfaction was growing, fuelled by negative media and political narratives that have eroded trust in general practice. Evidence from the Town Gate Practice in Chepstow stated:

“Over the last ten years primary care has been driven into the ground through under-resourcing and a systematic destruction of primary care’s reputation in the media. This scandalous erosion of public trust by the media has been allowed to continue unchecked by government.”¹⁹²

276. Participants in our engagement work told us that GP and general practice workforce morale and self-esteem was greatly affected by the negative narrative experienced by them from many directions including government, health boards, other healthcare professionals and the general public. John Williams, a practice manager in Wrexham, told us:

“the image of general practice, which has really taken a bashing, I think unfairly—I think really unfairly—since the pandemic, and an image bashing that’s, sadly, often perpetuated by politicians as well as the media, which means that we’re not often seen as an attractive place to work.”¹⁹³

277. Dr Rebecca Towner, a GP in Cardiff, said that in recent years it seemed to have become the norm in primary care “to make personal sacrifices, both financially and mentally to ensure we are able to continue provide a service that is decreasingly valued by both the public and government as we are labelled as lazy and money-grabbing.”

“This has all affected the morale of staff, both clinical and administrative.”¹⁹⁴

278. Specific reference was also made to the front desk workforce in practices.

¹⁹¹ GP57 Cllr Lister, Cllr Thorne and Cllr Abdul-Sattar, Grangetown, Cardiff

¹⁹² GP30 Town Gate Practice

¹⁹³ RoP, 10 July 2025, paragraph 79

¹⁹⁴ GP03 Dr Rebecca Towner

279. For many people, the first person they make contact with is the practice receptionist. Mind Cymru highlighted the importance of that first contact:

“We know that demand on GPs is extremely high. The pressure that comes with the role of triaging patients can result in unintended outcomes. We have heard from people with lived experience that the response they received from reception staff is not always compassionate or trauma-informed, and this can have a lasting impact. It is incredibly important for all staff within surgeries to take a trauma-informed approach.”¹⁹⁵

280. We also heard concerns about people having to disclose personal information to non-clinical staff.

281. Llais Cymru said they often heard from people that they were unhappy or did not understand why they had to provide detailed and personal information to receptionists:

“It makes them feel uneasy if they are not clear on the need for it, viewing reception staff as a barrier or ‘gatekeeper’ between them and a doctor. Clearer communication to people from practices as to why this is necessary will help to reduce those concerns.”¹⁹⁶

282. Similarly, Fair Treatment for the Women of Wales described ‘having to recount sometimes highly personal symptoms to administrative staff who don’t always have the knowledge or expertise to accurately report patient needs to medical personnel’.¹⁹⁷

283. A number of witnesses called for improved staff training for reception and administrative staff to ensure they handled patient inquiries with empathy and professionalism.

284. However, participants in our engagement activity defended the front desk staff:

“Receptionists get a bad name, but they’re very instrumental and very helpful to our day. They actually know which patients we should be worried about and they come and let us know...”

¹⁹⁵ GP48 Mind Cymru

¹⁹⁶ GP54 Llais Cymru

¹⁹⁷ GP61 Fair Treatment for the Women of Wales

They don't need the abuse that they get, at the end of the day it's not their fault. The abuse is not acceptable and it's escalating all the time."¹⁹⁸

285. Witnesses stressed the need for improved communication and engagement to rebuild trust and clarify the evolving role of general practice. A national communications strategy could help manage expectations and promote understanding of the multi-disciplinary primary care model.

Continuity of care

286. Continuity of care and being able to see a known and trusted clinician is highly valued by patients and linked to better patient outcomes. Llais Cymru told us:

*"Lots of people tell us they don't like not being able to see the same or their 'own' doctor. People clearly value and want continuity of care. When they say they want to see their 'own GP' what they are asking for is someone who knows them and their medical history, understands what matters to them and is likely to provide the care and treatment they need. It is a trusted relationship that's often built up over years and which makes people feel safe and cared for and about."*¹⁹⁹

287. Royal College of General Practitioners Cymru Wales said that patient outcomes were enhanced by the development of trust, mutual respect and co-production with their clinician. Dr Rowena Christmas, Royal College of General Practitioners Cymru Wales, told us:

*"If you see the same GP regularly, you're much less likely to be referred to secondary care. You're much less likely to present as an emergency at the hospital."*²⁰⁰

