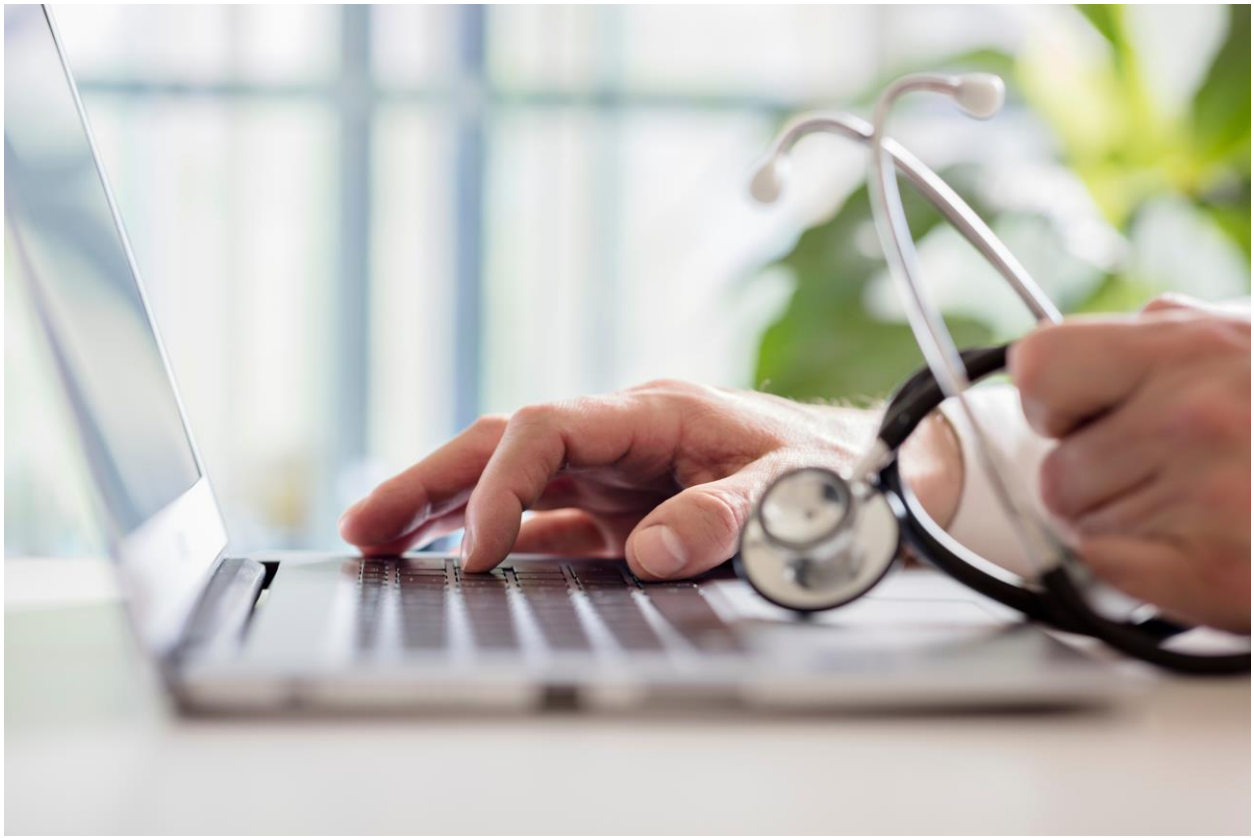
cWelsh Parliament
Citizen Engagement Team

Inquiry into the future of general practice in Wales: Engagement Findings

May 2025



Contents

1. Engagement Summary

The following engagement summary offers an overview of the engagement programme design, delivery, and key findings.

Background

1. 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 general practitioners (GPs), members of the general practice workforce, and service users across Wales.

2. 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.

Objectives

3. The objective of the focus groups and interviews was to deepen the Committee's understanding of the issues within the inquiry's terms of reference and to explore participants' views and experiences.

