

Agenda – Health and Social Care Committee

Meeting Venue:	For further information contact:
Hybrid – Committee Room 3, Senedd and video conference via Zoom	Sarah Beasley Committee Clerk
Meeting date: 12 November 2025	0300 200 6565
Meeting time: 09.30	SeneddHealth@senedd.wales

Private pre-meeting

(9.00–9.30)

Public meeting

(9.30–11.00)

1 Introductions, apologies, substitutions, and declarations of interest

(9.30)

2 Inquiry into the future of general practice in Wales: evidence session with Welsh Government

(9.30–11.00)

(Pages 1 – 61)

Jeremy Miles – Cabinet Secretary for Health and Social Care

Alex Slade – Director of Primary Care, Mental Health and Early Years

Paul Casey – Deputy Director for Primary and Community Care

Research brief

Paper 1 – Welsh Government brief: inquiry into the future of general practice in Wales

3 Papers to note

(11.00)

3.1 Additional information from BMA Cymru following evidence session on 17 September 2025

(Pages 62 – 65)

- 3.2 Additional information from Royal College of General Practitioners (RCGP) following evidence session on 17 September 2025**
(Pages 66 – 70)
- 3.3 Submission from Dispensing Doctor’s Association (DDA) Ltd to inform the inquiry into the future of general practice in Wales**
(Pages 71 – 87)
- 3.4 Letter to Chief Executives of Swansea Bay University Health Board (UHB) and Health Education and Improvement Wales (HEIW) regarding the lack of Band 5 adult nursing positions within Swansea Bay UHB.**
(Pages 88 – 89)
- 3.5 Response from Chief Executives of Swansea Bay University Health Board (UHB) and Health Education and Improvement Wales (HEIW) regarding the lack of Band 5 adult nursing positions within Swansea Bay UHB**
(Pages 90 – 92)
- 3.6 Letter from Minister for Children and Social Care – update on progress made to prepare Local Health Boards (LHBs) for new Continuing Healthcare (CHC) direct payment responsibilities**
(Pages 93 – 94)
- 4 Motion under Standing Order 17.42 (ix) to resolve to exclude the public from the remainder of the meeting**
(11.00)

Private Meeting

(11.00 –12.30)

- 5 Inquiry into the future of general practice in Wales: consideration of evidence**
(11.00–11.10)

Break

(11.10–11.20)

6 Briefing from Public Health Wales on primary care and general practice

(11.20 – 12.30)

(Pages 95 – 105)

Professor Jim McManus – National Director of Health and Wellbeing,
Public Health Wales

Jim McManus, National Director of Health and wellbeing, Public Health Wales

Zoe Wallace, Director of Primary Care, Public Health Wales

Kerry Bailey, Consultant in Public Health, Public Health Wales

Rachel Andrew, Consultant in Public Health, Public Health Wales

Paper 2 – Public Health Wales brief: inquiry into the future of general practice
in Wales

Agenda Item 2

Document is Restricted



Health and Social Care Committee

Evidence Paper: Inquiry into the Future of General Practice

29/10/2025

The Welsh Government ambition for General Medical Services (GMS) is clear: to create a system that is resilient, inclusive, and relentlessly focused on prevention, innovation, and care closer to home.¹ We are not content with incremental change. Our intent is to lead a transformation that sets a new standard for primary care in Wales. Building on our evolution to date, GMS is adapting to meet the changing needs of our communities, delivering the highest volume of NHS care, and acting as the main point of access for patients. The introduction of the Unified Contract (2023) has established clear national standards while enabling local flexibility, driving quality, and supporting innovation. Through Accelerated Cluster Development, we are bringing together multi-professional teams, data, and digital tools to improve access, prevention, and outcomes, making care more convenient, proactive, and closer to home. Our focus is firmly on the future: building a GMS that is easy to reach, inclusive, resilient, and attractive to the profession, ensuring every patient receives timely, person-centred care, and that the NHS in Wales continues to benefit from strong leadership, collaboration, and continuous improvement.

¹ [A Healthier Wales](#)

Contents

1. The Role of General Medical Services.....	3
2. The Challenges threatening sustainability of GMS	7
Overview of GMS funding	7
Efficacy of different models for managing GMS.....	9
Suitability and maintenance of GMS estates and access to digital technology.....	11
3. The GMS Workforce	12
Workforce Planning	12
Growth of the Multidisciplinary Team.....	13
4. The Patient Experience of GMS	14
The scale and reach of GMS	14
Trust, inclusion, and the patient voice	15
5. Opportunities to Improve GMS to Make it fit for the Future and take a more Preventative Approach to Care	16
Future approach.....	16
Key Enablers.....	17
Measuring Success	17
Conclusion	17
6. Annexes.....	19
Annex A: How GMS Is Funded and How It Has Evolved in Wales	19
Annex B: The GMS Workforce in Wales.....	22
Annex C: Evolution of Primary Care Clusters in Wales	25

1. The Role of General Medical Services

General Medical Services (GMS) is where the majority of people either receive most of their NHS care or where they start their NHS treatment journey. Most services are delivered by independent contractor GP practices, with health board–managed practices established where needed to support communities lacking independent contractor operations.

Funding for GMS is ring-fenced within health board allocations to protect core access and continuity in every community. Under the Unified Contract, every practice offers a clear, reliable core service and works to agreed clinical pathways, so most needs are resolved close to home, with onward referral only when secondary care intervention is required. This chapter sets out how general practice delivers access to general medical services, team-based care, and prevention from cradle to grave, and its role in the evolution of primary care cluster development.

From Aspiration to Action: Delivering the Future of General Medical Services in Wales

Policy Intent

GMS in Wales stands at a pivotal moment. 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.

The next phase for GMS is about embedding prevention, digital innovation, and multidisciplinary working as the norm, not the exception. Whenever possible, we are determined to provide care as close to home as possible, through team-

based services that blend GP expertise with the wider primary, community and social care workforce in collaboration with secondary care services.

The introduction of the Unified Contract (2023) has set national standards while enabling local flexibility, driving quality and supporting innovation. Health boards commission services to meet local needs, but always within a consistent national framework. The *Primary Care Model for Wales* sets our direction – care closer to home, prevention, and integration, with local coordination of GMS, pharmacy, dentistry, optometry, allied health professionals, social care, and the third sector to reduce unwarranted variation and improve outcomes.

GMS in Wales operates a mixed delivery model: most care is provided by independent contractor practices, with health board-managed practices established where needed to support communities lacking independent contractor operations. Funding is ring-fenced within health board allocations, protecting core access and continuity for every community, regardless of local pressures.

As demand grows, with more contacts, a higher proportion of same-day requests, increasing online access, and more people with multiple illnesses, including multiple chronic conditions, our emphasis is on earlier intervention, continuity for those who need it, and clearer pathways which enable primary care professionals to manage patients safely and confidently, without unnecessary referrals to other parts of the NHS.

We are committed to building a GMS that is proactive, inclusive, and resilient, ensuring every patient receives timely, person-centred care, and the NHS in Wales continues to benefit from strong leadership, collaboration, and continuous improvement.

Clusters and the Unified Contract: commissioning at pace

The Unified Contract (2023) defines a clear, core service provision and access standards that every practice must deliver, ensuring consistency and quality across Wales.² Health boards are equipped with commissioning tools to add Directed (DSS) and Local Supplementary Services (LSS) at both practice and cluster levels, building on this core.

² The core Unified Contract states that practices will provide safe, timely, person-centred primary medical care during core hours, covering first contact, ongoing management, and prevention, with effective access, coordination, and continuous quality improvement.

Accelerated cluster development provides robust governance, through professional collaboratives and pan-cluster planning groups, to set priorities, align delivery with health board strategy, and track outcomes for continuous improvement.

Realising the full potential of this model means delegating decisions and budgets to clusters, establishing common service specifications for like-for-like delivery, enabling inter-operable data for seamless teamwork, and deploying staff flexibly across practices and professions.

As demand rises, this collaborative, pathway-driven approach, anchored by the unified contract, ensures timely access, continuity for those who benefit most, and prevention embedded in everyday care

How GMS Delivers Value: Core Functions and Integration within the Health System

GMS delivers value by making the unified contract the foundation for every patient interaction. Value is created when people can get help easily, are matched to the right professional first time, and receive proactive care that prevents unnecessary escalation. Access is improved when practices offer multiple entry points, assess urgency on the day, and protect continuity for those who need it most, especially people living with frailty or multiple conditions.

GMS plays a central role in the diagnosis, treatment, and ongoing management of both chronic conditions and urgent care needs. Services are available Monday to Friday, from 8am to 6:30pm, ensuring timely access for patients. The GMS team provides initial assessment, clinical management, and follow-up for a wide range of health issues, referring to secondary care only when specialist intervention is required.

Team-based working ensures GPs, nurses, pharmacists, physiotherapists, mental health practitioners, and others operate as a single, integrated service, using each profession where it adds most value. Prevention is woven into daily practice through safe prescribing, planned recall, early risk identification, and timely review of long-term conditions.

GMS operates as part of an integrated health system, working closely with other local services that support chronic condition management and treatment, as well as secondary care for more specialist needs. For urgent care, GMS collaborates with services such as NHS 111, out-of-hours, and urgent primary care centres (UPCCs) to ensure patients receive the right care at the right time.

By resolving more needs within GMS and referring people into secondary care services only when necessary, patient journeys are shortened, duplication is reduced, and hospital capacity is protected for those who need it most. This integrated approach supports continuity, improves outcomes, and ensures the sustainability of the wider health system.

2. The challenges threatening sustainability of GMS

GMS in Wales is under increasing pressure from rising demand, workforce pressures, and financial constraints. GMS currently receives around 6.4% of the overall NHS Wales budget. While investment has helped to support the workforce and improve access, practices continue to manage rising costs and balance budgets within this allocation.

Overview of GMS funding

GMS funding is ring-fenced within health board allocations to protect core access and continuity. Welsh Ministers set the contract and issue directions to health boards about the Statement of Financial Entitlements (SFE), which specifies payments to GMS contractors.

Core funding is delivered through the Global Sum, paid per weighted patient using the Global Sum Allocation (Carr-Hill) formula, so resources reflect workload and population need. Practices also receive additional payments for support, quality improvement, supplementary services, and premises costs. Health boards can commission extra Local Supplementary Services (LSS) where needed.

While funding models must continue to evolve, particularly to reflect changes in deprivation, multimorbidity and an ageing population,³ our policy direction is clear – sustained investment, innovation, and a commitment to review and improve the framework for service delivery will underpin the continued success and sustainability of GMS in Wales.

Further detail about the funding system, including the Global Sum Allocation formula and its application, is detailed in the annex.

³ Report of projections, health evidence and policy recommendations | GOV.WALES

Key Sustainability Challenges

The challenges facing GMS are driven by a combination of rising costs, workforce pressures, and the need to modernise systems and infrastructure.⁴

Practice expenses are increasing due to higher staff pay, premises, utilities, and the need for ongoing investment in digital infrastructure. These rising costs put additional pressure on practices to deliver high-quality care within tighter financial constraints.

Recruitment and retention is challenging, particularly in rural areas. While multidisciplinary teams have expanded, ongoing support is essential to maintain workforce resilience and staff wellbeing, ensuring practices can continue to meet growing demand.⁵

The move to a single IT supplier in 2026 will standardise systems and improve demand management across practices. Continued investment in digital tools and premises is vital to keep general practice accessible, efficient, and fit for purpose.

Recent policy changes have helped to de-risk practice operations, with the introduction of state-backed indemnity and sustained investment in staff pay. These measures support recruitment, retention, and stability across the workforce, helping practices to remain resilient in the face of ongoing pressures

Forward Look

Transforming GMS will require sustained investment and new approaches to funding. We are committed to the approach set out in *A Healthier Wales*, which envisions care closer to home and more integrated health and care services. However, despite this accepted, long-term, overarching vision, the NHS remains, to a large degree, hospital-by-default.

We are determined to reorientate services away from secondary care and deliver a major transformation programme focused on prevention, support and community-by-design. This will mean integrating prevention, diagnostics, and treatment closer to home through multidisciplinary teams and local

⁴ [NHS Wales Staff Survey 2024 National Findings Report](#)

⁵ [Review Body on Doctors' and Dentists' Remuneration](#) pg. 130

collaboration. This approach will ensure care is proactive, accessible, and tailored to the needs of each community. Achieving this transformation depends on putting funding and support in place, so GMS can continue to innovate, adapt, and provide high-quality care for the future.

Efficacy of different models for managing GMS

Direct comparisons between models of general practice are inherently challenging, as much of the available evidence is of low scientific quality and reported outcomes are heavily influenced by local circumstances, patient demographics, and whether practices were initially taken on in response to extenuating circumstances.

A recent summary of the available literature conducted internally by the Welsh Government's Science Research Evidence division⁶ indicates that, although managed practices can foster innovation and support multidisciplinary teams (also supporting better links between primary and secondary care), they frequently incur higher operational costs, for example having higher locum use, and using different pay scales. Furthermore, the diversity in organisational structures, workforce arrangements and funding structures complicates meaningful comparisons with independent contractor models. Measures of continuity, access, quality, and cost vary widely, and the practical implementation of each model can differ substantially. As such, a pragmatic approach would be to tailor the choice of model and scale to local needs, prioritise relationship-based continuity, and enhance outcome measures to inform future evaluation.

Independent contractor model

This long-standing model sees GPs running practices as businesses under NHS contract. It supports local leadership, innovation, and accountability, enabling services to be tailored to community needs and supporting continuity of care, which is linked to better outcomes and patient satisfaction.⁷

⁶ See Annex D: Science Research Evidence, Models of General Practice in Primary Care: Library Literature Search Summary

⁷ [Personal GP continuity improves healthcare outcomes in primary care populations: a systematic review | British Journal of General Practice](#)

However, it exposes partners to financial and legal risks, especially around premises, which can deter new entrants and threaten sustainability as partner numbers decline.⁸

Salaried GP model

Salaried roles offer employment stability and removes personal financial risk, appealing to new GPs seeking a more preferential work-life balance, or portfolio careers which include maintaining specialist clinical skills delivered at cluster level or within secondary care.⁹

Larger practices can enhance management and integration, facilitating further integration with other parts of the NHS;; however, they may also risk reducing continuity of care and local responsiveness. This may be due to salaried GPs in these settings having less long-term commitment to a specific population. Additionally, it is suggested that, partner-led practices offer more agility to innovate and flexibility to change quickly.¹⁰

Hybrid/limited-liability models

Hybrid models, such as limited liability partnerships, federations, and super-partnerships, aim to combine the strengths of both traditional and salaried models. They spread risk, enable shared back-office functions, and support collaborative service delivery at scale, while retaining local leadership and continuity.

Accelerated cluster development supports joint planning and innovation across groups of practices, but commissioning remains at practice level. Successful hybrid and cluster-based models require robust governance, clear accountability, and investment in data and digital infrastructure to balance scale with relationship-based care.

⁸ [RCGP GP Partnership Principles Report May 2025](#) pg. 2 This assessment was part a review of the various models of GP services undertaken by the Royal College against their four principles to strengthen the GP Partnership Model

⁹ [RCGP Survey of ST3 AIT Members: Snapshot into GP jobs and visa issues - External Report](#). This survey indicates that new GPs actively prefer salaried roles, with 93% of applicants seeking such

¹⁰ [The partnership model in general practice predates the NHS. Is now the time to change it? | Nuffield Trust](#)

Suitability and maintenance of GMS estates and access to digital technology

Estates

A review of the NHS (General Medical Services – Premises Costs) (Wales) Directions 2015 is underway. The task and finish group undertaking the review is considering amendments, guidance, and support mechanisms for practices, and reviewing reimbursement arrangements. A key recommendation is to clarify minimum standards, such as heating, lighting, facilities, and security, to help practices meet expectations, supported by updated guidance and training aligned with the GMS Contract Assurance Framework.

Digital and data

GMS integrates in-person, telephone, and digital access, with data-driven improvement. National appointment and activity datasets provide transparency and inform service improvement. Digital transformation is not an add-on. It is central to our vision. We will accelerate the adoption of digital tools and data-driven care, making access easier, safer, and more convenient for all, with the NHS Wales App, electronic prescribing, and the Primary Care Information Portal (PCIP) improving access and efficiency.

The NHS Wales App allows the public to manage appointments, view their records, and order repeat prescriptions, reducing the administrative burden for practices and improving patient convenience.

The National Data Resource (NDR) is creating a secure, cloud-based platform for health and social care data, enabling real-time access to patient records across care settings. This supports continuity, reduces duplication, and enhances clinical decision-making. The next step is a community electronic patient record, providing a single, interoperable record for primary and community care, accessible by the whole neighbourhood team and patients, with open standards and clear governance boundaries.