288. However, BMA Cymru Wales told us that while a good doctor-patient relationship was an important part of general practice, it was becoming increasingly uncommon:

"Continuity of care helps patients feel more comfortable with disclosing their problems, and doctors can get a better sense of

¹⁹⁸ Inquiry into the future of general practice in Wales: [engagement findings](#)

¹⁹⁹ GP54 Llais Cymru

²⁰⁰ RoP, 17 September 2025, paragraph 20

a patient's diagnosis the more they can understand them as a person. Unfortunately, doctors are operating in an environment in which a lack of capacity means flexibility is essential.”²⁰¹

289. Further, it said that in order to meet the access commitments implemented by the Welsh Government, GPs had to assign any available doctor to a patient rather than whoever they would prefer to see, and as a result continuity of care was removed.

290. Deep End Cymru said it believed that continuity of care should be the top priority for general practices, especially for those with the most complex needs:

“It is not a zero-sum game with access, because greater continuity reduces demand and allows better access. However, a focus on access alone causes fragmentation of care, increased encounters and poorer outcomes.”

291. Similarly, Doctors in Unite Cymru told us that continuity of care must be at least as important a goal as access to care because it reduced mortality and inequalities in health outcomes.²⁰²

Length of appointments

292. Standard GP appointments in Wales typically last 10 to 15 minutes. A number of witnesses raised concerns about this, particularly in the case of patients with more complex needs.

293. The Royal College of General Practitioners Cymru Wales said that the time constraint imposed by 10-minute consultations meant that GPs increasingly needed to be reactive, treating the immediate symptoms presented to them, rather than having the time to focus on potentially deeper-rooted causes. According to its 2024 GP Voice survey:

“When asked whether there is enough time during appointments to build the patient relationship needed to deliver quality care, 57% of our members disagreed. Furthermore, 65% of members felt that they do not have

²⁰¹ GP34 BMA Cymru Wales

²⁰² GP22 Doctors in Unite Cymru

enough time during appointments to adequately assess and treat patients.”²⁰³

294. Nia Boughton, Royal College of Nursing Wales, told us:

“The whole of primary care is predicated on a 10 or 15-minute appointment, a sort of speed-dating philosophy, if you like, which worked fine when it was an illness system, as it was designed 50 years ago, but that’s not the type of presentation that we’re dealing with now. We need longer appointments to spend with those that need us the most, that need us to advocate for them in a very different way to other parts of our community.”²⁰⁴

295. Mind Cymru said that the limited time available to discuss concerns could add pressure and worry for people seeking support for their mental health, many of whom will already feel overwhelmed by the prospect of reaching out for support. This, it said, could be an additional barrier to people accessing help when they most needed it.²⁰⁵

296. Evidence from Age Cymru highlighted that the increased complexities of health needs that were more likely with age meant that older people might need a longer time slot to discuss the range of their health care needs:

“As one respondent to our annual survey in 2024 said, “It is pointless trying to contact the GP. Firstly, is the difficulty of getting through by phone to make an appointment. Secondly is the shortness of the appointment, impossible to discuss everything.”²⁰⁶

Language and cultural sensitivity

297. Many service users emphasised the importance of being able to communicate and engage in the language of their choice, particularly when they were at their most vulnerable.

298. Llais Cymru highlighted the variability in access to Welsh-language services in GP practices across Wales:

²⁰³ GP38 Royal College of General Practitioners Cymru Wales

²⁰⁴ RoP, 2 October 2025, paragraph 86

²⁰⁵ GP48 Mind Cymru

²⁰⁶ GP42 Age Cymru

“Some areas provide excellent Welsh-language support, while others fall short. When services do not actively support the use of Welsh, people often feel dismissed or unimportant.”²⁰⁷

299. It also said that signage, leaflets, forms, and questionnaires were not always available in Welsh at the same time as the English versions, which could lead to people feeling frustrated or that they were an inconvenience for requesting information in Welsh.

