

Inquiry into the future of general practice in Wales:

Case studies



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Inquiry into the future of general practice in Wales:

Case studies

- The Health and Social Care Committee is undertaking an inquiry into the future of general practice in Wales. As part of this work, the Committee was keen to hear directly from those with first-hand experience of general practice, including GPs, members of the general practice workforce, and service users.
- To support this aim, the Citizen Engagement Team delivered a programme of engagement comprising a series of in-person and online focus groups, as well as individual interviews. The findings from this engagement were presented to the Committee in a detailed report, helping to deepen its understanding of the issues within the inquiry's terms of reference and to explore participants' views and lived experiences.
- In addition to the main engagement findings, some participants kindly agreed to contribute further by developing personal case studies. These accounts help bring key themes to life and offer valuable context to the challenges and realities faced within general practice in Wales.
- This resource contains four case studies: three from general practitioners and one from a general practice manager, each based in a different health board area in Wales.
- We would like to thank the contributors for their openness and willingness to share their perspectives.
- For more information about the inquiry, please click the link below:
[Inquiry into the future of general practice in Wales](#)



Case Study 1

GP working for 30 years in Swansea within the lowest 30 most deprived practice areas in Wales

Main challenges facing the sustainability of general practice

PATIENT FACTORS

Increasing number of patients with complex needs, co-morbidities, frailty, and polypharmacy with poor social support.



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separate funding considerations for staff and building.

The rise in NI and the Minimum Living Wage has hit us significantly. Consequently, we cannot afford to replace retiring staff with subsequent extra workload on the remaining staff.

INEQUALITY OF HEALTH

Carr-Hill formula underestimates the impact of socio-economic factors.

CLINICIAN FACTORS

i) Recruitment and retention challenges:

our practice has been short of GPs for a few years which contributes to **increased stress and burnout** for those left. Often no applicants respond to advertisements. We employed a pharmacist but not as effective as a GP.

FINANCIAL CONSTRAINTS

Government need to understand that **practices are small non-profitmaking businesses** with limited options to increase income. In addition to GMS contract payment, **we need**



Carr-Hill formula underestimates the impact of socio-economic factors.

ii) We are proud of our commitment to teaching and training students and GP trainees to ensure future GPs. However, three of our recent trainees have decided to leave the UK due to better working conditions overseas. Visa issues also a factor. **Lack of space is a major constraint to enable training.** Improvement grants are scarce with strict caveats for eligibility and only partially funded our renovation.

IT SYSTEMS

Uncertainty for our practice with VISION on brink of collapse.

SECONDARY FACTORS IMPACTING GENERAL PRACTICE AND PRIMARY CARE

Shifting workload onto primary care, for example, insulin management.



Poor support from health boards.

Poor support from health boards, for example, obstacles in vaccination programmes, limited funding when allocated care of patients from closing practice, and application of cluster model.

Ambulance delays is a serious concern and cause of patient death at home and lost windows of opportunity for treatment, for example, for MI/stroke.



Community services that work to avoid hospital admissions do not work together and are often short staffed and cannot accept urgent referrals. This increases GP workload.

Patients fear and refuse hospital admission due to poor experiences when left on trolleys for 24- 72 hours whilst unwell. Delays related to lack of hospital beds.

Community services that work to avoid hospital admissions do not work together and are often short staffed and cannot accept urgent referrals. **This increases GP workload having to ensure patient's welfare at home.**

Opportunities to make a difference

PATIENT FACTORS

Pharmacists allocated to practices would help medication reviews and reduce waste and admissions related to complications from medications; can focus on reduction of opioid and gabapentin prescribing; address drug shortages.

Needs **review to consider elderly population** and deprivation so funding is allocated to patients' needs.

FINANCIAL CONSTRAINTS

Need **a better funding model** to allow practices to recruit and retain clinical and non-clinical staff and maintain buildings. **Need exemption from NI rises.** Practices have worked on limited budgets for years and should be recognised as good financial managers allowed to provide specific services to the needs of their patients.

CLINICIAN FACTORS

Acknowledge that GPs are better trained to undertake the clinical and administrative tasks in primary care and thus more cost effective so need provision to support them. We value the role of allied professionals, but funding should be reviewed. Need **realistic patient access.**



Pharmacists allocated to practices would help medication reviews and reduce waste.