3. The GMS Workforce

Our healthcare workforce is our greatest asset. We champion new roles, support professional development, and foster wellbeing and collaboration so every GMS team member can thrive. The number of fully-qualified GPs has grown over the last 25 years through targeted recruitment and retention. While there are challenges – workload pressures and rural recruitment – investment in multidisciplinary teams and staff wellbeing is helping to build a more resilient, adaptable workforce.

Workforce Planning

Sustainability

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. The gender balance of GPs has reversed over the last decade, towards a female majority (57% female by September 2024¹¹).

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.

Recruitment and retention

As of June 2025, Wales had 1,572 FTE fully-qualified GPs, which has remained broadly stable over the last four years.¹² Recruitment is supported by targeted trainee incentives, especially for rural and deprived areas. The GP specialty training programme consistently meets its annual target of 160 new trainees, and Locum Hub Wales has expanded the locum pool for flexible staffing.

¹¹ [General practitioners workforce trend by age and gender](#)

¹² [General practice workforce | GOV.WALES](#)

Retention has been boosted by incentives for experienced GPs, including the Partnership Premium and Retainer schemes. While more GP partners left than joined, partner turnover remains lower than for other staff groups.¹³ Burnout remains a concern, highlighting the need for ongoing wellbeing support.

Annual contract uplifts and pay parity help ensure fairness, and continuing professional development is prioritised through structured learning and national events, with a strong focus on interprofessional learning and wellbeing.

Continuing Professional Development

Continuing professional development is essential to maintaining high standards in GMS. Resident GPs follow a structured training programme, including group learning, tutorials, and self-directed study. For fully qualified GPs, the Revalidation Support Unit (RSU) at Health Education Improvement Wales (HEIW) delivers an annual programme focused on clinical priorities and learning needs identified through appraisal. Recent events have covered women's health and safeguarding, with further multi-day sessions planned to support collaborative learning and service improvement.

Growth of the multidisciplinary team

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. Between June 2020 and June 2025, wider practice staff increased by 565 across Wales. By June 2025, there were 991 FTE registered nurses, 929 FTE direct patient care staff, and 3,924 FTE administrative or other non-clinical practice staff.¹⁴

¹³ [General practice workforce: as at 30 September 2024 \[HTML\] | GOV.WALES](#)

¹⁴ [General practice workforce | GOV.WALES](#)

4. The Patient Experience

Patient experience is defined by access, continuity, and quality of care. GMS delivers the highest volume of NHS activity in Wales, with 18.3m appointments attended in 2024-25 and 3.3m patients registered as of July 2025. Most needs are met within GMS, minimising escalation to other NHS services. While challenges remain, such as access barriers for older people, carers, and those experiencing digital exclusion, Welsh Government and NHS Wales are actively working to address these issues.¹⁵

The scale and reach of GMS

Scale and Access

GMS supports the population by providing face-to-face and remote appointments. Significant investment has modernised access pathways providing practices with a combination of telephone, digital, and in-person access.

In 2023–24, practices handled 26.7m calls and 6.1m digital requests. The Unified Contract sets mandatory standards for appointment systems, and practices are required to provide inclusive access routes and reasonable adjustments for neurodiversity and sensory needs.¹⁶

Managing Demand and Continuity

The aim of the *Primary Care Model for Wales* is to ensure people are directed to the right professional, with clinically-led triage and service navigation. The move

¹⁵ These issues are not unique to Wales. International evidence from the OECD's PaRIS survey shows common challenges across primary care systems, particularly for older people with chronic conditions, including barriers to access, gaps in continuity/coordination, and limited or uneven access to digital services that can exacerbate digital exclusion

https://www.oecd.org/en/publications/does-healthcare-deliver_c8af05a5-en/full-report/executive-summary_e7073a79.html?

¹⁶ <https://statswales.gov.wales/Catalogue/Health-and-Social-Care/General-Medical-Services/general-practice-activity>

to a single IT supplier in 2026 will further standardise processes and improve demand management. Practices are encouraged to balance rapid access with sustained relationships, as continuity is increasingly valued by patients and linked to better outcomes.

Recent reforms to pharmacy and optometry contracts have significantly expanded the range and scope of clinical services available in primary care, including independent prescribing and the Common Ailments Scheme. 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.

Continuity of Care

Continuity of care is recognised as a core aim for GMS, given its proven links to better health outcomes, improved patient satisfaction, and reduced use of emergency health services.. Strengthening continuity remains a key priority as part of ongoing quality improvement reforms, ensuring it becomes an embedded feature of everyday practice. . A new quality improvement project will encourage practices to measure and enhance continuity, recognising that continuity and access are complementary and that improved continuity can reduce demand failure and lead to better access.¹⁷

Trust, inclusion, and the patient voice

Public trust in GMS is strong – 86% of people said they were satisfied with their care in the National Survey for Wales (2024–25).¹⁸ Access standards are embedded in the Unified Contract, and practices are expected to provide safe, responsive pathways throughout the day. Patient voice is central to service improvement, with cluster-level engagement and national bodies like Llais amplifying feedback. Wales’ approach is digital-by-choice, not digital-only, ensuring no group is left behind.

¹⁷ [continuity_of_care_final_independent_evaluation_mixedmethodsevalreport_2022.pdf](#)

¹⁸ [National Survey for Wales headline results: April 2024 to March 2025 \[HTML\] | GOV.WALES](#)

5. Opportunities to Improve GMS to Make it fit for the Future and take a more Preventative Approach to Care

Wales is committed to a community-by-design approach, bringing prevention, diagnostics, and treatment closer to home through integrated, community-led services. The goal is a system that is easier to navigate, more proactive, and sustainable, with multidisciplinary teams, digital tools, and contractual levers supporting prevention and continuity.

Future approach

We are leading a whole-system community-by-design transformation programme to align governance, commissioning, and delivery, ensuring GMS and wider primary care are prioritised. This will embed population health management at cluster level, setting a national model for urgent and same-day care, and move more care and services out of hospital into local communities, closer to people's homes. Digital enablement and workforce flexibility will underpin this approach, making care more proactive, integrated, and sustainable.

The Collaborative Directed Supplementary Service (CDSS)

A Collaborative Directed Supplementary Service (CDSS) will accelerate integrated health services by enabling GMS to work collaboratively, shifting diagnostics and treatments into community settings, and unlocking skills and capacity across the system. This approach supports faster access, improved quality, and more efficient use of resources, aligned with health board priorities.

Prevention, Chronic Conditions, and Urgent Care

Prevention will be strengthened by embedding care bundles, such as vaccination, blood pressure checks, and smoking cessation into chronic and urgent care, commissioned at cluster or locality level. Population health management will proactively support the whole population, integrating self-management and personalised care planning. Nationally-agreed clinical pathways which are locally adapted, support the management of many disease areas including chronic conditions via the community health pathways platform, improving outcomes, and reducing variation. This is available to multidisciplinary

teams anchored in community care with additional urgent clinical care support via digital platforms such as Consultant Connect.

For urgent care delivery in the community, a national pathway and minimum standards for urgent care centres will improve navigation and timely access.

Continuity of Care

Promoting continuity of care is a priority. To support this, we are implementing a Quality Improvement Project focused on helping practices to measure, monitor, and enhance continuity for patients. This initiative underlines our commitment to ensure that continuity is not only preserved but strengthened as part of everyday practice, recognising its proven benefits for patient outcomes and satisfaction.

Key Enablers

Key enablers include removing barriers to data sharing, deploying digital solutions, and building sustainable multidisciplinary teams. Working at scale and collaborative contracting will underpin integrated, prevention-focused care, supported by staff wellbeing initiatives.

Measuring Success

Success will be measured by improvements in outcomes, patient satisfaction, sustainable GMS, effective prevention, better patient navigation, and strong primary care leadership. Achieving these goals will require commitment across the system and active engagement at all levels.

Conclusion

The future of GMS in Wales requires the Welsh Government, the NHS and GMS to act and collaborate to transform and evolve the service. 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.

Transforming the health and care system will depend on placing GMS at its centre, ensuring it is resilient, sustainable, and able to meet the needs of the population now and in the future.

6. Annexes

Annex A: How GMS Is Funded and How It Has Evolved in Wales

Origins of the GMS Contract (2004 Onwards)

The 2004 general medical services (GMS) contract was introduced across the UK, replacing the previous, activity-based arrangements with a rules-based national contract. This approach enabled consistent standards to be introduced, while allowing practices to organise locally.

In Wales, GMS is delivered under regulations made by Welsh Ministers, with health boards holding contracts and practices operating as independent contractors delivering NHS services. Welsh Ministers issue directions to health boards on the Statement of Financial Entitlements (SFE), which acts as the practical “Blue Book” for payments, covering the Global Sum, practice-level support, quality payments, and other items. Premises costs are managed separately through the Premises Costs (Wales) Directions, which set out reimbursement for rent, borrowing, and running costs, with national valuation rules and regular reviews.

From 2004 to the Unified Contract (from 2023)

Following the pandemic, the need for a simpler, clearer core offer became evident. The Unified Contract, introduced in 2023, clarifies three pillars – the Unified Services (the core GMS services every practice must provide, including new access standards), Quality Improvement (a national, developmental approach focused on learning and outcomes), and Supplementary Services (commissioned where they add value, with flexibility for health boards to meet local needs).

Accelerated cluster development has formalised cluster-level planning and delivery, linking GMS to community services, public health, social care, and the third sector through professional collaboratives and pan-cluster planning groups.

The Global Sum Allocation Formula (“Carr-Hill”)

The Global Sum Allocation formula, commonly known as the Carr-Hill formula, converts a practice’s registered list into a weighted population so core funding

reflects workload and legitimate cost pressures. Developed by Professor Roy Carr-Hill and colleagues, it considers patient age and sex, additional-needs proxies (such as morbidity and mortality), list turnover, care-home components, and unavoidable cost adjustments like rurality.

Welsh Ministers set a national rate per weighted patient in the SFE, and health boards pay practices accordingly. Other payments, such as practice support, quality improvement, and supplementary services, are specified in the SFE, while premises reimbursements are paid under premises directions. Given changes in deprivation, multimorbidity, and case-mix, Wales has signalled a formal review of the methodology to ensure weighting remains fair, up-to-date, and aligned to the *Primary Care Model for Wales*.

What is in the Funding Envelope

The core contract includes the Global Sum (Carr-Hill weighted), practice support payment, quality improvement, Directed (DSS) and Local Supplementary Services (LSS), enhanced services, out-of-hours (where held locally), and other technical items.

Premises funding covers notional or lease rent, borrowing, running costs including non-domestic rates, and improvement grants. De-risking GMS through policies such as the General Medical Practice Indemnity (GMPI), which was introduced in 2019, cover clinical negligence liabilities for NHS GP work.

Annual GMS settlements have funded uplifts for GPs and practice staff, supporting recruitment, retention, and stability.

Trends Over Time: Levels and Shares

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.

The Welsh Government has stabilised GMS by embedding access standards, investing in digital improvements, introducing state-backed indemnity, funding

staff pay in line with national agreements, and supporting premises costs to help practices manage financial pressures.

Practice Cost Structure: Proportionality and Drivers

Practice expenses now account for around 68% of contract value. The largest component is staff costs, including GP and non-GP pay, pensions, and National Insurance. Recent policy has funded DDRB-equivalent uplifts for the whole practice workforce within the GMS settlement. Premises and estates costs have risen due to energy, insurance, maintenance, and compliance, with reimbursement via premises directions, helping to mitigate exposure. Interest and finance costs have increased where borrowing or mortgages exist, reflecting rate rises. Fuel, travel, and consumables have also seen inflationary increases, with contracted services and supplies rising faster than CPI post-pandemic.

The latest data show average partner income at around £119,800, alongside significant expense growth. Wales has also supported salaried GP pay rises, aiding recruitment where partnership appetite is lower.

Annex B: The GMS Workforce in Wales

Overview and Planning

GMS in Wales relies on a resilient, well-supported workforce. Recent years have seen growth in fully-qualified GPs and consolidation across wider practice roles. The Welsh Government, Health Education and Improvement Wales (HEIW), health boards and the profession are aligning recruitment, retention, training, and wellbeing around a single aim: a sustainable, mixed workforce that delivers timely, person-centred care closer to home.

Current position (at 31 March 2025)¹⁹

- Fully qualified GPs (FTE): 1,581 (+40; +2.6% year on year)
- Partners: 1,019 FTE (+2.4%)
- Salaried: 461 FTE (+16.9%)
- Locums who worked in the quarter: 90 FTE (-35.4%)
- Retainers: 10 FTE (-1)
- GP registrars (FTE): 439 (+2.1%)
- Wider practice staff (FTE): 1,002 nurses (-3.6%); 940 direct-patient-care (-1.5%); 3,912 admin/non-clinical (-1.1%)
- Managed practices: 24 (-1 vs 31 March 2024), employing 77 FTE fully qualified GPs and 417 FTE wider staff (included in totals above).

Recruitment, Retention and Training

Wales has consolidated its annual target of 160 new GP trainees, supported by targeted incentives for hard-to-fill areas and a national jobs platform to widen recruitment. Retention is underpinned by the partnership premium scheme, the GP retainer scheme, and annual contract uplifts that support pay parity and fairness.

¹⁹ Number of GPs employed in general practices (headcount and full-time equivalent), by GP type and area | StatsWales

Despite these efforts, survey data highlight ongoing risks of burnout, reinforcing the need for protected time and wellbeing support. Training and professional development are prioritised through structured learning, in-practice tutorials, and hybrid CPD programmes, with a strong emphasis on team-based and interprofessional learning.

Multidisciplinary Teams (MDT)

Expansion among pharmacists and pharmacy technicians, physiotherapists, podiatrists, occupational therapists, psychologists, paramedics, and healthcare assistants has safely transferred workload, improved access, and resilience, and supported continuity for people with complex care needs.

Over the three years to June 2025, the wider practice staff (FTE) rose by 56 overall. Within that, nurse FTE fell (-37), direct-patient-care rose (+14, largely pharmacy workforce), and admin/non-clinical rose (+78). Practices are also required to maintain inclusive access and reasonable adjustments for neurodiversity and sensory needs.

²⁰

Joiners and Leavers (Between September 2023 and September 2024)

Around 93.3% of GP partners were also partners a year earlier; partner turnover is lower than other groups. The largest inflow was new joiners to salaried GP; the largest inter-group flow was salaried to partner, indicating a healthy progression pathway.

Locum Hub Wales (LHW) and the All-Wales Locum Register

Locum Hub Wales (LHW) was developed to support the temporary sessional needs of practices, with further enhanced functionality following feedback from practice and GP locum users. It enables GP practices across Wales to advertise their sessional needs, and to choose and book a GP locum quickly and efficiently.

NHS Wales Shared Services Partnership is responsible for the management of

²⁰ Over the longer term, only headcount data is available, and this shows more growth, with wider practice growing by 565: direct patient care by 219, administrative staff by 353 and no change for nurses (note the headcounts of the staff groups don't sum to the wider practice staff headcounts because some staff are employed in more than one staff group and the overall wider practice staff category only counts each person once)

LHW and the All-Wales Locum Register and is also the data controller under GDPR.

At June 2025, there were 470 GP locums working in Wales, and while the number has fluctuated over recent years, it remains broadly stable compared to the previous year, following a period of growth from 2021 to 2023.²¹

²¹ [Number of GPs employed in general practices \(headcount and full-time equivalent\), by GP type and area | StatsWales](#)

Annex C: Evolution of Primary Care Clusters in Wales

Purpose and Population Focus

Primary care clusters are a key feature of the *Primary Care Model for Wales*, bringing together GP practices and partners from pharmacy, dentistry, optometry, allied healthcare, social care, public health, and the third sector. They plan and deliver care for populations of between 25k and 100k, aiming to provide tailored care closer to home, with a focus on prevention and also coordinate services to minimise duplication and fragmentation.

Timeline and Development

- **2014:** Clusters established to organise care at a population footprint large enough to share resources but close enough to remain personal.
- **2015–17:** Welsh Government investment supports innovation, “pacesetter” projects, and shared workforce models, moving clusters from planning to delivery.
- **2018–21:** Consolidation through shared data, joint planning, and maturing governance.
- **2022:** Accelerated cluster development launched, introducing a national toolkit, maturity framework, and formalised governance.
- **2023 onward:** Recurrent funding embeds clusters in health boards’ planning and accountability frameworks, aligning work with Regional Partnership Boards and the Unified Contract.