300. Action of Children Wales raised the complexity of language used when accessing health care:

“This particularly presents a barrier for those who do not speak English as a first language and have a lack of trust in systems, meaning they often are unable to both explain their healthcare needs, nor fully understand the advice they are being given.”²⁰⁸

301. Llais Cymru also highlighted how ‘a lack of cultural understanding and wider cultural awareness can impact on the quality of care people from ethnic minorities receive’:

“There can be issues with insufficient information and resources available for people (and professionals in some healthcare settings, not just GP services) so, where people may be trying to access support, or advice about a sensitive health matter and there is a fear of judgement, or misunderstanding within their own community people may ‘suffer in silence’ and not share details about their illnesses, conditions or issues.”²⁰⁹

302. We were also told by members of the deaf community, who took part in our engagement activity, of the difficulties they faced in accessing services:

“Many deaf people cannot make phone calls, yet appointment letters routinely instruct patients to call to confirm, reschedule, or request further information.”²¹⁰

303. They also highlighted how the reliance on calling patients’ names aloud in waiting rooms led to them missing their turn, and suggested simple solutions,

²⁰⁷ GP54 Llais Cymru

²⁰⁸ GP45 Action for Children Wales

²⁰⁹ GP54 Llais Cymru

²¹⁰ Inquiry into the future of general practice in Wales: [engagement findings](#)

such as text message notifications or visual display screens, to make the system more accessible:

“Most people have phones. Why not send a text message when you’re being called for your appointment? Simple things make all the difference.”²¹¹

Evidence from the Welsh Government

304. The Cabinet Secretary warned against the negative narratives circulating in the media and also in the political arena which were undermining the profession. He highlighted the huge level of activity carried out by GPs, stressing that most patients have a positive experience:

“They’re doing a fantastic job in difficult circumstances, and most of our patients think that as well.”²¹²

305. The Cabinet Secretary pointed to recent reforms to pharmacy and optometry contracts, which had significantly expanded the range and scope of clinical services available in primary care. The public now had multiple choices about how and where to access treatment for a wide range of common illnesses from appropriately-trained professionals, without the need for a GP appointment. He noted a generational shift, where older patients expected to see a GP as a first contact:

“So, if you’ve been brought up in a health service where the GP is the first and last port of call, then there’s always going to be a journey that you’re going on, whereas for people who are maybe younger today, who are experiencing an NHS that is more differentiated in that way, it will be a more familiar option for them. So, I think there’s more to be done to make this a kind of systematic set of arrangements.”²¹³

306. The Cabinet Secretary said that strengthening continuity of care remained a key priority as part of ongoing quality improvement reforms, ensuring it becomes an embedded feature of everyday practice. He advised that a new quality improvement project would encourage practices to measure and enhance

²¹¹ Inquiry into the future of general practice in Wales: [engagement findings](#)

²¹² RoP, 12 November 2025, paragraph 154

²¹³ RoP, 12 November 2025, paragraph 143

continuity, recognising that continuity and access are complementary and that improved continuity can reduce demand failure and lead to better access.²¹⁴

307. He went on to say that the mechanism being used focused on the cohort of the most complex cases, so people managing more than one chronic condition:

“So, GP practices are being supported to identify those and to provide increasing levels of continuity of care for those patients. It’s called relational continuity, where that relationship is one where you can expect increasingly to be with the same practitioner if you’re in one of those cohorts.”²¹⁵

308. He said he expected to see benefits over 2–3 years, with a formal review planned for year 3. However, while extending continuity more widely was the long-term goal, urgent care pressures made this challenging.

309. In terms of improving equitable access to services, the Cabinet Secretary said that the unified contract contained provisions for this, with extra support for practices in deprived communities:

“So, different kinds of ways of engaging practices: digital, obviously, non-digital as well. You’ll be aware of the vast volume of people who have a vast number of contacts, both digital, phone and face-to-face and remote, which the NHS has, but also, as part of the negotiations that we have around GMS, there is a weighting in the formula for some of the particular challenges that practices serving deprived communities face.”²¹⁶

310. We asked the Cabinet Secretary about the potential for greater use of the NHS Wales App in booking GP appointments. He told us:

“So, just to be clear, there’s a delicate balance to strike here. So, going to see a GP is not the same as ordering a pizza; you’re going to see somebody with a complex set of skills and you’re asking for a professional judgment. So, it can’t simply be based

²¹⁴ HSC Committee, 12 November 2025, paper 1

²¹⁵ RoP, 12 November 2025, paragraph 149

²¹⁶ RoP, 12 November 2025, paragraph 147

on first-come, first-served; there needs to be an element of clinical triage.”²¹⁷

311. He went on to say that where there was potential for use of the App was where triage was less important, for example repeat appointments for a condition that was well established.