4. Views were gathered to ensure that those with lived experience contributed to the evidence-gathering programme, with specific focus on the following inquiry terms of reference:

- Challenges threatening the sustainability of general practice, including:
    - The funding model for general practice and current financial pressures,
    - The efficacy of different models for managing general practice,
    - The suitability and maintenance of general practice estates and access to digital technology.
- The general practice workforce, including workforce planning, the recruitment of new staff into general practice, the retention of experienced

staff, staff workload and wellbeing, training and continuing professional development, and the growth of the multidisciplinary team.

- The patient experience of general practice, including equitable access to care, effective management of patient demand, the quality of care, and public trust in the services provided.
- Opportunities to improve general practice to make it fit for the future and take a more preventative approach to care.

Methodology

5. Given the rigorous schedule associated with general practice, both daytime and evening face-to-face as well as online focus group and interviews were conducted to provide flexibility in gathering qualitative data from GPs, members of the general practice workforce, and service users.

6. The engagement comprised of the following:

- 8 online interviews
- 11 online focus groups
- 2 face-to-face focus groups.

7. Notes of each session are available to Members upon request.

8. The Citizen Engagement Team recently engaged with the Deaf community on a broader engagement programme. The objective was to understand the issues faced by BSL signers and potential solutions to those issues. Where applicable and relevant, the views of those participants have been included in this report, providing a wider and more robust sample.

9. 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.

10. The case study pack, written by three GPs and one general practice manager, each based in a different health board area, can be read by clicking the link below:

Inquiry into the future of general practice in Wales: Case Studies

11. Five other participants were also invited to contribute to a visual resource providing tangible context for the issues raised during the engagement programme.

12. Three GPs, one general practice manager and one general practice nurse from three different health board areas kindly contributed to the video shared with the Committee.

Participants

13. A screening survey was designed and shared with healthcare professional and service user organisations. They invited GPs, general practice workforce and service users across Wales to express their interest in taking part in the programme of engagement.

14. The Citizen Engagement Team received an overwhelming response to the screening survey, 344 in total, including 147 GPs.

15. Given the time available to engage and the method chosen for the engagement, it was impractical to hear from everyone. But the unprecedented response to the recruitment call showed an enormous desire to share views and experiences and call for change.

16. The engagement programme included a sample of the responses based on role, experience, geographic location, socio-economic status, urban/rural area, language, gender and ethnicity.

17. The engagement programme took place between 13 February – 16 April, 2025.

18. 135 participants across all five Senedd regions, eighteen local authorities and all seven health board areas were involved in the engagement programme.

19. Given the terms of reference participant composition included:

- General Practitioners (partner, salaried, locum and retired)
- General Practice Managers (including partner managers)
- General Practice Nurses (including Advanced Nurse Practitioner)
- Occupational Therapists

- Physiotherapists
- Pharmacists
- Service users

20. Several other invited participants were unable to attend sessions, primarily due to work commitments. However, the engagement programme includes a rich variety of experiences and viewpoints helping to identify common themes according to the inquiry's terms of reference.

Ethical Considerations

21. In order to gather potentially sensitive quality data, focus groups were conducted with participants with similar roles and/or experiences.

22. All methods used in this engagement programme adhered to the standards set out in the Market Research Society Code of Conduct and complied with relevant data protection and safeguarding legislation to ensure the ethical treatment and privacy of all participants.

Key Findings

Funding and the current model

23. Participants widely agreed that the current funding system, based on the *"outdated"* Carr-Hill formula, does not reflect the reality of modern general practice. It fails to consider areas of deprivation or increasing patient complexity. Many practices rely heavily on enhanced services and struggle with financial uncertainty caused by delays in receiving the General Medical Services (GMS) contract. Participants called for a funding model that enables innovation and supports preventative care.

Unsustainable workload and burnout

24. GPs and general practice workforce described overwhelming workloads, often far exceeding recommended patient contact limits. Rising demand, increased complexity of cases, and the transfer of responsibilities from secondary care were highlighted. Limited time for appointments and administrative overload are common. These pressures are causing burnout, leading many to reduce their hours or leave the profession entirely.