Functions and Delivery

Clusters collaborate on shared priorities: access, prevention, long-term conditions, inequalities, and urgent/same-day care. The 25k to 100k population footprint supports shared multidisciplinary team capacity, community diagnostics, social prescribing, and targeted outreach. Standardised pathways and operating procedures reduce variation and support practical local delivery.

Governance and Improvement

Accelerated cluster development provides a toolkit and self-reflection process, supported by peer review. Professional collaboratives bring together clinical and professional leaders to align skills to local need. Pan-cluster planning groups prioritise investment, commission supplementary services, and track outcomes,

linking cluster plans to health board strategies and Regional Partnership Boards. Core metrics underpin improvement cycles and transparent reporting.

Illustrative Programmes

- **Access modernisation:** Cluster-wide telephony upgrades, reception navigation training, and same-day care models.
- **Urgent care centres :** Same-day alternatives to emergency departments, co-designed with NHS 111.
- **Prevention bundles:** Opportunistic blood pressure/atrial fibrillation detection, vaccination catch-up, smoking cessation, and weight management.
- **Long-term conditions:** Standardised community pathways for cardiovascular, diabetes, chronic obstructive pulmonary disease, musculoskeletal disorders, and mental health.
- **Inequalities:** Deep End-style initiatives, targeted outreach, and practical links to money advice and housing support.

Commissioning and Funding

The Unified Contract defines the core offer every practice must provide, including access standards and quality improvement. Directed Supplementary Services (DSS) and Local Supplementary Services (LSS) are commissioned at cluster footprint when population need justifies at-scale delivery. Core cluster funding supports coordination, data/analytics, and improvement capacity, while programme funding channels DSS/LSS resources through clusters for agreed place-based services. Cluster plans and outcomes feed into health board performance arrangements.

Data, Digital, and Access

Routine publication of appointment mode/volume, call handling, and digital request data enables comparison and targeted support. Standardisation of telephony and online requests, alongside safeguarding non-digital routes and reasonable adjustments, is being advanced across the system. The move to a single GP IT supplier from 2026 is expected to standardise workflows and strengthen demand management.

Workforce and MDT at Scale

Skill-mix is planned across clusters to match demand, with pharmacists, musculoskeletal practitioners, advanced nurse practitioners, mental health practitioners, paramedics, and healthcare assistants. Locum Hub Wales and shared bank arrangements help fill gaps quickly, while accelerated cluster development supports protected learning time and cross-practice supervision. Cluster models preserve relationship-based care for complex patients while widening first contact capacity for same-day need.



Llywodraeth Cymru
Welsh Government

Science Research Evidence

Models of General Practice in Primary Care: Library Literature Search Summary

September 2023



gov.wales

Limitations

This document aims to summarise the results of a recent library search which looked at the grey literature around different models of general practice in primary care. They are not scientific research articles as there is insufficient evidence available to draw upon. Results should be interpreted with caution and in the context of informing further work. Some light reference searching of the library results was undertaken however this is not an evidence summary nor a systematic review. Critical appraisal of the literature found by the library search is outside of the scope of this paper.

Introduction

A literature search was undertaken on the 3rd September 2023 by the Welsh Government Information, Library and Archive Services. The purpose was to identify the evidence available to compare the quality, cost and effectiveness of Health Board managed practices versus independent general medical services (GMS) contracts. Specific interests were the implications of transitioning GP practices from a GMS contract to a Health Board managed practice in terms of: short and long term finances; quality of care (including continuity of care; access to services and patient perceptions of care).

This was requested by the Senior Medical Officer for Primary Care, Mental Health, Substance Misuse & Vulnerable Groups Division and the work led by the Science Research Evidence (SRE) Division within the Health, Social Care and Early Years group.

Background

Health boards in Wales are experiencing pressures within GP practices which threaten their sustainability. In Aneurin Bevan specifically, it is reported that increasing numbers of GP partners are retiring. High numbers of patients with complex conditions placing a greater demand on clinical time as well as poor condition of practice premises have been cited as factors contributing to workforce issuesⁱ.

Occasionally, GP practices are handed over to the health board because GP partners have retired and a suitable replacement to take over the GMS contract has not been found. This can occur with as little as three months' notice. This historically was a temporary measure and the Health Board only had one at a time but in recent times this has become more common and it has proven increasingly difficult to return managed practices to GMS contract holders despite advertising widely and providing new premises. There is a move towards GP partners merging practices and sometimes GP surgeries closing entirely because of difficulties staffing themⁱⁱ. A review of primary care services in Hywel Dda in 2019 found that the number of managed practices increased from 2 to 3 in 2017 due to 'handing back' of the contract which occurred when one of three partners relocated overseas and the others felt unable to continue, as an example. No reason is given for the other

managed practicesⁱⁱⁱ. In an article by the Royal College of General Practitioners, 'The future of the partnership model' (2023), it was reported that GP partnerships in Wales now stand at 386 compared with 420 in 2018^{iv}.

Similar challenges are discussed in England, where the extreme strain General Practice is under, is attributed to people finding it harder to book GP appointments, reduced patient satisfaction, threat to professional wellbeing and challenges around continuity of care for people with complex conditions.

An article by The Health Foundation discusses that appointments in general practice are at a record high but the number of full-time equivalent qualified GPs has fallen since 2015. It reports that reforms to general practice have been suggested which include transitioning away from the traditional GP partnership model to one where GPs are salaried NHS employees. A similar integration of general practice and community services has been noted in Spain, the US, New Zealand, and Denmark. The aim is to enhance service collaboration, better manage population health needs, share back-office resources like facilities and IT, improve the sustainability of general practices, and adapt to evolving career paths and training preferences. There is a range of ways the traditional model is being adapted in the UK, some where acute hospital trusts manage general practices, which is referred to as vertical integration and some where they are combined with community or combined acute and community trusts, referred to as horizontal integration. The approach, context and how these work in practice, as well as their outcomes in terms of performance, varies between countries^v.

A BMA report 'Save our Surgeries' (2023) reported that there is a lot of variation across health boards in the number of managed practices, ranging from none in Cardiff and Vale to 15 in Betsi Cadwaladr University Health board. The cost of running them also varies considerably^{vi}.

Methods

A library search was conducted which aimed to identify literature which may help with comparing the quality, cost, and effectiveness of Health Board managed practices with independent general medical services (GMS) contracts. Specifically, what the implications are of transitioning GP practices from a GMS contract to a Health Board managed practice considering: short and long-term finances; quality of care (including continuity of care); access to services; patient perceptions of care.

The date range used was 2018-2024 with a geographical range of Wales and Scotland. There is very little scientific evidence in the form of research in this area internationally which would be generalisable to the specific NHS system in the UK and Wales. Publication types used therefore were in the grey literature; comprising largely, published articles and government reports. Details of the search methods are included in the library report in the appendix.

Summary (from the library search)

The library team gave the following summary:

“Information on this topic appears to be limited, using the limits outlined above, and the search strategies and sources listed at the end of this document. The most relevant report located was that published by BMA Cymru in 2023 as part of their “Save Our Surgeries” campaign. There are also mentions of managed practices, within the Audit Wales and Healthcare Inspectorate Wales reports listed, although these are not the main focus of the reports. An article published by the Health Foundation in 2023 – “Should NHS trusts manage general practice?” has also been included, although the main focus of this is of vertical and horizontal integration. This aspect has not been included in this search but, if relevant, could be conducted as a separate search. Some additional search suggestions have also been included in the “Next Steps” section below, which may also yield relevant material. Retrieving publications on websites – especially older ones, may be limited. I encourage you to scan through all results and to select items based on your own relevance and quality evaluations. I would also advise scanning the references in the most relevant publications.”

Based on the references provided from this library search, the Science Policy Interface team of the Science Research Evidence division present this summary of the main findings. The advantages and disadvantages of practices being managed by Health Boards are discussed, focusing on their cost and quality in comparison to GMS contracts. From the literature found, it was not possible to compare the short- and long-term finances, access to services or patient perceptions of care. Further research is likely needed to be able to fully answer these questions. All of the literature summarised is from grey literature and does not form strong evidence to support decision making, but may provide an indicator of areas for future work.

Cost of the Partnership Model compared to Health Board Managed Practices

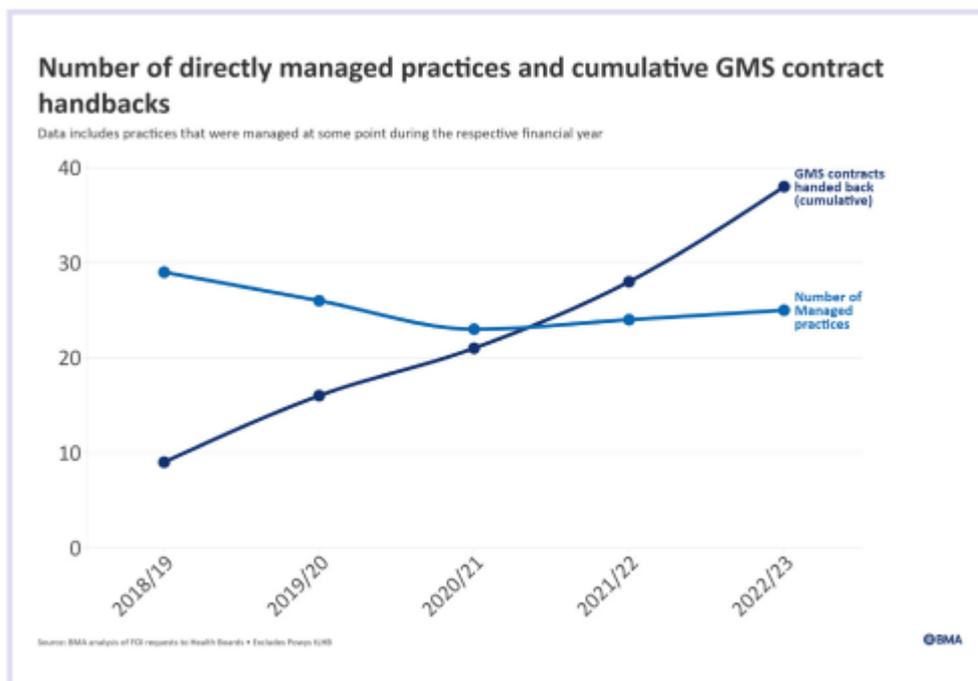
The ‘Future of the partnership model’ (2023) article by the Royal College of General Practitioners (RCGP), highlights that there have been political comments around a need for significant change and redesign of the way GP services are delivered. Their stance is that ‘reform’ proposals fail to address the underlying problems facing the GP system, which they state to be historic underfunding and workforce issues. They give quotes which highlight the value for money of the partnership model, since it relies on the vested interest of GPs in the success of their practice, which results in GPs going ‘above and beyond’. They state that a mixed provision solution alongside the partnership model might be a solution^{vii}.

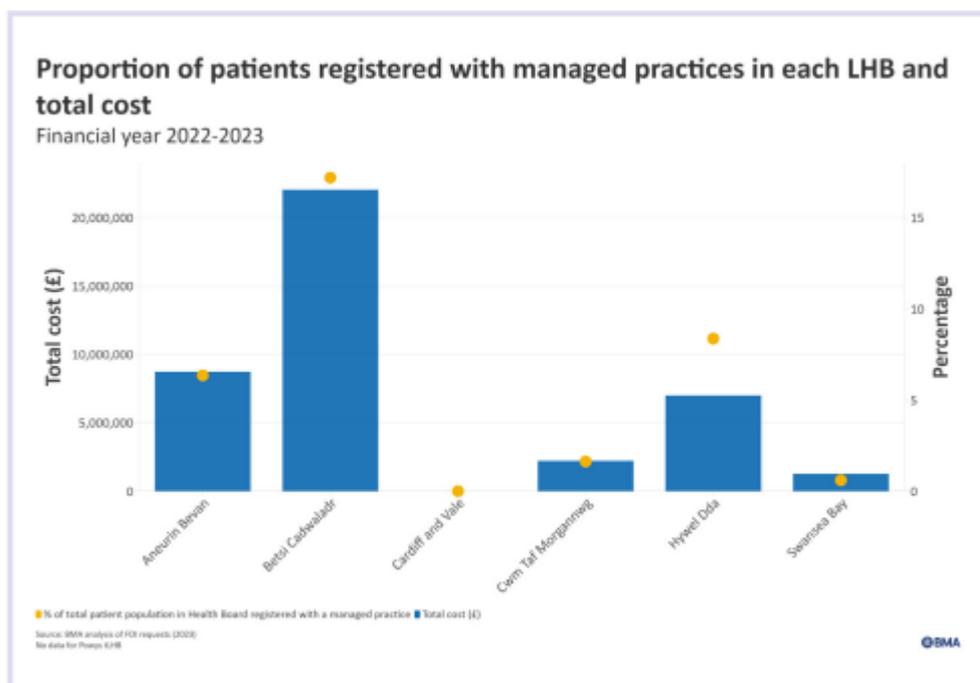
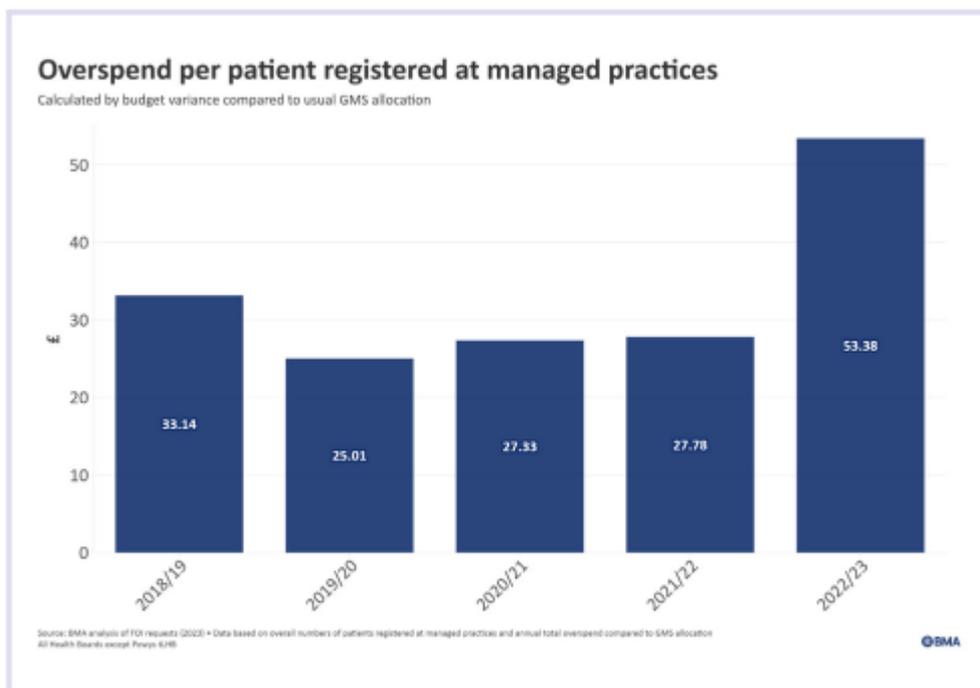
A news article which wasn’t included in the literature search but was found from reference searching the above article was a 2018 issue in ‘Management in Practice’. It discusses the overspends by health boards in Wales, attributing a £1.3m overspend in 2017/18 in Betsi Cadwaladr University Health board and £1.1m in Hywel Dda University health board, to an increase in managed practices. They report that there was heavy reliance on locum sessional GPs and salaried GPs which provides some substance to the argument that managed practices are more expensive to run. They report that the average overspend of each of the managed practices in a year was £100,355 and one of them had overspent by £599,296.

There are also however, quotes from the Betsi Cadwaladr executive director for primary care which report that there were factors which were not included in the BMA report such as costs relating to training and raising staff wages. There was also a quote from a director of primary care, community and long-term care at Hywel Dda University health board which states that there was an aim to return managed practices back to independent status with a GMS contract in 2019 as well as proposal for a locum cap^{viii}.

The RCGP article also references an independent review into the partnership model, which describes the partnership model as a cost-effective but not aligned to secondary care which is funded by activity rather than the registered patient list. This, it states, can cause conflicts in setting priorities and integrated working since the financial incentives do not align. It also highlights the challenges of GP practices operating as a small business including the indemnity costs, premises and staff costs, citing the personal risk partners take on in an unlimited liability partnership as a barrier to GPs becoming partners. This is further compounded by the increasing workload which also can be a barrier to GPs entering partnerships as well as a reason they are reducing the sessions they work and retiring early^{ix}.

A further article which discusses the cost of managed practices was part of the 'Save our Surgeries' report. They advise that in managed practices there was a cumulative overspend compared to their GMS allocation of £31.62m from 2018/19 to 2022/23. Costs were said to have escalated particularly rapidly in 2022/23 with an overspend of £10.96m, equivalent to 24%. They state there is a lot of variation between health boards, with some overspending by over 80% in 2022/23. This brings the average overspend per patient at managed practices to £53.38^x.





