Llywodraeth Cymru
Welsh Government

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

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 division[6] 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 2024[11]).

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.

Annex D

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, Soicial 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 issues[i].

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 GMT 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 them[ii]. 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 practices[iii]. 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

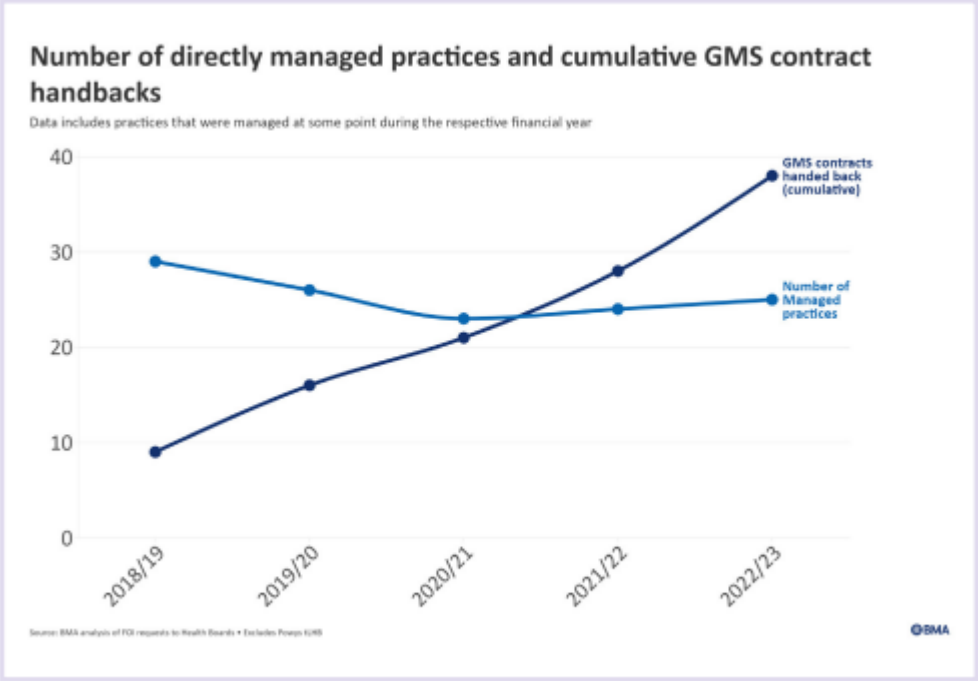
The 'Future of the partnership model' (2023) article by the Royal College of General Practitioners (RCGP), highlights that there have been political comments around a need for significant change and redesign of the way GP services are delivered. Their stance is that 'reform' proposals fail to address 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].

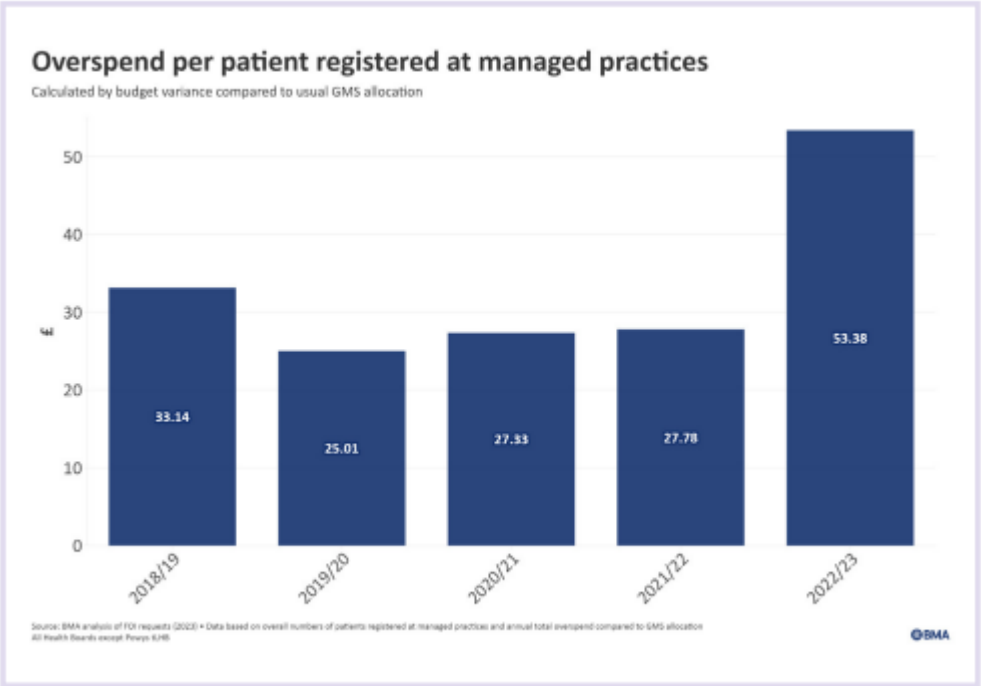
A news article which wasn't included in the literature search but was found from reference searching the above article was a 2018 issue in 'Management in Practice'. It discusses the overspends by health boards in Wales, attributing a £1.3m overspend in 2017/18 in Betsi Cadwaladr University Health board 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.