Recruitment and retention challenges

25. Attracting and retaining staff, especially in rural and deprived areas, is a growing issue. Temporary contracts, poor leave rights, and low wages for general practice workforce were key concerns. Practices are losing experienced staff to better-paid, more secure roles elsewhere. There is strong support for growing and training the workforce within Wales, including more Welsh-speaking practitioners.

Estate and infrastructure limitations

26. Many practice buildings are described as outdated and unfit for purpose, with maintenance falling to GPs themselves. Lack of space is limiting the ability to expand services or host training placements. Health board rent arrangements do not support investment in improvements, and disparities in infrastructure between areas are evident.

Multidisciplinary teams

27. Multidisciplinary teams are seen as vital for sharing workload and improving patient care. However, participants said their full potential isn't being realised due to unclear role definitions and insufficient space or resources. Greater investment in integrating multidisciplinary teams could support both patients and GPs more effectively.

Digital technology

28. Digital tools have the potential to transform general practice, but infrastructure is poor and inconsistent. Outdated systems, lack of integration, and poor internet access in rural areas are major barriers. Participants support expanding e-prescribing and patient communication tools, but say rollout is slow and underfunded. Concerns about digital exclusion also persist.

Patient experience and barriers to access

29. Many patients reported good care once seen, but reaching that point can be difficult. The "8am phone rush" remains a common frustration. Disabled people, Welsh speakers, and D/deaf service users face added barriers, especially where alternative access methods are not available. Digital tools sometimes help, but can also exclude those without internet access. Patients asked for better appointment flexibility, communication, and access to continuity of care.

Public Trust and Narrative

30. GPs and staff described a disconnect between the public's positive individual experiences and the broader negative narrative about general practice. Misunderstanding of GPs' roles and media portrayals has eroded morale. Participants urged greater recognition of GPs' contribution and a clearer definition of what general practice can realistically offer.

Thank you to all the participants for their time, openness and willingness to share their perspectives for this programme of engagement.

2. Engagement Findings

This section outlines the key themes and views expressed by the people interviewed.

Funding model

31. 'The GMS contract payment mechanism is complex, but fundamentally based upon the number of patients registered at a surgery. The Global Sum, the amount paid to the practice per patient, reflects the majority of a practice's income. The Global Sum payment for each practice is based on a weighted sum for every patient on the practice list. The Carr-Hill formula is used to apply these weightings, which account for factors such as age, rurality and gender. The global sum amount is reviewed quarterly to account for changes to the practice's patient population."[1]

32. A number of GPs and practice managers raised concerns about the *"outdated"* Carr-Hill formula and explained its impact on the funding of their practices.

[1] bma-gp-contract-in-wales-mythbuster.pdf

> *"The Carr-Hill formula has been in for years and years and years and hasn't been updated for ages. So obviously it doesn't really reflect what what's going on at the moment."*
>
> *General Practice Pharmacist*
>
> *"We can't escape that it's a business model, but it's a business that impacts the whole population.....so it's a funding model of a business meeting community needs - this is the difficulty."*
>
> *General Practice Pharmacist*

33. One GP reported that their practice received approximately £433,000 less than another practice of the same size due to the Carr-Hill Formula. As a result, maintaining a practice and offering services in a safe atmosphere is becoming increasingly difficult.

34. Many GPs noted that the Carr-Hill formula does not take deprivation into account. Participants emphasised the importance of considering areas of deprivation in funding allocations, citing worse health literacy as a significant factor because of the greater need for longer and more frequent appointments. It was noted that individuals living in the most deprived areas visit their general practice three times more often than those in less deprived areas.

> *"Over the last five or ten years, about 10% of practices providing services to the most deprived communities have closed. There is something about the way the funding is arranged that doesn't encourage GPs to maintain practices in areas of deprivation."*
>
> *GP*

35. Participants spoke of the need to align the funding model with modern patient needs and focus on a preventative approach to long term conditions rather than urgent on the day services.

36. General Practices rely on funds from enhanced service because of insufficient core funding, the Global Sum.

> *"I don't know of any practice that could exist on the basis of the Global Sum alone……We're doing as much as we possibly can from the enhanced services….that's what keeps us going."*
>
> *GP*

37. One GP partner explained how he also works as a salaried GP in a health board managed practice in order to financially support his partner practice.