Source: [gp-report-save-our-surgeries-gpc-wales-english-final-web.pdf](https://www.bma.org.uk/gp-report-save-our-surgeries-gpc-wales-english-final-web.pdf)
[bma.org.uk](https://www.bma.org.uk)

This issue of overspend was also raised in the article from Aneurin Bevan University Health Board, which estimates that the cost of a managed practice is £200,000 a year more than through GMS contracts. They attribute this to reliance on higher-cost

locums^{xi}. BMA Wales estimates that managed practices are 30% more expensive to run than those operating under the traditional mode^{xii}.

Conversely, in the strategic vision for managed practices (2023), they state that when a practice is changed from independent contractor status to health board management, the budget has not been adjusted to accurately reflect the practice's maximum capabilities and income. It is reported that they can have budgets set which are lower than an independent contractor GP practice. This can make it appear that managed practices are more expensive to run than independent contractor GP practices. There are ongoing actions within Hywel Dda University Health Board to address the budgetary requirements for managed practices such as capping of locum doctor fees. Despite this, staff costs remain high because staff are recruited elsewhere to new posts under Agenda for Change conditions, which GP practices do not have to follow^{xiii}.

The primary care services report for Betsi Cadwaladr Health board expands on this, stating that expenditure on managed practices had increased over three years. The Health board attempted to do some work to understand the costs associated with supporting managed practices however they struggled to compare costs with that of running an independent practice because they are run so differently^{xiv}.

Quality of the Partnership Model compared to Health Board Managed Practices

The 2019 independent review highlights the benefits of the partnership model in terms of continuity of care across generations, which they state improves outcomes and reduces the burden of demand on other services. The stability of the partnership model is said to facilitate this and is one of the reasons doctors train as GPs however this continuity of care is threatened by the recruitment and retention challenges at present^{xv}.

In terms of quality, one argument made supporting health board managed practices is the relief of the financial and business responsibilities of running a practice, such as HR. This is said to free up time for clinical work, reduce financial risk and enhance patient services while keeping them within the NHS^{xvi}.

The Health Foundations report 'Should NHS trusts manage general practice?' summarises some of the early emerging evidence on impact of NHS trust managed general practices. In terms of quality and patient satisfaction they report increased bureaucracy, threats to existing multidisciplinary team working and risk of staff leaving alongside an impact on the relationships between patients and their GP practice on a local level. There are however some advantages such as enhanced cohesion between primary and secondary care, more training and development opportunities for the primary care team and greater potential for service innovation. They report some early evidence of reduced emergency hospital admissions or readmissions for patients of vertically integrated practices compared to a synthetic control group which they attribute to more effective coordination. There is however a need for research on patient experience and outcomes in these approaches^{xvii}.

A paper presented at a University Health Board meeting, 'Strategic vision for managed practices' also discusses that although the health board is dedicated to supporting independent contractor status, it is acknowledged that managed practices have significantly contributed to essential services like the Alternative Primary Care Service and Covid-19 vaccinations. These practices have been crucial in developing workforce strategies and diversifying GMS delivery data. Moving forward, a mixed model of service provision via various contracts was planned to be included in a Primary Care strategy reviewed by the Board in early 2023.

In terms of workforce, managed practices have also enabled the health board to trial different models of working, such as employment and embedding of of pharmacists, pharmacy technicians, physicians assistants and advanced practitioners (paramedics and nurses) into the Primary Care teams. They report success in recruiting into the multidisciplinary team however this model is reliant on strong clinical leadership and GP presence for oversight of clinical care. There is potential for more work to be done to develop hybrid working models that integrate in hours managed practices with out of hours services across clinical professional groups^{xviii}.

Hywel Dda University Health Board developed a consultation service for its three managed practices called GP Hub Wales. Its aim was to improve primary healthcare access within GP practices via remote telephone GP consultation and triage support. It allowed bookings equivalent to the hours a whole time GP with full secure access to practices' electronic systems to work as though they were working in the practice. This highlights one of the potential benefits of managed practices.

Contrasting this, an annual report of GP inspections in 2017-18 raised concerns about the rapidly expanding and sometimes conflicting responsibilities for commissioning and directly managing GP services. They reported an increasing workload and pressure on the health board associated with managed practices. They highlight that sufficient management capacity and capability must be ensured to directly manage practices and that the sustainability of it should be considered in the long term^{xix}. Increased workload pressures on the health board as well as potentially unsustainable management requirements might contribute to quality issues if this was to become more widespread.

The article 'From the Frontline: The changing landscape of Scottish general practice' expands on this further, highlighting that managed practices can also reduce the capacity to train future GPs as 2C practices are often unable to maintain their training status. They recommend that proactive measures are taken to provide support to GP practices at an earlier stage to avoid health board having to manage them^{xx}.

Smith and Sidhu (2023) discuss some of the early evidence on vertical integration within the UK, which they say points to several issues and risks which may affect quality of GP services:

- fear of loss of GP and practice autonomy
- increased bureaucracy associated with larger NHS bodies
- a reduction in local patient and community attachment to their practice

- potential damage to relationships with other local GP practices
- threats to existing multidisciplinary team working
- staff leaving if they feel 'taken over'^{xxi}.

The 'Future of the partnership model' article from the RCGP acknowledges some similar points, highlighting that the strength of the partnership model is the relative autonomy, freedom to innovate and connection with the community, but acknowledges the system as it currently operates is not sustainable. It provides quotes from two case studies; a GP partner who celebrates the success of the partnership model and discusses the benefits to quality of care in terms of the GP partners' goodwill, which he thinks would be lost in a different model. There is also a case study of vertical integration where a GMS contract was subcontracted to the hospital trust. They report they have a degree of autonomy but had a lead GP who worked at the trust level. They believe patient experience in their practice did not change significantly. These are both only individual cases, so research would be needed to compare quality between partnership practices and trust managed ones to be able to draw any conclusions^{xxii}.

In terms of quality, concerns were also raised in the Healthcare Inspectorate Wales Annual Report 2017-18 concerning the high use of locum GPs in managed practices, which reduces continuity of care for patients^{xxiii}.

Returning managed practices to contracts

Through the literature found in the library search, the topic of returning managed practices to contracts is also discussed. In 'Strategic vision for managed practices' (2023), they report that such attempts had previously failed due to lack of commercial interest in the practice. The bidder costs were higher than the value of the GMS contract. They discuss that under the Accelerated Cluster Development programme, it is possible to award Alternative Provider Medical Services (APMS) contracts and the potential of Community Interest Companies (CICs) to deliver services. They report that a consistent national approach to procurement is needed as current methods do not align well with commissioning of contractor services. National discussions are ongoing in this area^{xxiv}. The same report also states that the current estate and configuration of managed practices would also need to be considered to make them more attractive to independent contractors as restrictions related to outdated buildings restrict opportunities for workforce and service development. They also state the importance of ensuring managed practices are operating at the highest possible standard, targeting GMS level contractual requirements as well as internal Health board requirements, with remedial timescaled action plans and evidenced improvements for areas which are underperforming.

Primary care support units

Some of the sources discuss the use of Primary Care Support Units (the name of which can vary), which assist with clinical and managerial roles as an alternative^{xxv}.

There were some concerns that these were recruited from the existing pool of GPs, further affecting the sustainability of the practices they were originally working in^{xxvi}.

The article 'Directly managed, NHS owned practices' by the BMA (2023) states that direct NHS management is not currently supported. They present the Northumbria Primary Care (NPC) model as a case study, whereby the NPC is a not-for-profit provider within the NHS. They cite that the establishment of the NPC model was complicated and bureaucratic and had issues relating to pension arrangements. The contract also requires GP premises to remain partner-owned, complicating premises outsourcing. They advise that future contracts should consider better financial and system support for such changes. The current contract makes replicating the NPC model difficult, reinforcing that a privately held GP model may be easier to establish than one within the NHS.

Conclusion

There are a number of factors to consider when comparing GMS contracts with Health Board managed practices and a sparsity of scientific evidence available to assist in decision making. It appears that although it could be said that there may be potential for better coordination between primary and secondary care in a managed practice as well as opportunity to diversity multidisciplinary teams within a GP practice, they are often staffed with locum doctors which increases costs and decreases continuity of care, affects local relationships and patient centredness of care may suffer. There are challenges involved in creating direct cost comparisons of the two models.

There are some alternative options such as the NPC model but the system does not currently facilitate this approach, making it costly and time consuming to set up. There is also concern about unintended consequences of moving towards a salaried GP model such as further loss of GPs. In terms of the grey literature, most sources agree that broader policy action particularly in terms of long-term staffing plans and government investment is needed to address the mismatch between demand and availability of GPs, which it is said, managed practices would not solve^{xxvii}.

The Strategic vision for managed practices (2023) notes that there is some work ongoing with the Primary and Community Services Academy established with HEIW funding which it is hoped, will help address some workforce challenges. It also discusses the ongoing sustainability issues with the GMS model and difficulties of considering managed practices in isolation of a wider Primary Care Strategy^{xxviii}.

Next Steps:

Most of the questions the literature search was aiming to address were not possible to answer based on the results of this search. Cost comparisons and some risks and considerations in terms of quality have been discussed. The short- and long-term finances, evidence around the quality of care, access to services and patient perceptions of care do not appear to be available at this stage and might indicate areas for future research.

The library team have offered the following options:

1. Broaden the geographical range and content type to include news articles and plenary sessions.
2. Conduct a more systematic search of NHS Board Local Health Board Meetings and papers.
3. Explore additional databases or websites for relevant material.

There is also the possibility to consider sourcing primary research and or consultation to explore attitudes and opinions on the future of GP services.

ⁱ [Aneurin Bevan University Health Board – Primary care services | Audit Wales](#)

ⁱⁱ [Aneurin Bevan University Health Board – Primary care services | Audit Wales](#)

ⁱⁱⁱ [Hywel Dda University Health Board – Review of Primary Care Services | Audit Wales](#)

^{iv} [The future of the partnership model | GP Frontline \(rcgp.org.uk\)](#)

^v [Should NHS trusts manage general practice? - The Health Foundation](#)

^{vi} [gp-report-save-our-surgeries-gpc-wales-english-final-web.pdf \(bma.org.uk\)](#)

^{vii} [The future of the partnership model | GP Frontline \(rcgp.org.uk\)](#)

^{viii} [Health boards go into deficit to sustain directly-managed GP practices - Management In Practice](#)

^{ix} [gp-partnership-review-final-report.pdf \(publishing.service.gov.uk\)](#)

^x [gp-report-save-our-surgeries-gpc-wales-english-final-web.pdf \(bma.org.uk\)](#)

^{xi} [Aneurin Bevan University Health Board – Primary care services | Audit Wales](#)

^{xii} [The future of the partnership model | GP Frontline \(rcgp.org.uk\)](#)

^{xiii} [hduhb.nhs.wales/about-us/your-health-board/board-meetings-2023/board-agenda-and-papers-30-march-2023/agenda-and-papers-30-march-2023/item-45-managed-practice-strategypdf/](#)

^{xiv} [Betsi Cadwaladr University Health Board – Primary care services | Audit Wales](#)

^{xv} [gp-partnership-review-final-report.pdf \(publishing.service.gov.uk\)](#)

^{xvi} [exploring-innovation-in-general-practice-design-final.pdf \(bma.org.uk\)](#)

^{xvii} [Should NHS trusts manage general practice? - The Health Foundation](#)

^{xviii} [hduhb.nhs.wales/about-us/your-health-board/board-meetings-2023/board-agenda-and-papers-30-march-2023/agenda-and-papers-30-march-2023/item-45-managed-practice-strategypdf/](#)

^{xix} [Annual Report General Medical Practices \(GPs\) Inspections 2017-2018 | Healthcare Inspectorate Wales \(hiw.org.uk\)](#)

^{xx} [RCGP-scotland-frontline-june-2019.pdf](#)

^{xxi} [Should NHS trusts manage general practice? - The Health Foundation](#)

^{xxii} [The future of the partnership model | GP Frontline \(rcgp.org.uk\)](#)

^{xxiii} [Annual Report 2017-2018 | Healthcare Inspectorate Wales \(hiw.org.uk\)](#)

^{xxiv} [hduhb.nhs.wales/about-us/your-health-board/board-meetings-2023/board-agenda-and-papers-30-march-2023/agenda-and-papers-30-march-2023/item-45-managed-practice-strategypdf/](#)

^{xxv} [Hywel Dda University Health Board – Review of Primary Care Services | Audit Wales](#)

^{xxvi} [Aneurin Bevan University Health Board – Primary care services | Audit Wales](#)

^{xxvii} [Should NHS trusts manage general practice? - The Health Foundation](#)

^{xxviii} [hduhb.nhs.wales/about-us/your-health-board/board-meetings-2023/board-agenda-and-papers-30-march-2023/agenda-and-papers-30-march-2023/item-45-managed-practice-strategypdf/](#)

Agenda Item 3.1

Cyflwynwyd yr ymateb i ymgynghoriad y [Pwyllgor Iechyd a Gofal Cymdeithasol ar ddyfodol meddygaeth deulu yng Nghymru](#)

This response was submitted to the [Health and Social Care Committee on the future of general practice in Wales](#)

GP34a : Ymateb gan: BMA Cymru Wales | Response from: BMA Cymru Wales



Senedd Cymru Health and Social Care Committee: Future of General Practice in Wales Inquiry - Questions following BMA Cymru Wales evidence session

21 October 2025

Estates

- **What are the most urgent improvements needed to the general practice estate in Wales to ensure premises are safe, accessible and fit for modern service delivery?**

The general practice estate in Wales faces critical challenges in safety, accessibility, and suitability for modern service delivery. Key issues include:

Physical Condition and Safety: A 2021 Welsh Government report found that 13% of GP premises were in Category C condition— “operational but major repair or replacement needed soon”. While no RAAC was found in a 2024 GPC Wales survey, many buildings continue to fall short of basic accessibility and energy-efficiency standards. Older converted houses and prefabricated structures often fail to provide compliant clinical and waiting-room space, falling short of accessibility standards.

Space Constraints: Many practices lack sufficient space to host training placements, multidisciplinary teams (MDTs) or additional consulting rooms for mental health and wellbeing practitioners. This constrains expansion of services and inhibits the growth of the workforce on a practice-by-practice basis, limiting service expansion and workforce development.

Digital Infrastructure Deficits: Poor internet connectivity and outdated IT infrastructure - especially in rural practices, limits the ability to use digital tools such as e-prescribing, remote monitoring, and online consultations.

Ownership and Liability Risks: The shift from GP-owned to leasehold premises has not eliminated risks particularly regarding escalating service charges. Owner-occupiers face “*last person standing*” liabilities, despite the Welsh Health Circular¹ policy instruction for health boards to provide support in these circumstances, which can leave a single partner with full financial and operational responsibility.

¹ WHC (2020) 018 www.gov.wales/sites/default/files/publications/2020-10/support-for-gp-premises-liabilities.pdf

- **What changes to premises-related funding and support arrangements could help reduce financial risk for practices and promote long-term sustainability?**

To reduce financial risk and promote sustainability, the following reforms are recommended:

Updated Premises Cost Directions: BMA Cymru Wales calls for a national estates' strategy and revised Premises Cost Directions to reflect modern needs and risks, including space for MDTs, teaching and digital infrastructure. A Wales-specific approach should provide flexibility for sustainability upgrades and ensure cost recovery for accessibility improvements.

Ringfenced Capital Investment: Health board capital budgets in recent years have almost exclusively been spent on upgrading secondary care estate, with no allocation for GMS premises for improvement grants and vital infrastructure improvements. General practice estates are treated as an afterthought and this needs to change.

Health Board Support Mechanisms: The 2020 Welsh Health Circular outlines options for health boards to support partners facing premises liabilities. However, we maintain that this should be strengthened so that every health board operates a clear, funded process for assuming or underwriting premises liabilities where partners are unable to do so. This would avoid circumstances such as the "*last person standing*" risk and provide stability for succession planning within GMS practices.

Transparent Reporting: Health boards should publish annual audited reports detailing GMS spending: to include per-practice premises investment, and related liabilities. This would enhance accountability and enable evidence-based targeting of future estate investment.

Multi-disciplinary teams (MDTs)

- **What do you see as the main barriers to effective multi-disciplinary team working in general practice in Wales, and how can these be addressed to support more integrated care?**

Several systemic and operational barriers limit the effectiveness of MDTs:

Role Clarity and Integration: Fragmented and inconsistent commissioning and integration of community services, district nursing, mental health, and social care teams can create confusion over accountability. Variation in Agenda for Change pay scales between health board-employed staff and GP partnership-employed staff also hinders recruitment and retention within practices.