Our view

312. The most common cause of frustration for patients is the struggle to get a GP appointment, often referred to as the ‘8am scramble’. Time and again, we hear of people struggling to get through, only to find that all the available appointments for that day have gone. Despite reassurance from the Welsh Government that this should not be the case, we know that it is still happening in a significant number of surgeries. This is an issue that the Welsh Government, health boards and individual practices urgently need to get to grips with, particularly as it may be putting certain groups of people, including older or neurodivergent people, at risk of not seeking medical help when they need it. We need a patient-centred approach to access, and should be looking at examples of good practice across Wales where they have tackled this problem.

313. We acknowledge the Cabinet Secretary’s point about the difficulties with online booking because of the need for clinical triage. It is also important to ensure equity of access so that any solutions do not disadvantage people who are unwilling or unable to access digital systems. While the Cabinet Secretary has committed to ‘taking further steps to strengthen the access standards, which will help people secure appointments when they need them’²¹⁸ it is not clear how he is proposing to do this, but clearly this is a problem that many GP surgeries are still struggling to address.

Recommendation 18. The incoming Welsh Government should set out how it intends to strengthen the existing GP access standards and publish a clear plan for ensuring that all practices meet them. This should include measures to support equitable access for people who cannot use digital systems and to reduce the reliance on time-limited booking windows such as the ‘8am scramble’.

314. The current negative narrative surrounding general practice is having a detrimental impact on workforce morale. General practice is the frontline of patient care. We agree with witnesses that there is a need for improved

²¹⁷ RoP, 12 November 2025, paragraph 124

²¹⁸ [Written Statement: General Medical Services Contract Reform for 2025-26, December 2025](#)

communication and engagement to rebuild trust and clarify the evolving role of general practice. A national communications strategy, as suggested in Recommendation 7, could help manage expectations and promote understanding of the multidisciplinary primary care model. This could also seek to promote and clarify the role of front desk staff in triaging patients to get them to the most appropriate practitioner, making clear that they are not a barrier to getting an appointment.

315. Continuity of care and being able to see the same GP is highly valued by many, particularly older patients, and is linked to better patient outcomes. The GP-patient relationship is a trusted one, often built up over many years and makes people feel safe and cared for and about. Unfortunately, increased demand and lack of GP capacity has impacted negatively on that continuity of care. We agree with witnesses that continuity of care should be a priority for general practices, especially for those patients with the most complex needs. We therefore welcome the Cabinet Secretary's commitment to strengthening continuity of care for that particular cohort.

316. Whilst the standard 10 to 15 minute appointment might be reasonable for many patients, there are groups of people where this is not the case. For example, people seeking help with their mental health should not feel under additional pressure in accessing the support they need. Similarly, older people or those with multiple health conditions also require longer consultations. There needs to be greater flexibility in the system to allow for longer appointments where needed.

317. Language and cultural sensitivity is essential for inclusive care and should be treated as a right, not a privilege. We should not underestimate the importance of being able to communicate and engage in the language of choice, particularly when people are at their most vulnerable. People should never feel they are an inconvenience for requesting information in the language of their choice. It is also not acceptable that people may be choosing to not access medical help due to a lack of cultural support and understanding. We therefore need to ensure Welsh-medium services and culturally sensitive care are embedded as a right, and that service design reflects diverse community needs.

Annex 1: List of oral evidence sessions.

The following witnesses provided oral evidence to the committee on the dates noted below. Transcripts of all oral evidence sessions can be viewed on the Committee's website.

Date	Name and Organisation
<p>10 July 2025</p>	<p>Dr James Pink, GP Partner, Cardiff</p> <p>Dr Richard Stratton, GP Partner, Powys</p> <p>Dr Elin McCarthy, GP Partner, Swansea</p> <p>John Williams, Practice Manager, Wrexham</p> <p>Kirsty Brookes, Pharmacist, Anglesey</p>
<p>17 September 2025</p>	<p>Dr Gareth Oelmann, British Medical Association Cymru Wales</p> <p>Dr Ian Harris, General Practitioners Committee, Wales</p> <p>Dr Rowena Christmas, Royal College of General Practitioners</p> <p>Dr Tom Kneale, Royal College of General Practitioners</p>
<p>2 October 2025</p>	<p>Nia Boughton, Royal College of Nursing Wales</p> <p>Calum Higgins, Chartered Society of Physiotherapy</p> <p>Kim Willis, Royal College of Occupational Therapists</p> <p>Liz Hallett Royal Pharmaceutical Society Wales</p> <p>Helen Davies, Royal Pharmaceutical Society Wales</p>