We value the role of allied professionals, but funding should be reviewed.

Grants to be accessible to meet needs of individual practices. Consider projects such as solar panels. **Better maintained buildings can help to retain staff** and keep utility bills low thus more cost effective and greener.

Governing bodies taking over the responsibility for visas would reduce workload and expense for GPs, helping retention of trainees.

IT SYSTEMS

Need to fast track conversion to EMIS with support to gain IT consistency across Wales and enable e-prescribing to be standard; this would be more efficient for pharmacists and practices allowing more time for patient care.



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month contracts, services started then stopped due to lack of funding or change in priorities, for example, physio & mental health services.

Need increased hospital beds to allow better flow of patients. Current suggestion of too many hospital beds does not tally with increased elderly population with complex needs.

SECONDARY FACTORS IMPACTING GENERAL PRACTICE AND PRIMARY CARE

To be more circumspect when increasing GP responsibilities/ **allow resources to follow that workload.**



Need increased hospital beds to allow better flow of patients.

Need to increase beds in the community (care homes need support regarding NI and MLW); need improved social services to enable safe discharge to patient's home and help avoid admission.

Need better efficiency and understanding of what is necessary and to **review objectives of cluster funding** as some poor and temporary investments made, for example, 12

Need to ensure a full working service rather than 2-3 partially working services.

Case Study 2

Dr Chris Horn

GP Partner, GP Trainer and GP Training Programme Director

I work in a very rural part of Carmarthenshire which covers a large geographical area and serves a relatively elderly population with a high proportion of first language Welsh-speakers.

Main challenges facing the sustainability of general practice

In my experience, traditional general practice in Wales is at a tipping point. Despite being the cornerstone of the NHS—responsible for around 90% of consultations—general practice receives less than 7% of NHS Wales funding.

Meanwhile, patient numbers continue to rise while 18% of practices have closed over the past decade. Increasingly, GP partners are handing back contracts, unable to sustain services in the face of overwhelming demand and underwhelming financial support.

At our practice, we have committed to preserving a GP-led model of care. We continue to offer the vast

majority of consultations face-to-face, with minimal reliance on telephone triage or electronic consulting. **This traditional, personal model fosters trust, continuity, and exceptionally high**

patient satisfaction.

Our GPs are trained to manage complex, multi-faceted issues efficiently in a single consultation—something few other healthcare professionals are equipped to do.

However, delivering this model has

become significantly harder. **In Wales, each full-time GPs is responsible for around 2,200 patients—more than double the BMA-recommended ratio of 1,000.**

“
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My partners and I routinely start work before 8am and often don't finish until after 6:30pm, managing complex care across physical, mental, and social domains. The

hours most people work in a week, I work in three days.

The financial strain is relentless.

Practice running costs have risen sharply—staff wages, employer pension contributions, medical indemnity, energy bills, building maintenance, insurance, IT systems, and equipment costs have all increased. Yet practice funding has remained largely static or sub-inflationary. Any increases from the Welsh Government are modest at best and often tied to new contract requirements, adding yet more work to already saturated practices. These additional obligations are rarely backed by evidence that they improve patient outcomes or workforce wellbeing.

Despite this, newly qualified GPs across Wales are struggling to find jobs. The workforce is there—



We offer incredible value for money, but this value is being stretched to breaking point.

but practices simply cannot afford to hire them. It's a stark failure of resource allocation. At the same time, many practices have been forced to restructure care around Allied Health Professionals (AHPs)

like paramedics, pharmacists, and physiotherapists.

While skilled in their own right, AHPs have narrower competencies and often cannot deal with the complex, multifactorial cases that GPs handle routinely. As a result, patients may need multiple appointments or face delayed care, increasing inefficiency and frustration.



You cannot move care out of hospitals without strengthening the system it's being moved into.

We have resisted outsourcing core clinical work—not out of tradition, but because we believe that continuity and holistic GP care offers the safest, most effective model.

However, it is a constant battle to maintain. **We are efficient and we do not run at a loss—unlike Health Board-run practices, which cost around a third more to operate.** We offer incredible value for money, but this

value is being stretched to breaking point.