In addition, several intermediate or community services ostensibly set up to remove workload from hospitals have no effective escalation policies or procedures when patients can't be managed by MDT members - with support and responsibility usually defaulting back to GPs and their practices. This has undermined trust in the MDT model and silently increased GP workload without any resource shift to manage that demand.

Estate Limitations: Many practices lack adequate physical space to co-locate AHPs, pharmacists, and wellbeing practitioners, preventing the day-to-day interaction that builds true multidisciplinary care, especially in practices with outdated infrastructure

Digital Fragmentation: While native GMS systems could be said to be at the forefront of digital care in the NHS, the interface with systems used by community teams and other MDT components can be difficult. All too frequently systems cannot interact, and e-mail or paper must be relied on for information sharing.

Workforce Pressures: High workloads and recruitment challenges reduce the capacity for team-based care

- **How can the contribution of allied health professionals be maximised while maintaining appropriate clinical leadership and oversight by GPs?**

To fully leverage Allied Health Professionals (AHPs) while maintaining GP oversight, we must ensure:

Funding: AHP roles operating within general practice in Wales also need sustainable, allocated funding as opposed to ad-hoc pilot schemes which are usually patchy and time limited. Each MDT should have at least one designated GP clinical lead with time allocated for governance and mentorship to reflect the additional pressures on an often already stretched workload.

GP leadership of the team: GPs are skilled risk managers with a longitudinal knowledge of their patients. GPs work autonomously and therefore oversight of others reduces individual GP efficiency and output. Increasing the role of the MDT requires more GPs to backfill delivery as well as protected time - too often GPs are expected to juggle these duties with existing service delivery without sufficient time or clinical headspace.

Training and Development: Expanding training placements for AHPs in general practice must be matched with estate upgrades to accommodate increased demand.

Collaborative Culture: Promoting mutual respect, shared goals, and inclusive leadership is essential for successful MDTs. Clarity of purpose and role when dealing with a population who present in an undifferentiated manner is also paramount, so that AHPs are not invidiously placed in a position outweighing their competence and skills.

Agenda Item 3.2

Cyflwynwyd yr ymateb i ymgynghoriad y [Pwyllgor Iechyd a Gofal Cymdeithasol ar ddyfodol meddygaeth deulu yng Nghymru](#)

This response was submitted to the [Health and Social Care Committee on the future of general practice in Wales](#)

GP38a: Ymateb gan: Coleg Brenhinol y Meddygon Cyffredinol | Response from: Royal College of General Practitioners

Improvements Needed to the General Practice Estate in Wales

What are the most urgent improvements needed to the general practice estate in Wales to ensure premises are safe, accessible, and fit for modern service delivery.

There is an urgent need for investment in the general practice estate in Wales to ensure premises are safe, accessible, and fit for modern service delivery. Many practices are operating from buildings that are outdated, inflexible, and no longer meet the demands of contemporary multidisciplinary care.

1.Space and Capacity

The most immediate priority is space. Practices need sufficient room to train, supervise, and accommodate the growing multidisciplinary workforce. Without adequate clinical and shared working space, practices cannot safely or effectively deliver care or provide essential training placements for future clinicians.

2. Safety and Security

GP premises must be secure for both staff and patients. This includes appropriate reception layouts, discrete consultation spaces, and controlled access points. Many practices are now open longer hours, with smaller staffing levels at times, so investment in staff safety measures such as alarm systems, CCTV, and secure entry is important, especially with growing numbers of verbal and physical attacks by patients towards primary care staff.

3. Modernisation and Digital Readiness

Buildings must support modern models of care, including digital consultations and remote monitoring. Reliable connectivity, appropriate soundproofing, and confidential spaces for online consultations are now basic requirements. Many current premises are not digitally enabled and lack the infrastructure to support integrated or hybrid care.

4. Accessibility and Inclusion

Practices must be physically accessible to all patients, including those with disabilities, sensory impairments, or mobility difficulties. This requires compliance with accessibility standards, accessible toilets, parking, and child-friendly design. With the move to increasing

care closer to home, premises should also be adaptable for the needs of an ageing population and for community-based services such as vaccination clinics or group consultations.

5. Sustainability and Energy Efficiency

Modernising the estate offers an opportunity to align with Wales's commitment to sustainability and net-zero targets. Energy-efficient heating, insulation, lighting, and the use of renewable technologies would reduce environmental impact and running costs, freeing up more resources for patient care.

6. Flexibility for Future Models of Care

Primary care premises need to be adaptable to evolving patterns of service delivery, allowing co-location with other health and social care professionals, community mental health teams, or voluntary sector partners. Flexible, modular design would allow practices to expand or reconfigure as local needs change.

7. Tackling Inequality

Investment must also address inequity in the estate, with targeted support for practices in deprived and rural areas, where buildings are often least suitable and where recruitment and retention challenges are greatest.

Premises-Related Funding and Support Arrangements

What changes to premises-related funding and support arrangements could help reduce financial risk for practices and promote long-term sustainability.

Current premises funding arrangements place significant financial risk and administrative burden on GP partners, many of whom hold personal liability for ageing or inadequate buildings and for Private Finance Initiative leases. This, coupled with the particular liability of 'Last Person Standing' situations deter new partners, threatens practice viability, and undermines the sustainability of the independent contractor model.

To address this, we would support an opt-in model similar to the approach taken in Scotland, where the Government offers to purchase GP-owned premises and lease them back to practices on fair and flexible terms. This would allow practices to remain independent with all the associated financial benefits this model offers the taxpayer, while relieving individual partners of long-term financial risk associated with property ownership, repair, and compliance costs. Such an arrangement could:

- Encourage new partners to join practices without being deterred by property liabilities.
- Stabilise the estate by enabling systematic upgrades, accessibility improvements, and energy efficiency measures.

- Facilitate workforce and service transformation, with government-owned or co-owned premises designed to support multidisciplinary and integrated models of care.

Additional supportive measures could include:

- Capital grants and low-interest loans for refurbishments, energy efficiency upgrades, or digital modernisation.
- A dedicated Welsh Premises Improvement Fund, to ensure equitable access across urban, rural, and deprived areas.
- Clearer national guidance and consistency in health board support for rent reimbursement, service charges, and premises development.
- Flexibility in lease arrangements to accommodate evolving service models and co-location with wider primary care or community services.

Barriers to Effective Multidisciplinary Team Working in General Practice

What do you see as the main barriers to effective multi-disciplinary team working in general practice in Wales, and how can these be addressed to support more integrated care.

The main barriers to effective multidisciplinary team working in general practice are time, space, and workload. Practices need protected time for teaching, supervision, in-house appraisal, and team development, all of which are essential to ensure safe, confident, and cohesive teamworking. Yet these activities are often squeezed out by clinical pressures. Physical space constraints compound the challenge, with many practices struggling to accommodate additional staff or provide suitable environments for consultation, collaboration, or training.

Workload intensity remains the single biggest barrier. The sheer volume and complexity of patient demand leave little capacity for leadership, mentorship, or service improvement. Many practices lack the resources to recruit sufficient staff to meet demand, meaning that time for team-building and reflective learning becomes a luxury rather than an integral part of care.

The current GMS funding arrangements do not allow for anything but patient facing work, and this restricts GMS GPs. Even one centrally funded nonclinical session per GP per week would transform the ability of GPs to be involved in leadership and MDT work. The concept that only seeing patients is the only work GPs should be doing is quite entrenched in the public and GPs psyche and this will only change with governmental leadership and action.

Alongside these core issues, several systemic factors hinder effective multidisciplinary integration.

- Short-term and fragmented funding streams for MDT roles create instability and prevent long-term planning, e.g. Cluster funded roles.

- Inconsistent role clarity and induction can lead to confusion, duplication, or inefficiency.
- Poor interoperability of IT systems between primary care, community and secondary services undermines coordination and communication.
- Variation in Health Board structures and governance means practices experience differing levels of support and accountability.
- Cultural and professional divides between disciplines can persist, especially when time for shared learning is unavailable.

To support genuine multidisciplinary working, practices need stable, long-term funding, shared digital infrastructure, and adequate protected time for collaboration and supervision. Equally, they require fit-for-purpose premises as highlighted above to house expanding teams and provide confidential, accessible spaces for patient care. MDT team members not only bring their own skills which could enhance patient care but also contribute to the core functions of the system including continuity of care, care coordination and prevention.

Maximising the Contribution of Allied Health Professionals While Maintaining Clinical Leadership: How can the contribution of allied health professionals be maximised while maintaining appropriate clinical leadership and oversight by GPs.

Allied Health Professionals (AHPs) bring valuable skills that can enhance patient access, broaden clinical expertise, and improve the quality and sustainability of primary care.

To maximise their contribution while maintaining appropriate GP leadership and oversight, we need to focus on clear role definition, structured supervision, protected time for collaboration, and supportive funding and governance frameworks.

Effective multidisciplinary teams work best when every member's scope of practice is clearly defined and mutually understood.

Consistent national frameworks for AHP roles in general practice, covering training, competencies, and supervision expectations would help ensure safe delegation, efficient use of skills, and public confidence.

Clinical leadership by GPs remains essential, particularly in complex care, undifferentiated illness, and safeguarding. GPs should retain responsibility for overall clinical governance and quality assurance, ensuring that patient safety and holistic care remain at the centre of service delivery. To do this well, practices need time and resource for clinical supervision, enabling AHPs to develop and work to their full potential while maintaining safe oversight.

Maximising AHP input also requires investment in team infrastructure: shared induction programmes, access to integrated clinical records, and co-located working wherever possible.

Fragmented IT systems, siloed contracts, and short-term funding all hinder continuity and shared learning.

Equally important is leadership development for AHPs themselves. Creating structured opportunities for leadership training, joint case reviews, and multidisciplinary quality improvement work will foster mutual respect, shared purpose, and resilience across teams.

Agenda Item 3.3

Cyflwynwyd yr ymateb i ymgynghoriad y [Pwyllgor Iechyd a Gofal Cymdeithasol](#) ar [ddyfodol meddygaeth deulu yng Nghymru](#)

This response was submitted to the [Health and Social Care Committee](#) on the [future of general practice in Wales](#)

**GP62: Ymateb gan: Cymdeithas Meddygon Dosbarthu Ltd | Response from:
The Dispensing Doctor's Association Ltd**





DISPENSING DOCTORS' ASSOCIATION

Submission to the Senedd Health and
Social Care Committee Inquiry

The Future of General Practice in Wales

Dispensing Practice In Wales

Addressing The Disparities

October 2025

**Victory Mill, Priestmans Lane, Thornton-Le-Dale,
Pickering. YO18 7RU**

**Registered No: 3406619 | Registered in England
and Wales**

Pack Page 72

Contents

1. Executive Summary
2. About DDA Wales
3. What is a Dispensing GP Practice?
4. How Dispensing Works Financially
5. Contractual and Financial Ties to England
6. Dispensing Fee and Erosion of Value
7. Discount Abatement and Clawback Inequities
8. Electronic Prescription Service (EPS)
9. Digital Exclusion and Innovation Gap
10. Modernising the Dispensing Quality Services Scheme (DSQS)
11. Summary of Recommendations
12. References

1. Executive Summary

- ▶ Dispensing GP practices play a critical but increasingly fragile role in the delivery of primary care across rural Wales. More than 17% of all GP practices in Wales provide dispensing services to patients who live more than 1.6 km from a pharmacy — often much further. These practices are the only NHS access point for medicines in many rural areas, ensuring continuity of care for geographically isolated communities.
- ▶ Despite their importance, dispensing practices are tied to a contractual framework set in England, leaving them without a direct voice in Welsh policy decisions. Costs have risen sharply over the past decade, while dispensing fees have barely changed. Without reform, the continued erosion of dispensing income, combined with exclusion from innovation funding, risks destabilising rural healthcare provision.

A dispensing practice serving 4,000 rural patients may be responsible for every prescription and repeat medicine within a 20-mile radius — the same workload as an urban practice with two to three pharmacies nearby, but with none of the same infrastructure or funding support.

2. About DDA Wales

- ▶ The Dispensing Doctors' Association (DDA) represents over 1000 dispensing GP practices across the United Kingdom.
- ▶ DDA Wales supports 68 dispensing GP practices, each with a main site and between them an additional 41 branch sites across Wales. These dispensing practices serve rural and remote communities where population density is too low to sustain a community pharmacy.
- ▶ In these areas, the GP practice provides both clinical care and medicines supply under strict NHS regulations.
- ▶ DDA Wales works with BMA GPC Wales and the Welsh Government to advocate for fair funding, contractual reform, and the integration of dispensing into national primary care policy.

These 68 dispensing practices represent just under 17% of all GP practices in Wales but serve approximately 191,000 patients — nearly 6% of the Welsh population.

3. What is a Dispensing GP Practice?

- ▶ 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 1.6 km 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 and hence provide essential pharmaceutical services to rural patients.
- ▶ Dispensing practices:
 - ▶ Prescribe and dispense medicines on-site under NHS regulation.
 - ▶ Offer medication reviews and patient support.
 - ▶ Manage repeat prescribing safely and efficiently.
 - ▶ Provide continuity of care, often as the only NHS healthcare provider within large catchment areas.
- ▶ Most dispensing practices do not employ pharmacists; instead, they train and supervise qualified dispensers working under strict Standard Operating procedures (SOPs) and GP oversight, ensuring both safety and efficiency.

In many Welsh villages, the dispensing GP surgery is the only NHS facility within 15-20 miles — meaning without it, patients would need to travel over 30 minutes to access their medicines.

4. How Dispensing Works Financially

- ▶ Dispensing practices purchase medicines from wholesalers and supply them directly to patients. They are reimbursed by the NHS through two mechanisms:
 - ▶ **1. Reimbursement:**
Covers the medicine's cost at the NHS Drug Tariff price. Practices may buy below tariff, but available discounts have reduced sharply in recent years.
 - ▶ **2. Remuneration:**
The dispensing fee — intended to cover staff, overheads, and GP clinical responsibility. Historically, 60% of the fee covers operational costs and 40% represents GP remuneration for responsibility and risk.
- ▶ The average Welsh dispensing practice dispenses around 7,000 items per month, with an annual drug spend exceeding £500,000. All operational, staffing, uniforms, training, compliance, and consumable costs must be met from the dispensing fee, which has not risen in real terms for over a decade.

In April 2012, the dispensing fees ranged from £1.95-£2.29 per item

In April 2025, the same fee scale ranged from £2.07-£2.34 per item.

Expenses have more than doubled in that period, while the dispensing fee has risen by barely 1–5%.

5. Contractual and Financial Ties to England

- ▶ Dispensing practices in Wales operate under a model entirely tied to English contract negotiations.
 - ▶ There is no independent Welsh decision-making power for dispensing.
 - ▶ The dispensing fee paid to Welsh practices mirrors the English scale and is copied into the Welsh Statement of Financial Entitlements (SFE).
 - ▶ Changes made in England are automatically reflected in Wales.
 - ▶ If GP pay or fee uplifts differ between nations, the 40% GP portion of the dispensing fee still follows England's rate, not Wales's.
- ▶ Dispensing funding is governed by an 'envelope' in England — a fixed national pot adjusted every six months to maintain total value, based on national dispensing volumes.
 - ▶ If total volume decreases, the per-item fee is increased
 - ▶ If total volume increases, the per-item fee is reduced

WE ASK THE SENEDD COMMITTEE TO:

Recommend the creation of an independent Welsh dispensing contract and funding envelope, enabling Welsh negotiation, oversight, and review.

6. Dispensing Fee and Erosion of Value

- ▶ In 2012, the dispensing fee ranged from £1.95 to £2.29 per item.
In 2025, it stands at £2.07–£2.34 — an increase of between 1% and 5% over thirteen years.
- ▶ Over the same period:
 - ▶ The National Minimum Wage rose from £6.19 (2012) to £12.21 (2025) — up 97%.
 - ▶ Employer National Insurance rates increased twice, most recently in 2025.
 - ▶ Energy and compliance costs have doubled.
- ▶ If the dispensing fee had risen in line with staffing and overhead costs, it would now average around £3.90 per item — almost double the current rate.
- ▶ This sustained erosion leaves practices under acute financial strain, forcing consideration of staffing reductions, reduced hours, or even handing back dispensing rights.
- ▶ *Example:* For an average site dispensing 7,000 items per month, the 2025 fee shortfall represents a real-terms annual funding loss of over £130,000 compared with 2012 value.