> *"The Health Board pays me much, much more than I do as a partner and it's a lot less work."*
>
> *GP*

38. The need for timely General Medical Services (GMS) contract negotiations to maintain cash flow and workforce stability was highlighted throughout the engagement programme.

39. The pressures of not receiving the GMS contact, sometimes until almost the end of the financial year were highlighted.

> *"In no other business would you be expected to work for 10 months with no contract, it is simply unacceptable."*
>
> *General Practice Manager and Partner*

40. Some participants shared their experiences of working in both partner and health board managed practices and practices managed by eHarley Street.

> *"They [eHarley Street] are shocking. They are never to be seen, you can't get hold of them and they just don't understand how the Welsh landscape works."*
>
> *GP*
>
> *"I know of one GP who works for eHarley Street, who is broken by it. Tomorrow, the GP will be the only doctor in the practice for 1,2000 patients. It's totally unsafe."*
>
> *GP*

41. Participants spoke about the need for a *"grown up conversation"* about the partnership model and the innovation needed to make it fit for purpose for the future. GPs should be part of such conversations and decisions on the funding model.

> *"The partnership model is, in my experience, probably the most efficient way to deliver the primary care that we've got. But, we need to think of a way to give GPs some sort of contract that gives them the freedom to innovate and deliver care for their patients in a way that perhaps they know better than anybody else."*
>
> *GP*
>
> *"One of the strengths of general practice is its flexibility to innovate."*
>
> *GP*
>
> *"The current funding model, the partnership model, is well established but is creaking....it could be sound if the funding matched the model."*
>
> *GP*

Funding

42. Lack of funding is the primary challenge threatening the sustainability of primary care, affecting all aspects of it, including general practice.

> *"I've already been in primary care for five years and I was very optimistic and cheery about everything. But over the last two to three years, my optimism has completely gone and it's purely down to funding."*
>
> *General Practice Manager*

43. The need for appropriate remuneration, equitable distribution of funds, and the importance of core funding for general practice were highlighted by participants.

> *"Funding is the main challenge. Everything I ever think of about innovating and improvement with regard to patient care, access and changing the way in which we do things is always hampered by lack of funding,"*
>
> *GP*

44. The disparity in distribution of funding for primary care and secondary care was a significant issue highlighted throughout the engagement programme.

> *"One of the problems is that general practice isn't seen as being particularly sexy. If you had the choice of spending £1,000,000 on general practice or £1,000,000 on an MRI scanner, I'm sure most people would say let's have the scanner, whereas if you're looking for value for money £1,000,000 in general practice would be huge and the impact that that would have on patients close to where they live would be huge."*
>
> *GP*

45. 90% of NHS patients are seen in primary care, predominantly within general practice, yet the level of NHS funding for primary care is less than 7%.

46. Participants commented that investing in general practice gives a better return than investing in other areas of the health service.

> *"General practice is huge value for money. £1 spent in general practice is the equivalent to £4 spent in the rest of the NHS in terms of patient benefit…It's really important that we value general practice."*
>
> *GP*

47. Concerns about the principle of a GP paid-for service was shared by some participants.

> *"There's no way back from there. It's really a very real proposition that many of us in primary care are quite scared of and don't want."*

GP

48. A number of GPs and general practice managers expressed deep concerns about the crippling impact of the increase in National Insurance contributions.

> *"A normal business will be able to pass those [national insurance] costs on to the customers, but you can't do that in general practice."*
>
> *GP*

Workload

49. All participating GPs and general practice workforce emphasised the significant rise in general practice workload.

> *"Work is coming from everywhere into general practice at the moment, whether that's the consequence of secondary care, stresses, waiting lists, everything is being pushed out from every specialty and it is massive....it's overwhelming at the moment."*
>
> *General Practice Pharmacist*

50. Citing the British Medical Association (BMA) safe workload guidance of 25 patient contacts per day, GPs spoke of "*the usual 35-40 patient contacts a day*", especially in deprived areas. One GP mentioned 90 patient contacts in one working day.