Date	Name and Organisation
	<p>Steve Simmonds, Community Pharmacy Wales</p> <p>Dai Williams, Community Pharmacy Wales</p> <p>Paul Mears, Cwm Taf Morgannwg University Health Board</p> <p>David Andrews, Cwm Taf Morgannwg University Health Board</p> <p>Elaine Lorton Powys Teaching Health Board</p>
6 November 2025	<p>Professor Adrian Edwards, Cardiff University</p> <p>Dr Neil James, Deep End Cymru</p> <p>Joanna Watts-Jane Deep End Cymru</p> <p>Dr Jonny Currie, Deep End Cymru</p> <p>Sam Hall, Digital Health and Care Wales</p> <p>Rhidian Hurle, Digital Health and Care Wales</p> <p>Dr Sayma Ahmed, Digital Health and Care Wales</p>
12 November 2025	<p>Jeremy Miles MS, Cabinet Secretary for Health and Social Care</p> <p>Alex Slade, Welsh Government</p> <p>Paul Casey, Welsh Government</p> <p>Professor Jim McManus, Public Health Wales</p> <p>Zoe Wallace, Public Health Wales</p> <p>Kerry Bailey, Public Health Wales</p> <p>Rachel Andrew, Public Health Wales</p>

Annex 2: List of written evidence

The following people and organisations provided written evidence to the Committee. All Consultation responses and additional written information can be viewed on the Committee's website.

Reference	Organisation
GP01	Dr Kate Parry
GP02	Dr Gareth Lucocq
GP03	Dr Rebecca Towner
GP04	Professor Adrian Edwards
GP05	Dr Mark Goodwin
GP06	Individual 01
GP07	Community Pharmacy Wales
GP08	Rachel Dodsworth
GP09	Marilyn Ann Griffiths
GP10	Older People's Commissioner for Wales
GP11	Nicholas Prigg
GP12	Royal College of Podiatry
GP13	Dr Angharad Fletcher
GP14	Individual 02
GP15	Royal College of Nursing Wales
GP16	Individual 03
GP17	All Wales Primary Care Lead Nurse Network
GP18	Dr Matthew Jones
GP19	Marie Curie
GP20	Stroke Association
GP21	Dr James Pink

Reference	Organisation
GP22	Doctors in Unite Cymru
GP23	Equality and Human Rights Commission
GP24	Individual 04
GP25	General Medical Council
GP26	Individual 05
GP27	Dr Noel McLoughlin
GP28	Professor Mitchel Langford and Professor Gary Higgs
GP29	Medical Defence Union
GP30	Town Gate Practice, Chepstow
GP31	North Cardiff Medical Centre Patient Participation Group
GP32	Welsh NHS Confederation
GP33	Asthma+Lung UK Cymru
GP34 & GP34a	British Medical Association Cymru Wales
GP35	Royal College of Speech and Language Therapists
GP36	Crohn's & Colitis UK
GP37	Medicines Management Research Group, Swansea University
GP38 & GP38a	Royal College of General Practitioners
GP39	Royal College of Occupational Therapists
GP40	British Psychological Society
GP41	Power Up, Platform
GP42	Age Cymru
GP43	Allied Health Professions Federation Cymru
GP44	Optometry Wales
GP45	Action for Children Wales
GP46	Royal College of Paediatrics and Child Health (Wales)
GP47	Cwmpas
GP48	Mind Cymru

Reference	Organisation
GP49	Alzheimer's Society Cymru
GP50	Chartered Society of Physiotherapy
GP51	Individual 06
GP52	Deep End Cymru
GP53	Dr Naomi Potter
GP54	Llais Cymru
GP55	Partners of Felinheli and Porthaethwy Surgery, North Wales
GP56	Individual 07
GP57	Cllr Lister, Cllr Thorne and Cllr Abdul-Sattar, Grangetown, Cardiff
GP58	Dr Virginia Iles
GP59	Individual 08
GP60	Royal Pharmaceutical Society Wales
GP61	Fair Treatment for the Women of Wales
GP62	Dispensing Doctor's Association Ltd