WE ASK THE SENEDD COMMITTEE TO:

Recommend that the Welsh Government recalibrates the current dispensing envelope to reflect 2025 market costs before developing any new contractual model.

7. Discount Abatement and Clawback Inequities

- ▶ Dispensing GP practices face persistent inequity through the discount-abatement (clawback) mechanism. This system was created decades ago, when wholesalers and manufacturers offered large purchase discounts to both pharmacies and dispensing doctors. Those discounts have since diminished, but the clawback system has not been modernised.
 - ▶ Community pharmacies face a flat 5.9% clawback on reimbursed medicines.
 - ▶ Dispensing GPs face a sliding scale that rises to 11.18%, regardless of whether any discount was actually received. Most practices are clawed back the full 11.18%.
- ▶ Two further mechanisms widen this inequality:
 - ▶ **Discount Not Deducted (DND) list:**
Medicines such as insulins, vaccines, and biologics are recognised as not attracting wholesale discount. Pharmacies dispensing these are reimbursed in full and exempt from clawback. Dispensing practices remain subject to the full 11.18% deduction on those same medicines. So far in 2025, over 1,300 medicines have been listed on the DND schedule representing a significant and recurrent loss.
 - ▶ **Concessionary prices:**
When medicine shortages inflate costs, both pharmacies and dispensing GPs can claim a temporary “concessionary” price. However, because these items are automatically placed on the DND list, pharmacies are protected from clawback while dispensing practices still lose the extra 11.18% on a known loss-maker.
- ▶ *Example:* A dispensing GP dispensing £10,000 worth of insulin and vaccines in a month can lose over £1,100 in clawback deductions that a pharmacy would not face.

WE ASK THE SENEDD COMMITTEE TO:

Recommend immediate extension of DND protections to dispensing GP practices in Wales, while reviewing options to abolish the clawback system altogether.

8. Electronic Prescription Service (EPS)

- ▶ The Electronic Prescription Service (EPS) operates in two stages:
 - ▶ **1. Prescription generation and transmission:**
GPs can now send digital prescriptions to the NHS “spine.” This is fully funded for all practices, dispensing and non-dispensing.
 - ▶ **2. Prescription download and dispensing:**
To receive and process these prescriptions, the dispensary needs separate software and hardware capable of downloading the prescription items, generating the labels, and claiming the reimbursement. Without it, prescriptions can be sent to the spine but cannot be downloaded for dispensing or be claimed electronically.
- ▶ Dispensing GP practices must self-fund all the necessary hardware and software.
 - ▶ EPS-ready systems such as Titan cost around £2,500 per branch to install, £250 per month per branch in ongoing fees, plus 4p per dispensed item.
 - ▶ For an average two-branch practice dispensing 7,000 items per month, this equates to set up costs of £5,000 plus over £9,500 annually in running costs — all currently unfunded.
- ▶ Many PMR systems already used by pharmacies are now capable of receiving EPS prescriptions, meaning there is no additional set-up costs.
- ▶ The pharmacy sector also received up to £1,250 per site in EPS setup funding.
- ▶ There is no funding available for comparative payments to dispensing practices.

WE ASK THE SENEDD COMMITTEE TO:
Recommend that the Welsh Government provides dedicated funding for both the setup and operational costs of EPS for dispensing practices

9. Digital Exclusion and Innovation Gap

- ▶ Community pharmacies across Wales have benefited from successive waves of digital investment — including robotic dispensing, barcode systems, and 24-hour collection ATMs — improving efficiency, safety, and access for patients.
- ▶ Dispensing GP practices, however, have been excluded from these innovation funds.
Despite providing the same NHS medicines supply service, they must rely on manual processes with no access to capital for automation or infrastructure support.
- ▶ Automation has proven benefits: it reduces dispensing errors, improves workflow, and frees staff time for patient-facing work.
- ▶ Even entry-level systems remain unaffordable.
 - ▶ A small semi-automated robot costs around £35,000–£60,000, while full automation systems exceed £90,000.
 - ▶ Automated prescription collection machines add a further £30,000–£50,000, far beyond what rural practices can fund from static dispensing income.
- ▶ As a result, rural patients continue to face limited collection times and manual service delivery, while urban pharmacies move ahead with digital efficiency.
- ▶ Without access to capital investment, rural dispensing practices cannot modernise alongside community pharmacy, widening the digital divide, entrenching health inequality and potentiating workforce strain in these rural areas.

WE ASK THE SENEDD COMMITTEE TO:

Recommend that the Welsh Government establish a Digital and Automation Innovation Fund for Dispensing GP Practices, to support investment in:

- Safe automation and robotic dispensing systems
- Secure 24-hour prescription collection units
- Barcode verification and digital stock control tools

10. Modernising the Dispensing Services Quality Scheme (DSQS)

- ▶ The Dispensing Services Quality Scheme (DSQS) was introduced to support safe and high-quality dispensing standards in GP practices, rewarding good governance, staff training, and patient safety audits.
However, the payment has been frozen at £2.58 per patient per year since 2006, with no inflationary uplift for almost two decades.
- ▶ In real terms, that value has eroded by more than 40%, leaving the scheme unable to cover even a fraction of the compliance and training costs it was designed to support.
If DSQS had risen in line with inflation, the payment today would be around £4.47 per patient per year.
- ▶ The requirements placed on dispensing practices to meet the DSQS payment all require investment and staff time and include:
 - ▶ Mandatory audits, controlled drug monitoring, and medicines governance reviews,
 - ▶ Increasing staff training and revalidation requirements,
 - ▶ Drug usage reviews.
- ▶ Each of these adds administrative time and cost.
Dispensing GP practices must fund these requirements entirely from within their dispensing income — income that has itself stagnated.
- ▶ The frozen DSQS payment therefore fails both in fairness and in purpose: it does not reflect modern compliance expectations, nor does it support safe, high-quality dispensing in the way originally intended.

WE ASK THE SENEDD COMMITTEE TO:

Recommend an immediate uplift of the DSQS payment from £2.58 to £4.47 per patient per year, with a guarantee that it will:

- Be indexed to inflation or DDRB recommendations annually, and
- Include recognition of new governance and safety standards introduced since 2006.

11. Summary of Recommendations

DDA Wales asks the Committee to recommend the following actions to ensure the sustainability and parity of dispensing GP practices in Wales:

1. **Stabilisation and Immediate Support**

We ask the Committee to recommend an emergency stabilisation payment for dispensing GP practices — similar to that received by community pharmacies — to protect services while longer-term reforms are implemented.

2. **Establish a New Welsh Dispensing Contract**

We ask the Committee to recommend that the Welsh Government develops a Wales-specific dispensing contract, independent of English negotiations, moving from the current item-based model to a capitation-based funding system that reflects rural workload, patient need, and the true costs of safe dispensing.

3. **Fair Baseline Funding Before Reform**

We ask the Committee to recommend that any new capitation model begins from a realistic, uplifted baseline, reflecting 2025 operating costs, staffing levels, and overheads, rather than converting the existing underfunded dispensing fee into a new structure without adjustment.

4. **Reform the Discount Abatement (Clawback) System**

We ask the Committee to recommend immediate access for dispensing GP practices to Discount Not Deducted (DND) protections, followed by a full review of the clawback system with a view to abolition, ensuring parity with community pharmacy and removing penalties where no discounts are achieved.

5. **Modernise the Dispensing Services Quality Scheme (DSQS)**

We ask the Committee to recommend an uplift of the DSQS payment from £2.58 per patient per year to £4.47, indexed annually to inflation or DDRB recommendations, to accurately reflect the true cost of maintaining safe, compliant dispensing.

11. Summary of Recommendations

(continued...)

6. **Fund EPS Implementation for Dispensing GP Practices**

We ask the Committee to recommend full capital and ongoing funding for Electronic Prescription Service (EPS) functionality within dispensing GP systems, enabling parity of access with community pharmacies and ending digital exclusion for rural practices.

7. **Create a Digital and Automation Innovation Fund**

We ask the Committee to recommend that the Welsh Government establish a Digital and Automation Innovation Fund for Dispensing GP Practices, providing targeted investment for automation, barcode verification, and secure 24-hour prescription collection technology to improve efficiency, safety, and patient access.

8. **Support Workforce Sustainability and Efficiency**

We ask the Committee to recommend contractual flexibility that allows longer prescribing intervals and efficiency measures without financial penalty, supporting better use of staff time and improved continuity of care.

9. **Ensure Welsh Representation in All Dispensing Negotiations**

We ask the Committee to recommend formal representation for Wales in all future UK-wide dispensing and reimbursement negotiations, ensuring that Welsh priorities and rural realities are reflected in decision-making.

10. **Reinstate IT Infrastructure Funding for Dispensing Practices**

We ask the Committee to recommend that IT hardware and software required for dispensing operations should be returned to the core NHS Wales IM&T budget, ensuring equitable support with non-dispensing practices and community pharmacies.

12. References

1. **Welsh Government (2023).** *General Medical Services (GMS) Contract: Statement of Financial Entitlements (Wales)*. Defines the dispensing fee framework in Wales and its link to the English model.
2. **Department of Health and Social Care (2012).** *Statement of Financial Entitlements (Amendment Directions) 2012*. Establishes the last negotiated changes to the dispensing fee and payment structure.
3. **NHS Business Services Authority (NHSBSA) (2025).** [*Drug Tariff and Dispensing Data for England and Wales*](#). Provides current dispensing fee ranges, discount abatement rates, and item volume statistics.
4. **Community Pharmacy England (2025).** [*Discount Not Deducted \(DND\) List Update – October 2025*](#). Confirms over 700 active DND items and outlines the protection mechanism for pharmacies.
<https://cpe.org.uk>
5. **ABPI (2024).** [*Code of Practice for the Pharmaceutical Industry*](#). Explains the reduction in manufacturer and wholesaler discounting that has eroded the original rationale for discount abatement.
6. **Community Pharmacy Wales (2024).** [*Pharmacy Contract Reform and Stability Payment Framework*](#). Details pharmacy funding uplifts (including the 24% increase since 2017 and 2025 stability payment).
7. **Welsh Government (2022).** [*Pharmacy Contract Reform: Enhanced and Advanced Services Framework*](#). Describes the shift to service-based payments and innovation funding for community pharmacies.
8. **Welsh Government (2023).** *Primary Care Workforce Strategy for Wales*. Addresses [*workforce pressures in rural healthcare, including recruitment challenges*](#).
9. **NHS Wales Shared Services Partnership (NWSSP) (2023).** *IM&T Infrastructure Support Framework*. Outlines NHS-funded IT for GP practices and notes the exclusion of dispensing systems from central funding.
10. **Community Pharmacy Wales (2023).** [*Digital Transformation and EPS Implementation Programme*](#). Confirms EPS funding for pharmacy PMR systems, contrasting with lack of GP dispensing funding.

12. References

11. **DDA (Dispensing Doctors' Association) (2024).** [*Podcast Series: Dispensing Finance and Fee Structure Explained \(Episode 1\).*](#)
Explains the 60/40 dispensing income model and real-terms erosion of funding.
12. **BMA Cymru Wales (2025).** [*Submission to the Senedd Health and Social Care Committee: The Future of General Practice in Wales.*](#)
Provides background on GP contract pressures and workforce impact, including rural access issues.
13. **NHS Employers / DDRB (2012–2025).** *Annual Reports on GP Pay Awards.*
Details annual GP pay recommendations relevant to the 40% remuneration component of dispensing income.
14. **Office for National Statistics (ONS) (2025).** *Consumer Price Index and Average Earnings Data (2012–2025).*
Used to quantify the real-terms fall in the dispensing fee relative to cost growth.
15. **Welsh Government (2024).** [*Pharmacy Automation and Innovation Grants Pilot Evaluation.*](#)
Evaluates automation benefits in community pharmacies and the lack of an equivalent GP scheme.
16. **NHS Digital (2024).** *Electronic Prescription Service (EPS) Technical and Financial Overview.*
Details implementation costs and funding structures for EPS, showing exclusion of dispensing GP practices.
17. **Senedd Health and Social Care Committee (2024–25).** [*Inquiry into the Future of General Practice in Wales – Evidence Programme.*](#)
Sets the policy context for this submission and identifies omission of dispensing from earlier inquiry evidence.
18. **Dispensing Doctors' Association Wales (2025).** *Internal Briefing: Financial Pressures on Dispensing Practices in Rural Wales.*
Collates Welsh-specific data on costs, closures, and service reductions among dispensing practices.
19. **Welsh Government (2006).** [*Dispensing Services Quality Scheme \(DSQS\) Introduction and Guidance.*](#)
Defines DSQS aims and payment structure — last uplifted in 2006.
20. **DDA Wales (2025).** *Survey of Dispensing GP Practices.*
Provides anonymised examples of fee erosion, staffing impacts, and service risk in Welsh rural practices.

Agenda Item 3.4

Y Pwyllgor Iechyd a
Social Cymdeithasol

Health and Social Care Committee

Senedd Cymru

Bae Caerdydd, Caerdydd, CF99 1SN
Seneddlechyd@senedd.cymru
senedd.cymru/Seneddlechyd
0300 200 6565

Welsh Parliament

Cardiff Bay, Cardiff, CF99 1SN
SeneddHealth@senedd.wales
senedd.wales/SeneddHealth
0300 200 6565

Abigail Harris

Chief Executive, Swansea Bay University Health Board

Alex Howells

Chief Executive, HEIW

23 October 2025

Dear Ms Harris, Ms Howells

We have been contacted by the March 2023 cohort of Adult Nursing students at Swansea University, who tell us that no Band 5 adult nursing positions have been made available to newly qualified nurses within Swansea Bay University Health Board through the recent NHS Wales Streamlining process. As a result, they tell us that up to seventy students are facing unemployment following completion of their nursing training, which has been funded by NHS Wales under the Welsh Government's bursary scheme. They also say there are limited vacancies in the surrounding health board areas, making those positions highly competitive.

The students who have contacted us are, understandably, extremely concerned about their future and their ability to work within the Welsh NHS workforce. Many of them live locally to Swansea and have trained within the health board area but now find that they are unable to access employment locally. They are also worried about the implications for their bursary conditions which, they tell us, require employment within three months of qualification and for that employment to be within Wales for a minimum of two years post-qualification.

If the above position is correct, it would be extremely concerning not just for the 2023 cohort who are currently facing an uncertain future, but for nursing students more broadly as well as the wider workforce. It would also highlight significant deficiencies in the workforce planning and staff recruitment and retention processes.

As a Committee, we are well aware of the staffing shortages and working pressures facing the NHS workforce in Wales, and we have heard, as part of previous inquiries, of the efforts by HEIW and health boards to both recruit new staff and to retain existing staff. A decision not to offer entry-level nursing posts to newly qualified students would seem to fly in the face of this.

In light of this, and as a matter of urgency, can you:

1. confirm the position as regards Band 5 nursing vacancies for the 2023 training cohort – are any such vacancies available in Swansea Bay University Health Board; do you intend to make any vacancies available in the near future and, if so, how many;
2. outline what advice has or will be made available to the current cohort on next steps and the options that are available to them;
3. confirm whether this position is similar across other health boards in Wales, not just in relation to nursing but as regards wider healthcare roles; and
4. outline what advice has or will be given to the current cohort about the position regarding their bursary funding if they are unable to meet the terms of their bursary agreement due to a lack of suitable posts being made available by the health board.

A copy of this letter goes to the Cabinet Secretary for Health and Social Care, the Chair of the Children, Young People and Education Committee, and the Executive Director of RCN Wales.

I look forward to your swift response.

Yours sincerely



Peter Fox MS
Chair, Health and Social Care Committee

Croesewir gohebiaeth yn Gymraeg neu Saesneg. We welcome correspondence in Welsh or English.

Pencadlys HEIW

HEIW Headquarters
Ty Dysgu
Cefn Coed
Nantgarw CF15 7QQ

Bwrdd Iechyd Prifysgol Bae Abertawe

Swansea Bay University Health Board
Un Porthfa Talbot | One Talbot Gateway
Parc Ynni, Baglan | Baglan Energy Park
Port Talbot SA12 7BR

03rd November 2025

Peter Fox MS
Chair, Health and Social Care Committee
Senedd Cymru
Cardiff Bay
Cardiff
CF99 1SN

Dear Mr Fox

Thank you for your letter of 23rd October regarding the job vacancies available for the March 2023 cohort of Adult Nursing students. These graduates form part of a wider cohort of graduating nurses who have studied a specific field of nursing practice as part of their nursing degree. There are four fields of nursing, namely adult nursing; children's nursing; learning disabilities nursing; and mental health nursing. Firstly, please be assured that HEIW, SBUHB, HDUHB, and other NHS system partners continue to work collaboratively to identify employment opportunities for these graduating nurses.