51. GPs highlighted the impact of such demands and complexities on their day-to-day work.

> *"We're firefighting every day, but that's not what a GP should be doing....We're supposed to be doing prevention work to stop ill health."*
>
> *GP*

52. A number of GPs conveyed the need to record and acknowledge time spent on administrative tasks to provide a true reflection of GP workload.

> *"We're not good at documenting the number of letters we receive, how many prescriptions we write, how many queries are requested, how many emails we receive from outside agencies, how much time we spend doing a safeguarding form, or how many hours we spend completing information for the coroner. All of this is part of our role but none of that is calculated, which can significantly extend the hours spent working."*
>
> *GP*

53. The ten minute appointment constraint often leads to revisits. Extending the appointment to fifteen minutes would improve patient outcome and GP workload.

> *"The longer the appointment, the more you're able to achieve in one appointment rather than having the patients come back to finish off the conversation because you've got a waiting room full of patients. It also gives you more opportunity to do a little bit of health promotion, promoting healthy lifestyle, giving a bit more preventive advice."*
>
> *GP*

54. A General Practice Nurse spoke about how the business approach to measuring outputs does not reflect nor acknowledge the actual workload.

> *"You're being expected to work in a very task driven, mechanistic way with people that don't fit neatly into boxes."*
>
> *General Practice Nurse*

55. A MSK First Contact Practitioner described how unsustainable the role was until recently.

> *"It was completely unmanageable. On a Tuesday I would work three appointments in one surgery, the next three appointments in a different surgery and then a 45 minute commute to the next surgery."*
>
> *MSK First Contact Practitioner*

56. A number of participants gave examples of having to go without lunch, working excessive additional hours in their own time as well as the physical impacts on them.

> *"We get a 10 minute toilet break, but you get a patient put in that break sometimes, so you don't wee all day.....that's the reality of what it's like."*
>
> *General Practice Nurse*

57. Participants referenced a range of excellent training and continuing professional development opportunities available to them, such as online courses on Y tŷ dysgu (HEIW). However, because of their workload there is very limited or no protected time allocated for training in general practice. One GP compared the one afternoon a month protected time for training in the local practice with the one day a week given to consultants in secondary care.

58. Opportunities to attend face-to-face training and conferences are exceedingly rare with GPs and general practice workforce missing out on vital chances to network, share experiences, and boost morale.

> *"It's those conversations over a cup of coffee where you say, how are you managing this or I've come across an interesting patient with this or whatever....it's those conversations that really change your practice."*
>
> *GP*

59. Significant factors have contributed to the increase in general practice workload including:

Complexities

60. The demands of an ageing population, the complexities of comorbidity and the mental health of all ages, especially the younger generation, were highlighted.

> *"It's all happening at the same time and these aren't quick, five minute conversations. It's a very different climate than in the past."*

GP

"We've got an ageing growing population with multi morbidities....it's very rare for a patient to come in having twisted their ankle and that's it."

MSK First Contact Practitioner

Secondary care

61. All GPs, general practice managers and healthcare professionals conveyed their deep concern for the ever-increasing transfer of work from secondary care to primary care, specifically to general practice.

"The massive transfer of work from secondary to primary care is becoming overwhelming. The days are becoming unsustainable in general practice because there's no way of saying 'enough is enough.'"

GP

62. Participants heeded the need for a better understanding of primary care - general practice in particular - by secondary care providers. For example, an appreciation of the time needed to admit a patient. This would improve patient experience too.

"I was trying to admit somebody the other day. It took 20 minutes for the Bed Bureau to answer the phone. And when you've got 10 minutes back-to-back, I know it's not their fault, they are overwhelmed by people trying to admit to hospital. Then the actual phone call took another 15 minutes, and that's after you've assessed the patient....you just get so far behind."

GP

63. One GP mentioned that 10% of the general practice appointments serve patients waiting for secondary care appointments.

"We get left holding patients for whom we cannot provide an adequate level of care, but they've got nowhere else to go."