Retired GP colleagues often note how the number of hospital consultants has ballooned over the years, while GP numbers have

remained flat. If the Welsh Government is serious about delivering more care in the community, it must address this imbalance. You cannot move

care out of hospitals without strengthening the system it's being moved into.



Recognise and protect the cost-effective, skilled care GPs deliver.

Opportunities to make a difference

The opportunity to make a difference is clear: invest in general practice—specifically in GP partnerships. Recognise and protect the cost-effective, skilled care GPs deliver. Increase funding to the RCGP Wales-recommended 11% of the NHS budget.

Correct the public narrative that suggests GPs are unavailable or unwilling—we are working to our limits and beyond. What we lack is not commitment, but capacity.

Support us. Value us. Fund us fairly. If we are

to avoid further collapse, we must bring patient-to-GP ratios closer to sustainable levels and acknowledge that rising practice costs are not a “press pause” issue—they are accelerating, and they are affecting care now.



Correct the public narrative that suggests GPs are unavailable or unwilling—we are working to our limits and beyond. What we lack is not commitment, but capacity.

By sustaining practices like ours, we preserve a model of care that delivers quality, continuity, and cost-efficiency. If it fails, the consequences for the NHS in Wales—financially and socially—will be profound.

Case Study 3

I am currently a locum general practitioner but have held salaried posts for a number of years in the past.

I regularly work in general practice as well as out of hours. I have considerable experience working in managed practices. Given my range of roles I work across multiple health boards in south Wales.

Main challenges facing the sustainability of general practice

The main challenges facing the sustainability of general practice in my experience are **lack of resource, workforce and funding.**

General practice has seen huge shifts in work from secondary care to primary care. With ever increasing pressures on Accident and Emergency, there has been a drive to manage far more acutely unwell patients in primary care.

Often, patients will come to the surgery to avoid long waiting times in Accident and Emergency, even with life threatening conditions such as sepsis and chest



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pain. This can lead to prolonged waits on the phone whilst trying to refer a patient to hospital or phone for an ambulance, as well as managing life threatening conditions with limited resources.

Ideally, patients should still be encouraged to use services appropriately to avoid harm caused by delays in care.



Primary care now manages the bulk of chronic diseases with ever increasing shared care protocols creating additional work in general practices.

Primary care now manages the bulk of chronic diseases with ever increasing shared care protocols creating additional work in general practices. This benefits the patient by obtaining care closer to home. However, it is questionable as to

whether the correct remuneration is being received by practices for the work involved in managing these patients safely and effectively.

There are huge volumes of administrative work generated from reviewing secondary care letters, reviewing blood results and prescribing medication, **most of which is unaccounted for during the average GP working day.**



I work in many areas of socio-economic deprivation and it clear that practices in these areas have a heavier workload.

I work in many areas of socio-economic deprivation and it clear that practices in these areas have a heavier workload. Many of the patients suffer from extensive medical conditions from a younger age leading to complex consultations. Given poor transport links, unwell people are often unable to travel to the practice, creating a higher burden from time consuming home visits.

Opportunities to make a difference

Opportunities to make a difference include **transparency about the calculation of doctor to patient ratio, particularly in deprived areas.**

There is a sense that the Carr-Hill formula is outdated and does not adequately consider the complexities of co-morbidities and broader social determinants of health. Given the additional workload pressures leading to burnout and high staff turnover, these practices struggle to make a profit and as a result contracts are



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handed back to the health board. It therefore feels prudent to obtain an up-to-date assessment of the health conditions that require treatment in these practices so that satisfactory provision in terms of funding, resource and workforce can be made. Lack of workforce in these areas is further compounded by the lack of GP training posts available in managed practices. Despite a wealth of opportunities to learn, managed practices do not benefit

from the work of GP trainees and subsequently this make them less likely to take a salaried post when qualified.

Given the increasing complexity of patients, RCGP recommends GP consultations to change to a **15 minute model**. In order to preserve quality and safety, the BMA recommend the maximum number of patient contacts per day to be capped at 25 per GP.

Protected administrative time and continuous personal development should be routinely factored into the working of all GPs. These changes could **improve satisfaction at work and reduce burnout, providing stability to the workforce**.