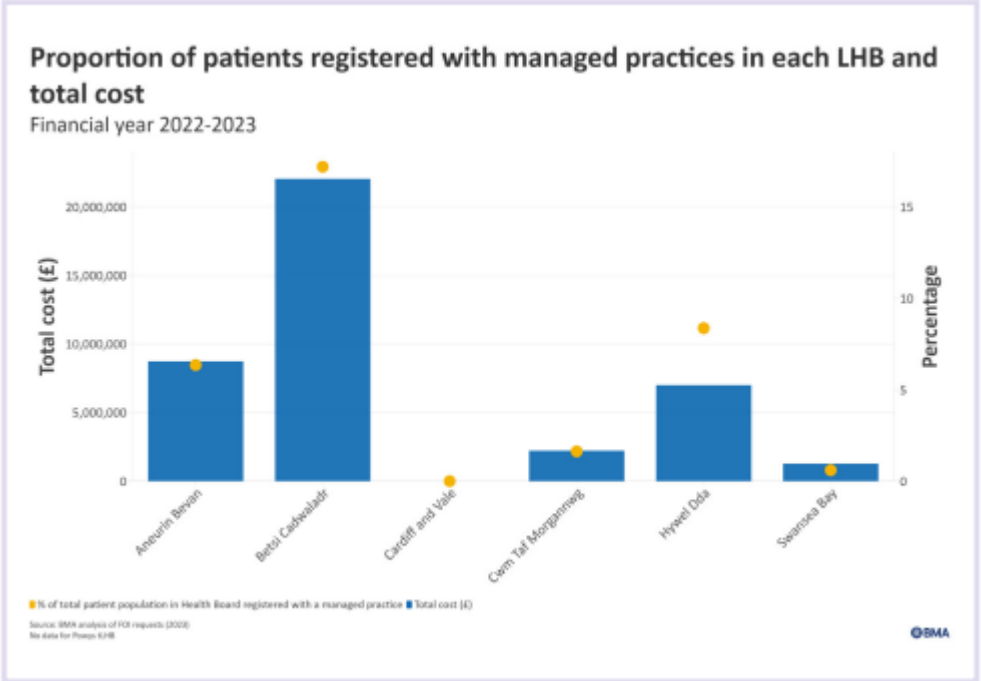
There are also however, quotes from the Betsi Cadwaladr executive director for primary care which report that there were factors which were not included in the BMA report such as costs relating to training and raising staff wages. There was also a quote from a director of primary care, community and long-term care at Hywel Dda University health board which states that there was an aim to return managed practiced 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 (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.

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[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 PracticeManagement 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)
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[xx] RCGP-scotland-frontline-june-2019.pdf
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[xxiii] Annual Report 2017-2018 | Healthcare Inspectorate Wales (hiw.org.uk)
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[xxv] Hywel Dda University Health Board – Review of Primary Care Services | Audit Wales
[xxvi] Aneurin Bevan University Health Board – Primary care services | Audit Wales
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