Thank you for your specific questions, which are addressed in turn below:

- 1. The position regarding band 5 Nursing vacancies for the 2023 training cohort – are any such vacancies available in Swansea Bay University Health Board: do you intend to make any vacancies available in the near future and, if so, how many**

Swansea University is commissioned to provide Nurse Education for both Swansea Bay and Hywel Dda University Health Boards. This education is across the four fields of practice. The table below details the current position in relation to numbers of graduating students per field, and vacancies available in Swansea Bay and Hywel Dda:

Cadeirydd/Chair: **Dr Chris Jones**
Prif Weithredwr/ Chief Executive: **Alex Howells**
Pencadlys HEIW/HEIW Headquarters, Ty Dysgu, Cefn Coed Nantgarw CF15 7QQ

Cadeirydd/Chair: **Jan Williams**
Prif Weithredwr/Chief Executive: **Abigail Harris**
Pencadlys Bae Abertawe, Un Porthfa Talbot, Port Talbot, SA12 7BR
Swansea Bay UHB Headquarters, One Talbot Gateway, Port Talbot, SA12 7BR

	Swansea University Graduates	SBUHB available posts	HDUHB available posts	Total available posts	Current position (30.10.25)
Adult	65	0	22	22	-43
Mental Health	12	31	3	34	+22
Child	0	0	0	0	0
Learning Disability	3	11	2	13	+10

Collaborative work is ongoing between Swansea Bay and Hywel Dda University Health Boards, HEIW and NHS Wales Shared Services Partnership (NSSSP), to identify additional vacancies for graduates. The geographical distribution of available posts is also being reviewed in relation to graduates' home postcodes to understand the suitability of posts in specific geographical locations across the Southwest Wales region.

2. Outline what advice has or will be made available to the current cohort on next steps and the options that are available to them.

Information on the streamlining process (the mechanism for recruiting graduates into NHS roles) is provided at several points during students' programme of study. This includes information sessions with each individual University during the summer to prepare students for the process. When streamlining was delayed by one month – from an opening date of 22nd September to 20th October - communications were sent to students, Health Boards, and Universities.

Following the decision to extend streamlining by 2 weeks a further communication was sent to students, Health Boards and Universities. The revised timeline will see:

- Streamlining closed to students on 24th November.
- Health board recruiting managers shortlisting period between 14th and 28th November.
- Allocation based on application and recruiting manager shortlisting on 2nd December
- Outcomes provided on 16th December.

When the outcome of the streamlining process is confirmed, an escalation process starts immediately. For any students not placed at that point. Escalation provides individualised support to help find appropriate employment.

3. Confirm whether this position is similar across other health boards in Wales, not just in relation to nursing but as regards wider healthcare roles.

The position for all other fields of nursing is more positive for the March graduating cohorts, with the small discrepancies between graduates and vacancies likely to be addressed within a short period of time. There are issues with job opportunities for Physicians Associates, resulting from different factors that are being considered through other mechanisms, and there were also issues with Paramedics this year which we have worked with the Welsh Ambulance Service to resolve.

Cadeirydd/Chair: **Dr Chris Jones**
 Prif Weithredwr/ Chief Executive: **Alex Howells**
Pencadlys HEIW/HEIW Headquarters, Ty Dysgu, Cefn Coed Nantgarw CF15 7QQ

Cadeirydd/Chair: **Jan Williams**
 Prif Weithredwr /Chief Executive: **Abigail Harris**
Pencadlys Bae Abertawe, Un Porthfa Talbot, Port Talbot, SA12 7BR
Swansea Bay UHB Headquarters, One Talbot Gateway, Port Talbot, SA12 7BR

In relation to the other commissioned disciplines some Health Boards are seeing improvements in some previously hard to fill areas. This demonstrates the positive impact of increased education and training, the national retention programme and international recruitment. However, as this does potentially impact on the availability of vacancies for graduates in some areas/some professions strong collaborative work between all NHS organisations will be required to ensure a smooth transition for our summer 2026 graduates. We will be playing a key role in bringing partners together to ensure a proactive approach.

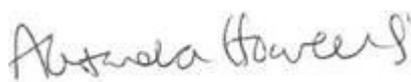
4. Outline what advice has or will be given to the current cohort about the position regarding their bursary funding if they are unable to meet the terms of their bursary agreement due to a lack of suitable posts being made available by the health board.

Our shared priority is to ensure that as many graduates as possible are supported to find roles in NHS Wales as we strive to ensure that they are retained for Wales and supported to have long, productive and rewarding careers.

The current cohort has received information on the bursary terms and conditions. We have assured them that students can be released from the obligation to work in Wales on graduation. It is emphasised that one of these circumstances is if there are insufficient employment opportunities available in Wales on completion of their programme.

We trust this information is a helpful update on the collaborative work that is being undertaken to identify employment for our nursing and other health professional graduates.

Yours sincerely



**ALEXANDRA HOWELLS
CHIEF EXECUTIVE
HEIW**



**ABIGAIL HARRIS
CHIEF EXECUTIVE
SWANSEA BAY UHB**

Cadeirydd/Chair: **Dr Chris Jones**
Prif Weithredwr/ Chief Executive: **Alex Howells**
Pencadlys HEIW/HEIW Headquarters, Ty Dysgu, Cefn Coed Nantgarw CF15 7QQ

Cadeirydd/Chair: **Jan Williams**
Prif Weithredwr/Chief Executive: **Abigail Harris**
Pencadlys Bae Abertawe, Un Porthfa Talbot, Port Talbot, SA12 7BR
Swansea Bay UHB Headquarters, One Talbot Gateway, Port Talbot, SA12 7BR

Dawn Bowden AS/MS
Y Gweinidog Plant a Gofal Cymdeithasol
Minister for Children and Social Care



Llywodraeth Cymru
Welsh Government

Ein cyf/Our ref: MA/DB/2691/25

Peter Fox MS
 Chair, Health and Social Care Committee
 Welsh Parliament

4 November 2025

Dear Peter,

Further to my letter of 2 May in which I provided responses to recommendations 9, 17 and 20 of the Health and Social Care Committee's stage one scrutiny report on the Health and Social Care (Wales) Bill, I am writing to provide an update on progress made to prepare Local Health Boards (LHBs) for new Continuing Healthcare (CHC) direct payment responsibilities, in line with agreed timescales for recommendation 20.

Recommendation 20

Preparations for the introduction of direct payments for CHC are progressing and Local Health Boards (LHBs) are working at pace to ensure that the necessary staff, systems, and processes are in place to support the implementation. My officials are supporting this implementation planning in parallel with the development of subordinate legislation, which is expected to come into force in April 2026.

Bimonthly links with CHC lead officers from all LHBs are supplemented by regular engagement with my officials to discuss key issues relevant to LHBs' new responsibilities. These engagement sessions provide opportunities to hear from guest speakers with direct payment experience from both within and outside Wales, enriching the implementation planning process. Information sessions from Local Authority (LA) direct payments leads have been particularly well received. LHBs have also been kept apprised of matters relating to the subordinate legislation including the consultation on the content of the draft regulations and the development of supporting guidance.

My officials maintain close contact with the lead LHB Chief Executive for CHC and the National Director for CHC, alongside wider discussions at both NHS and LA leadership level including ADSS Cymru. I was also pleased recently to approve £150,000 funding in this financial year to be utilised by LHBs for agreed preparatory work including a dedicated post to further coordinate implementation within the LHBs. This funding forms part of Welsh Government's three-year transitional funding package, as outlined in the Explanatory Memorandum and Regulatory Impact Assessment (EMRIA) that supports the Health and Social Care (Wales) Act 2025.

Yours sincerely,

Canolfan Cyswllt Cyntaf / First Point of Contact Centre:
 0300 0604400

Bae Caerdydd • Cardiff Bay
 Caerdydd • Cardiff
 CF99 1SN

Gohebiaeth.Dawn.Bowden@llyw.cymru
Correspondence.Dawn.Bowden@gov.wales

Rydym yn croesawu derbyn gohebiaeth yn Gymraeg. Byddwn yn ateb gohebiaeth a dderbynnir yn Gymraeg yn Gymraeg ac ni fydd gohebu yn Gymraeg yn arwain at oedi.

We welcome receiving correspondence in Welsh. Any correspondence received in Welsh will be answered in Welsh and corresponding in Welsh will not lead to a delay in responding.



Dawn Bowden AS/MS

Y Gweinidog Plant a Gofal Cymdeithasol
Minister for Children and Social Care

Briefing for the Senedd Health and Social Care Committee on The Future of General Practice in Wales

DRAFT V1.2 October 31st 2025

Contents

Background	2
Public Health Wales' interest in Primary Care and General Practice	2
Challenges threatening the sustainability of general practice	4
Funding model for general practice and current financial pressures	4
Key Issues	4
What could be done?	5
Efficacy of different models for managing general practice	5
Key Issues	5
What could be done?	6
Suitability and maintenance of general practice estates and access to digital technology	6
Key Issues	6
What could be done?	6
The general practice workforce	6
Key issues	6
What could be done?	7
Patient experience of general practice	7
Key issues	7
What could be done?	8
Opportunities to improve general practice to make it fit for the future and take a more preventative approach to care	8
Key issues	8
What could be done?	8
Relevant Key programmes led by Public Health Wales	9
Biographies of PHW Colleagues attending	10
Rachel Andrew MBBCH, MPH, FFPH (GMC: 4635527)	10
Kerry Bailey MBBS BSc MSc MRCGP FFPH	10
Jim McManus, FFPH, D.Sc, FBPsS, CPsychol, CSci	10
Zoe Wallace B.Sc (Hons), MPH	10

Background

In September 2025 Public Health Wales wrote to the Health and Social Care Committee Chair, Mr Peter Fox MS, summarising the work it is undertaking on primary care and offering support to the Committee in its inquiry into the future of General Practice in Wales. The Committee requested Public Health Wales meet them and also requested any additional briefing materials.

This briefing note seeks to introduce the work being undertaken within Public Health Wales and across the system. We work collaboratively in all our projects with the NHS.

Public Health Wales' interest in Primary Care and General Practice

Any health and care system needs to be focussed on prevention, early intervention, achieving high quality and value and continuously learning to ensure its medium to long term sustainability.

- A sustainable primary care system as part of this is central to achieving these outcomes and making a strategic shift to prevention and improving the health of our population and our economy.
- Public Health Wales supports this through providing evidence-based leadership and support for actions which will help primary care become more preventive and sustainable and collaborating with NHS Wales and communities to coordinate public health activities.

The need for sustainable healthcare is underscored by the increasing demand for health and social care in Wales due to an ageing population, health inequalities, health harming behaviours, environmental and social determinants.

- A recent blog by Public Health Wales for the Health Foundation highlights issues in preventable premature mortality [Premature mortality in Wales: closing the gap in early deaths - The Health Foundation](#)

These factors have created significant pressures on the health and care system, affecting access to timely treatment, causing avoidable harm, and impacting overall outcomes. Despite these immediate pressures, it is essential to focus on prevention, early intervention, and equity to develop sustainable care models that meet current and future population needs, reduce harm, address health inequalities, shift care from hospital to communities and improve outcomes.

Public Health Wales is helping to build a shift towards a prevention-focused approach across the health and care system in Wales.

- The Prevention Based Health and Care framework has been launched alongside a steering group to guide this transition¹.
- The All Wales Diabetes Prevention Programme (AWDPP) continues to show positive results, with nearly 10,000 people attending consultations².
- The Primary Care Obesity Prevention Programme developed a postnatal health and well-being programme in partnership with the Women's Health Network³.
- Efforts under the Cardiovascular Disease (CVD) prevention programme include a national quality improvement project in primary care on preventing cardiovascular disease through managing high blood pressure.

¹ [Prevention Based Health and Care - Primary Care One](#)

² [All Wales Diabetes Prevention Programme \(AWDPP\) - Primary Care One](#)

³ [Primary Care Obesity Prevention - Public Health Wales](#)

In response to the stark figures and future projections of the rise of diabetes in Wales, we established Tackling Diabetes Together, a programme which brings together key partners from across the system to improve outcomes for people living with Diabetes (types 1 and 2) and halt the rise in prevalence of Type 2 Diabetes by 2028. This work sits across this Strategic Priority (4) and Strategic Priority 3 in the PHW Long Term Strategy⁴.

A strong focus has been placed on reducing health inequalities through primary care. Key actions included co-producing with professionals a framework for action and collaborating with partners to create a multi-professional education framework on health inequalities and inclusion health, with resources made available on the Primary Care One website to support embedding these in practice⁵.

Our role in the national evaluation of the Primary Care Model for Wales continues, including cluster peer reviews and self-reflection cycles, with the development of key indicators to measure system progress. A cluster planning portal was launched on the Primary Care One website to aid in planning activities.

In dental care, national coordination of programmes like Designed to Smile and child dental health inspections all aim to prevent tooth decay in children. Collaborative work with the Care Inspectorate Wales (CIW) sought to improve the oral health of care home residents. Training and calibration events were held for the Dental Epidemiology Programme, and the Welsh Oral Health Information Unit provided resources and reports to stakeholders⁶.

We have supported the Welsh Government's Dental Reform Programme, advocated for a need-based, preventive dental care system, and worked with Digital Health and Care Wales (DCHW) on an annual Quality Self-Assessment for health boards and dental practices.

Our Greener Primary Care work has continued to grow from strength to strength with over 500 practices participating and over 4,200 climate friendly actions reported since the establishment of the Greener Primary Care Wales Framework and Award Scheme in 2022⁷.

- We continue to provide public health leadership and chair the National Decarbonisation Inhaler use and disposal Task and Finish Group. By working closer with the National Strategic Clinical Network on Respiratory Conditions and our colleagues across the four nations, we have provided a coordinated approach, national oversight, input and support to address inhaler use and disposal in Wales and across the UK. This has resulted in a substantial decrease in the use of high global warming potential inhalers and identified areas for improvement in the management of respiratory conditions.
- Our efforts in supporting primary care to be more environmentally sustainable and meet the Net Zero ambition have been recognised through winning at the NHS Wales Sustainability Awards 2024 and the Welsh Pharmacy Awards 2024.

Wales needs a General Practice system which, like other components of primary care, is preventive, focused on early intervention and high quality. A recent [Public Health Wales Time to Talk survey](#) found that 80 per cent of respondents felt primary care services including GP surgeries should have a greater role in supporting people with issues like diet, housing and staying physically active linked to their health. We believe there are a number of policy challenges, and potential solutions, which can help general practice be at the heart of a prevention-focused, healthier Wales. We set these out below.

⁴ phw.nhs.wales/about-us/working-together-for-a-healthier-wales/phw-long-term-strategy-pdf/

⁵ [Reducing Health Inequalities through Primary Care - Primary Care One](#)

⁶ [Primary Dental Care - Primary Care One](#)

⁷ [Greener Primary Care - Primary Care One](#)

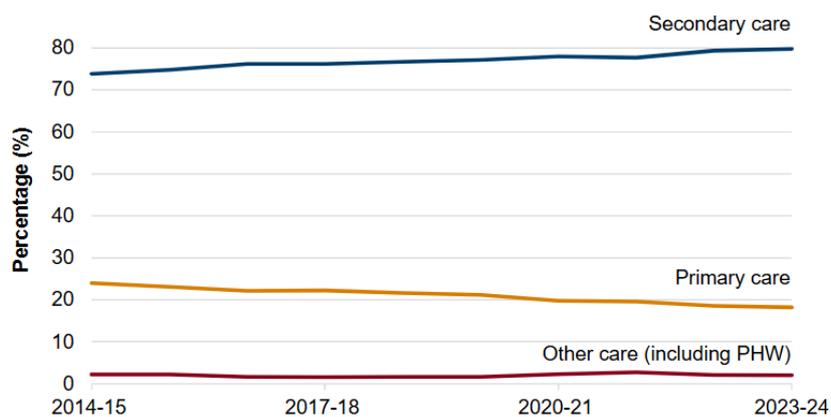
Challenges threatening the sustainability of general practice

Funding model for general practice and current financial pressures

Key Issues

- Integrated Local Health Boards are accountable for primary and community care and population health. Despite an increase in NHS expenditure over the last decade, Local Health Boards are increasingly spending different amounts on primary and secondary care.
- 79.8% of total NHS expenditure is within secondary care (an annual increase of 0.5%) and 18.2% is within primary care (an annual decrease of 0.3%)⁸.