Working in General Practice in Wales could be made more efficient by the use of technology. If all practices used the same system



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Working in General Practice in Wales could be made more efficient by the use of technology.

such as EMIS it would make the data easier to compare. Similarly, access to central work systems such as Welsh Clinical Portal should be readily accessible across all health boards the GP is working in. This would enable the GP to have access to the full patient records for **safer and more effective management**.

Electronic prescribing has been available in England for over 15 years. It is therefore disheartening that this has still not been rolled out across Wales. Not only, would it enable remote working, efficient prescribing by reducing the time to sign prescriptions but it would create more options for a patient to collect a prescription from the a pharmacy of their choice. Less printing of paper would also **reduce the carbon foot print**.

Case Study 4

Sean Langridge

Managing Partner/Practice Manager

I work in a rural GMS practice with over 4100 patients. The practice is over an hour away from the nearest district general hospital.

Main challenges facing the sustainability of general practice

Funding has been eroded over many years.

The contract enforces practices to increase staff wages by a percentage above any statutory rises. There is lack of realisation that the staff pay element does not cover these increased costs as they cost more than the base increase, practice are burdened with statutory increases prior to the uplift being calculated along with NICs and pension. The costs of the minimum wage rises and NICs/pension directly come out of the pay element increase awarded to partners meaning in real terms uplifts awarded to partners are not truly recognised in the profits/partners income.



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Rising practice costs

over the years has not been met with appropriate levels of funding increases which further exacerbates the reduction in partners income.



This year has been the first year we have had to pay funds into the practice to keep the cashflow stable.

This year has been the first year we have had to pay funds into the practice to keep the cashflow stable while we waited for the contract to be negotiated and paid out. **Welsh Government need to push for the contract to be implemented along with the funding for the 1 April.**

This will ease cashflow issues for practices and ensure the workforce feels the benefit of wage rises

sooner, as they are just as affected by the cost-of-living crisis as the practice.

With the new Medical Examiner Service there has been a reduction of income for practices but an increase in administrative workload, due to the systems in place along with a duplication of work processes in cases where the medical examiner's office requires the coroner's office to take over a case.

Welsh Government gives patients unrealistic expectations on access to services, with a deep lack of understanding of what the workload is for all staff in general practice. With regards the GP activity work, it is fundamentally flawed as the **data requested by Welsh Government is not accurate data.**

There are limited ways to capture some important data such as how many blood results have been dealt with, acute issues dealt with and communication issues such as Welsh Ambulance services, Medical Examiner services and pharmacy contacts. The data collections for

documents received and reviewed is limited. So fundamentally the

system is not fit for purpose and is a waste of taxpayers' money in its current format, there could be a much better way to capture data and perhaps some engagement with clinical system

suppliers could improve the data quality.

Since COVID-19 secondary care is still massively behind on waiting lists. We have seen a massive increase of patients needing more input, higher levels of pain relief and presenting with more complex

clinical issues. Often GPs are burdened with having to send expedite letters as requested by the hospital, which sees patients having multiple referrals for the same condition. Practices are also set targets with

reducing opioid burden for patients along with reducing other pain medications. However this is often unachievable due to long secondary care waiting lists.



Welsh Government gives patients unrealistic expectations on access to services.



patients needing more input, higher levels of pain relief and presenting with more complex clinical issues.

Opportunities to make a difference

General uplifts need to include additional elements

Welsh Government need to give full uplifts to practices to include, minimum wage increases and other oncosts to wage uplifts. A view also should be taken with regards inflation and the rise in costs. Currently uplifts have fallen very short in real terms. We appreciate this year's additional one-off funding, however one off funding is not continual commitment to primary care.

Contract negotiations to occur and be implemented prior to the contract period starting

This will directly stabilise practice cashflow, improve staff morale while coping with cost-of-living crisis and show that the Government values the service GMS practices offer.



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ICT engagement

To gain a real understanding on what happens in primary care a joint project could be undertaken with Welsh Government, clinical suppliers and practice management to get quality data for activity.

Increase of secondary and primary care appointments

I propose that NHS workers should be given a special tax code that allows them to either have a reduced tax burden of say 10% or

a reduced tax rate on any overtime work undertaken. This should encourage staff of all groups to take on overtime and increase the number of appointments available to patients to

reduce the secondary care backlog, whilst supporting General Practice to offer more support in the interim. This is a long-term goal.



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