GP

"Having a patient in surgery that you need to admit to hospital and having to wait with them hours and hours and hours - while you see them deteriorate - for an ambulance causes a moral injury to that person, and we're all increasingly being subject to this because the health service isn't able to deliver the care that we were trained to deliver, that we want to deliver, and our patients expect us to deliver."

GP

64. The demands from secondary care limits opportunities to address preventative work.

"We're working in that red zone consistently.....we can only deal with what we're seeing in front of us. We don't have a chance to pre plan or do any preventative health because we're always just seeing all the immediate complex patients who historically would have been in secondary care."

General Practice Pharmacist

65. Several participants expressed concerns about the lack of communication and opportunities for collaboration with secondary care. Examples were provided of instances where general practices were not consulted regarding changes directly impacting their operations. One participant cited the recent procurement of a system whereby secondary care letters are now physically mailed to general practices instead of being sent electronically.

"Now I have to pay someone to physically scan the letters and code them; that takes so much more resource....but no one asked us to be involved in that procurement."

General Practice Manager

Managing expectations

66. GPs and general practice workforce explained the challenges of managing health board, secondary care and patient expectations and responding to the *"ever-increasing supply and demand."*

> *"There's something around us creating or driving what I call the Amazon Prime culture. There's loads of people that are scared out there and don't have the level of health literacy to take any reassurance themselves. They've got busy lives and they want an instant fix."*
>
> *Advanced Nurse Practitioner*
>
> *"Sometimes it seems the health board still don't always seem to understand how general practice works. It's just difficult all round but despite everything we carry on doing what I think is a really amazing job on really limited funds."*
>
> *General Practice Manager*

67. Recognising that the general public has adapted well to numerous changes in general practice in recent years, it is essential for individuals to take responsibility for managing their own health conditions, whenever feasible.

> *"I think there does need to be greater awareness of the impact of what you do and how that affects the NHS as well."*
>
> *General Practice Pharmacist*

68. One participant explained the need to work with frequent flyers (*"people who attend the GP practice a lot, people who attend the hospital a lot for investigations and people who call the ambulance unnecessarily"*) to proactively reduce wasted resources.

Burnout

69. Burnout is one of the main challenges threatening the sustainability of general practice.

> *"It's the relentless and overwhelming fact that you can never get on top of your work. You never feel that you've finished your job and that you can walk away and go home."*
>
> *GP*

> *"I want to give people a good service.....But, I've seen a doctor I'm working with become ill, worked until he collapsed. Sometimes I'm worried that that will happen to me, and I'm in my early forties. It worries me what the impact is on our health."*
>
> *GP*

70. Several references were made to the detrimental effect on GP and general practice workforce mental health and the importance of providing counselling and confidential mental health support, such as Canopi, providing support services to NHS and social care staff across Wales.

71. Several GPs noted that many within the profession are now adopting a reduced working schedule of three to four days per week (0800-1830) in order to manage the workload pressures and ensure safe working conditions. This necessitates an increased demand for GPs, which consequently exacerbates the strain on general practice estate.

72. Workload pressures and burnout impacts recruitment and retention at all levels of employment in general practice, as well as the number of GPs wanting to stay in Wales after completing their training.

Recruitment and retention

73. Recruitment and retention were highlighted as a major threat to sustainability in general practice, even more so in rural areas: *"No one wants to come here."*

74. GPs and general practice workforce noted the difficulties in recruitment and retention, especially in deprived areas, largely due to the unattractive nature of long working hours, heavy workloads and patient demands. One General Practice Manager observed that of the ten practice managers in the cluster five years ago only three remain.

> *"I think the demands on staff is creating a culture that is very much around survival and that's impacting on how attractive that is to the future workforce."*
>
> *Advanced Nurse Practitioner*

75. Temporary contacts, lack of leave rights (such as maternity leave) and minimum wage deters many high-calibre healthcare professionals from pursuing a career in general practice.