Figure 1: NHS expenditure by service level, 2014-15 to 2023-24



- There is compelling evidence that investment in primary and community care settings yields the highest economic and health returns. Local areas that increased spending in these settings generated up to £14 in gross value added (GVA) per £1 invested, outperforming acute (secondary) care, which delivered around £11 per £1⁹.
- The current GMS funding models worsen health inequalities because they don't allocate resources based on people's needs or levels of deprivation. The capitation-based funding system, disadvantages General Practices (GP) in deprived areas, where patients often have greater and more complex health needs. Funding inequalities lead to poorer GP access in deprived areas, meaning higher A&E and emergency hospital admissions. Redistributing primary care funding based on need would reduce inequalities in health outcomes, life expectancy, and long-term condition management¹⁰.
- Public Health Wales are leading the development of a suite of system level assurance measures, to monitor progress towards the [Primary Care Model for Wales](#) (PCMW). One of the six PCMW Key Indicators is Finance, highlighting the need for an incremental shift in resource from secondary care to primary and community care.

⁸ [NHS expenditure programme budgets: April 2023 to March 2024 \[HTML\] | GOV.WALES](#)

⁹ NHS Confederation (2023). Creating better health value: understanding the economic impact of NHS spending by care setting. <https://www.nhsconfed.org/publications/creating-better-health-value-economic-impact-care-setting>

¹⁰ Ashworth, M., L'Esperance, V., and Round, T. (2021) Primary care funding entrenches health inequalities: time for a rethink. British Journal of General Practice, 71(704), pp. 102-104. Available at: <https://doi.org/10.3399/bjgp21X714965>

What could be done?

- Implement population-needs weighting (e.g. deprivation, multimorbidity, rurality) to allocate GMS funding more equitably and efficiently.
- Redistribute funding from secondary care to primary and community care, measuring progress using the PCMW Finance Key Indicator.
- Revise planning and commissioning processes to support longer-term planning, community participation, and service co-production, that focus on population health, equity, and prevention.

Efficacy of different models for managing general practice

Key Issues

- The Primary Care Model for Wales (PCMW), is a model for primary and community care and was developed as a whole system approach to sustainable and accessible local health and wellbeing care. Focusing on place-based care, care closer to home and multi-professional working¹¹. Clusters and professional collaboratives are the building blocks within the PCMW.
- Primary and community care is the cornerstone of the NHS in Wales and general practice are central to this, alongside the other Independent Contractors and broader health and care workforce. Therefore, general practices are part of the system delivering primary and community care.
- GPs are skilled generalists who often provide the first contact with healthcare services, in addition they provide continuity of care, in particular relational continuity of care from birth to death, comprehensive care and coordination of care across primary, secondary and social care¹².
- Continuity of care provides improved population outcomes, including a reduction in the use of healthcare services, a reduction in death rates, improved patient and staff satisfaction and a reduction in health inequalities¹³.
- A recent Time to Talk Public Health Survey, found that continuity of care is most valued by people when dealing with existing health conditions, in particular for people living in more deprived areas, older adults and women¹⁴.
- The increasing number of people with multiple long term/ chronic conditions, the wider determinants that impact on our health, such as poverty, and the aging population in Wales, will increase the demand upon primary and community care, including GP's¹⁵.
- To meet population health needs more effectively, health systems must adopt holistic care models that support fresh thinking around skill mix and multidisciplinary team (MDT) composition¹⁶.

¹¹ [Primary Care Model for Wales - Primary Care One](#)

¹² Starfield B. Is primary care essential? The Lancet. 1994; 344(8930): 1129–33. Available at [Is primary care essential? - ScienceDirect](#)

¹³ [A Public Health Approach to Primary and Community Care by 2035 in Wales - Primary Care One](#)

¹⁴ Public Health Wales (2025), Time to Talk Public Health Survey, February 2025 results <https://phw.nhs.wales/topics/time-to-talk-public-health/time-to-talk-public-health-panel-publications/publications/time-to-talk-public-health-february-2025-survey-results/>

¹⁵ [NHS in 10+ Years](#) Science Evidence Advice (SEA) Providing evidence and advice for Health and Social Services Group on behalf of the Chief Scientific Adviser for Health

¹⁶ Meadows, D., Maclaren, J., Morton, A. and Ross, D., 2024. Determining skill mix and optimal multidisciplinary team composition: A scoping review. Healthcare Management Forum, [online] Available at: <https://journals.sagepub.com/doi/pdf/10.1177/08404704241293095>

What could be done?

- Strengthen the planning and delivery of services, that are equitable, meet population need, and are delivered within the communities where people live.
- Policy, performance measures and contractual arrangements reviewed to prioritise continuity of care alongside access.
- Commission an evaluation of the Continuity of Care GMS Quality Improvement work.
- Strengthen and adequately resource the multi-disciplinary workforce across primary and community care, including in general practice, to provide holistic, pro-active care.

Suitability and maintenance of general practice estates and access to digital technology

Key Issues

- In order to deliver care closer to home/ community by design, primary and community care estates, including general practice premises, need to be able to host multi-disciplinary teams from a range of health and care organisations, in the communities where people live. This will require the investment in infrastructure, digital support, and organisational alignment to succeed¹⁷.
- Insight from the 2035 Roundtable events envisioned a future with a fully integrated digital infrastructure across primary and community care, where data flows seamlessly across services, supporting both clinicians and patients with timely, relevant information¹⁸.

What could be done?

- Implement shared care records across primary, community, social care, and voluntary sectors to enable timely, coordinated, and holistic care.

The general practice workforce

Key issues

- The [Strategic Workforce Plan for Primary Care](#) aligns with the themes of the Health and Social Care Workforce Strategy and aims to develop sustainable workforce models that support the ambition of A Healthier Wales and the Primary Care Model for Wales.
- There are an array of workforce challenges including recruitment, retention, and workload pressure and burnout¹⁹

¹⁷ Tung, C., Ashton, T., McIntosh, B. and Cumming, J., 2024. Integrated ambulatory care in the New Zealand health system: A scoping review. *Health Policy*, 138, p.105051. <https://doi.org/10.1016/j.healthpol.2024.105051>

¹⁸ Public Health Wales. A Public Health Approach to Primary and Community Care by 2035: technical report. 2025 [awaiting publication]

¹⁹ Public Health Wales. A Public Health Approach to Primary and Community Care by 2035: technical report. 2025 [awaiting publication]

What could be done?

- Prioritise investment in primary and community care sustainability, especially in areas experiencing high demand, poor access, or persistent health inequalities.
- Embed prevention and equity into all training and education by ensuring curricula cover health promotion, social determinants of health, cultural competence, and trauma-informed practice across all primary and community care roles.
- Implement systematic collection of staff wellbeing, staff satisfaction and staff retention rates, across primary and community care, including the Independent Contractors.

Patient experience of general practice

Key issues

- General practices are integral to and work with communities and provide personalised prevention, early intervention and treatment. They also have a pivotal role in improving the ways in which primary and community care can impact on health inequalities²⁰.
- In a recent Time to Talk Public Health Survey, when asked how much of an impact eight wider determinants have on whether a person experiences good health, the top three considered to have a large impact were: Ability to access health care (93%), Good quality, warm homes (89%) and Good financial security (78%). In addition, 70% of people said they support the allocation of money for primary care services being based on the needs of people in an area. This reduced to 51% when stated it may mean an area with people who have good health get less primary care services²¹.
- The OECD Patient Reported Indicator Survey (PaRIS) findings in Wales, provided insight, from people aged over 45 years with a chronic condition, on their experience of care received in general practice. Findings included²²
 - One out of five people (22%) with chronic conditions report good experiences of care co-ordination, which is below the OECD PaRIS average of 59%.
 - Less than half of people (46%) with chronic conditions trust their healthcare system in Wales compared to the 62% in the OECD PaRIS average.
 - Slightly more than four out of ten (43%) people with chronic conditions in Wales receive enough support to manage their own health, below the OECD PaRIS average of 63%.
- The [People's Experience Framework](#) and Survey are not consistently used in primary and community care.

²⁰ [Reducing Health Inequalities through Primary Care - Primary Care One](#)

²¹ Public Health Wales (2025), Time to Talk Public Health Survey, February 2025 results <https://phw.nhs.wales/topics/time-to-talk-public-health/time-to-talk-public-health-panel-publications/publications/time-to-talk-public-health-february-2025-survey-results/>

²² [Does Healthcare Deliver? Results from the Patient-Reported Indicator Surveys \(PaRIS\): Wales, United Kingdom | OECD](#)

What could be done?

- National and local policies should be aligned to prioritise reducing inequalities, prevention, supported by long-term political commitment and accountability.
- Individuals and communities, including those with lived experience, should be central in co-producing their local health and care services.
- The systematic use of person reported outcomes and experience to improve service delivery should be adopted in primary and community care. Including the collection of peoples experience across all primary and community care services/ contractors.

Opportunities to improve general practice to make it fit for the future and take a more preventative approach to care

Key issues

- The UK is facing a rising tide of ill-health, both in absolute numbers and per capita. The burden of disease, measured in disability-adjusted life years (DALYs), reveals a troubling trend: while people are living longer, they are spending more of those years in poor health. This decline in healthy life expectancy is particularly stark among younger generations, who are now expected to live longer lives with more illness²³.
- A systematic review highlighted that many cost-effective preventive interventions—particularly those targeting the leading causes of death such as cardiovascular disease, cancer, and diabetes—are well-suited for delivery in primary care and community-based settings²⁴.

What could be done?

- The [Prevention-Based Health and Care](#) (PBHC) framework should be fully implemented across all levels of the system to embed prevention into everyday practice.
- Across health and care funding mechanisms and performance measures must be aligned to reward prevention efforts, reduction of inequalities and long-term health outcomes rather than short-term activity.

²³ Jenkins, J., Harper, H. and Carter, R. (2024) Here's why it's impossible to save the NHS unless we invest in prevention right now. Nesta. Available at: <https://www.nesta.org.uk/blog/heres-why-its-impossible-to-save-the-nhs-unless-we-invest-in-prevention-right-now/>

²⁴ Khushalani, J.S., Song, S., Calhoun, B.H., Puddy, R.W. and Kucik, J.E. (2022) Preventing leading causes of death: systematic review of cost-utility literature. American Journal of Preventive Medicine, 62(2), pp.275–284. Available at: <https://doi.org/10.1016/j.amepre.2021.07.019>

Relevant Key programmes led by Public Health Wales

In addition to the above, the following reflects our evidence-based approaches to working with partners across the system to strengthen primary care, prevention, environmental sustainability and equity in health outcomes. These projects reflect our evidence-based approaches to working with partners across the system to strengthen primary care, prevention, and equity in health outcomes. We provide here a brief overview of the work but would be happy to assist the inquiry in any way you may find helpful to you.

Public Health Wales also hosts the National Primary Care One resource site which can be found here [Home - Primary Care One](#)

This initiative, a collaboration between Public Health Wales and the national Strategic Programme for Primary Care provides a platform for information and resources for professionals in primary and community care, with the goal of improving healthcare in Wales through collaboration and innovation. It does not provide direct patient care but works to improve the system by sharing best practice, supporting multi-professional working, and informing service planning.

Primary Care One provides an overview of the strategic direction of primary and community care in Wales, the Primary Care Model for Wales, and an overview of the roles and responsibilities of professional collaboratives, multi-professional clusters and pan-cluster planning groups. With the aim of sharing information, raising awareness and influencing action, to improve the health and well-being of the population of Wales.

Primary Care One provides professionals, with information, resources and signposting to:

- Support development of multi-professional working
- Strengthen professional collaboratives and cluster working
- Enable collaboration across partnerships
- Inform the planning and delivery of services that meet population need
- Facilitate sharing of innovation and practice.

[A Public Health Approach to Primary and Community Care by 2035](#) in Wales, this forward-looking piece of work outlines a vision for primary and community care that is rooted in public health principles. It emphasises prevention, integration, and community engagement—key themes for shaping the future of general practice.

[Prevention-Based Health and Care](#) this report sets out the case for a system-wide shift towards prevention, highlighting how general practice can play a key role in reducing demand on acute services and improving population health outcomes.

[Healthcare Public Health Framework](#) this new framework embeds public health values into healthcare delivery, promoting prevention and equity. It offers practical guidance for aligning general practice with broader public health goals and reducing health inequalities. Reducing Health Inequalities Our ongoing work in this area provides evidence and tools to support general practice in addressing the social determinants of health. The materials and tools we are making available may be particularly relevant to the Committee's focus on equitable access and outcomes.

[Cardiovascular Disease Prevention Plan](#) this newly launched report demonstrates the significant benefits of proactive prevention in general practice, particularly in reducing the burden of cardiovascular disease. It includes actionable recommendations for embedding prevention into routine care. Among other things, the report shows that if around 17,000 patients were supported to bring their blood pressure under control, then 102 heart attacks and 152 strokes would be prevented. If around 70,000

more patients could have their blood pressure controlled, then it would avoid 419 heart attacks and 626 strokes.

[Greener Primary Care](#) the Greener Primary Care Wales initiative has empowered general practices to integrate sustainability into daily operations—reducing waste, improving energy efficiency, and promoting healthier behaviours—while aligning with NHS Wales’s net-zero goals and enhancing patient care outcome. Projects include reducing single-use plastics to reduce cost.

Biographies of PHW Colleagues attending

Rachel Andrew MBBCH, MPH, FFPH (GMC: 4635527)

Consultant in Public Health, Primary Care Division, PHW.

Rachel initially qualified and worked as a GP in Wales (MRCGP (distinction) 2005). Since 2009, Rachel has trained and worked within Public Health Wales and the Betsi Cadwaladr University Health Board Public Health Team. On completion of Public Health training (2020), Rachel worked as a Consultant in Communicable Disease Control (CCDC), with geographical responsibility for the Hwyl Dda University Health Board region. Rachel joined the Primary Care Division in 2023, and has a lead portfolio for the [Primary Care Model for Wales](#), including implementation of the Monitoring & Evaluation plan and supporting Cluster working, Data and Digital, plus oversight of the [Primary Care One website](#). In addition, Rachel co-leads the [Public Health approach to Primary and Community Care by 2035](#) (Vision of Primary Care for Wales in 2035) work with Dr Kerry Bailey and supported development of the [Healthcare Public Health Framework](#).

Kerry Bailey MBBS BSc MSc MRCGP FFPH

Consultant in Public Health, Primary Care Division, Lead for Reducing Health inequalities, PHW.

Kerry is both a GP and a Fellow of the Faculty of Public Health. For Public Health Wales she is the Consultant lead nationally on reducing Health Inequalities through Primary Care and Inclusion Health and is working on a Vision of Primary Care for Wales in 2035. She has worked as a GP for over 25 years, focusing on people experiencing homelessness for 5 years. Her base for both specialty trainings was Swansea. Kerry sits on key Welsh Government Groups including the Population Health Management and the Strategic Health Inclusion groups and a Home Office group on access to Healthcare. In the past Kerry has chaired the Welsh Supporting People National Advisory Board, advising several ministers. Kerry has worked in both Primary Care and Public Health for over 25 years and in seven countries.

Jim McManus, FFPH, D.Sc, FBPsS, CPsychol, CSci

National Director of Health and Wellbeing, PHW

Zoe Wallace B.Sc (Hons), MPH

Director of Primary Care Division, Public Health Wales.

Zoe has worked in the NHS for over 25 years holding a number of positions centred on multi-agency partnership working, strategic planning and service redesign, primary care contractor and third sector commissioning, programme management, monitoring/evaluation across the full range of statutory and local health planning and partnership teams. Zoe has been the Director of the Primary Care Division in Public Health Wales since 2018 and took up the dual role of Programme Director for the Strategic Programme for Primary Care in 2021 leading the transformation of primary care in Wales.

After graduating from Keele University in 1996 with a First Class Honours BSc Biochemistry & Biology Zoe worked in Tanzania for three years – two years teaching A Level Biology in a Government Secondary School with Voluntary Services Overseas (VSO) and a Year with Save the Children Fund on an Emergency Food Relief Operation. On returning to the UK she undertook a Masters in Public Health in Cardiff

University School of Medicine graduating in Summer 2000 at which point she joined the NHS where she has worked for the last 25 years. Zoe has held a number of posts within NHS bodies in South Wales including a secondment to a partnership post in Bridgend County Borough Council. The focus of her career to date has centred on multi-agency partnership working, predominantly in primary and community care services, strategic planning and service redesign/improvement, primary care contractor and third sector commissioning, programme/project management, monitoring/evaluation across the full range of statutory and local health planning teams. Zoe joined Public Health Wales in March 2018. Her team portfolio spans dental public health, primary care prevention and primary care cluster transformation.

Zoe is the Programme Director for the Primary Care Hub which is hosted by PHW, the hub works to support the transformation of primary care that is informed by public health approaches to deliver, through primary care clusters, increased emphasis on prevention, equitable and improved health and well-being outcomes