> *"You're not going to attract good professional people with a yearly contract, we need long vision plans rather than quick fixes."*
>
> *GP*
>
> *"Maternity leave is a huge thing. I'm turning 30 and thinking am I going to have children. But my only way out is to leave general practice and work in the NHS for a year and then have children, which is really sad because I absolutely love working in general practice."*
>
> *General Practice Nurse*
>
> *"Our staff, don't deserve to be on minimum wage, they really don't. One of the biggest things about retention in my area was when ALDI opened over the road from us and the entry level shop assistants get paid £13.00 an hour and also get discount on your shopping and that's not to be sniffed at when you are on minimum wage."*
>
> *General Practice Manager*

76. The very nature of pilots and temporary projects, however successful, lead to instability in continuity of care for the patients and insecurity for the workforce.

> *"We're basically stuck in that cycle of every year looking if roles will continue or not. We employ to deploy really in Wales from an AHP [Allied Health Professionals] perspective."*
>
> *Occupational Therapist*

77. Participants emphasised the significant effort and dedication involved in training GPs; however, it is often the case that these trainees lack familiarity with the area and have no intention of remaining in the practice post-training. One GP shared an experience of a nine-month recruitment process to secure a partner who will not commence until 2026, creating considerable uncertainty within the practice.

78. Many participants spoke about the need to train and recruit GPs from Wales, in Wales, especially Welsh-speaking GPs.

> *"We need to train more Welsh-speaking doctors, in Wales. .We hear about young people in Wales who aren't accepted to study medicine, young people who have great communication skills but we're losing them..... Wales needs to look after itself."*
>
> *GP*

79. The bureaucratic and awkward process for GPs who want to return to general practice after a break, particularly affecting women in their 30s was highlighted.

> *"If you can't reach out to them, you can't find out what their barriers are to coming back, and it's such a loss to lose, especially women who've got the experience of bringing up children and would be very useful back in general practice... it's a big problem."*
>
> *GP*

80. Financial risks are preventing younger GPs from becoming partners in general practice while practices struggle to financially employ them.

Negative narrative

81. GP and general practice workforce morale and self-esteem is greatly affected by the negative narrative experienced by them from many directions including government, health boards, other healthcare professionals and the general public.

> *"The public perception is still that we're rubbish but we're not because they tell us all the time how amazing the doctor is and how grateful they are for everything we do. But the perception of the media seeps in and people don't realise this."*
>
> *General Practice Manager*

"It's not a criticism, but I don't think politicians ever have really understood nor have our secondary care colleagues ever really understood how much we do in our working day as GP partners."

GP

82. A number of participants spoke about feeling undermined, being taken for granted and about lack of recognition, even within the health service.

"GPs need to be valued for their experience and their training and their knowledge and their ability to deliver cost effective care quickly and on a massive scale....No other aspect of the health service, no other health professional in the health service do it quite like GPs."

GP

83. Specific reference was made to the unfavourable perception regarding the front desk workforce in practices.

"Receptionists get a bad name, but they're very instrumental and very helpful to our day. They actually know which patients we should be worried about and they come and let us know....They don't need the abuse that they get, at the end of the day it's not their fault. The abuse is not acceptable and it's escalating all the time."

GP

84. The negative narrative is often driven by the lack of awareness and understanding about the work of general practice leading to a call for a clear definition of the role of a GP to manage expectations.

"When people say GPs want more money I think the public think that I want more money myself as a partner and it really isn't, it absolutely isn't. If I'm asking for more funding for my surgeries it's because I want a pharmacist or a new nurse or a new doctor.... we do really do need to change the language."

GP

"GPs want nothing more than to see patients, they don't want to have patients waiting weeks to be seen. It would be nice to change the narrative……It doesn't matter what we do and what we say, we're always going to be the fall guys and that's the absolute reality of it."

GP

"We need to redefine what our role as GPs is because it seems like our role in society expects us to do everything that no one else does, and I think that's a really insulting thing for our profession."

GP

General Practice estate

85. Inadequate facilities, lack of funding for improvements, and the impact on service delivery were highlighted by many participants. Indeed, many shared their own experiences of working in premises *"falling apart"* and how the state of the premises often impacts how patients feel and how the workforce is treated.

"Of the four fluorescent lights in my consulting room, three of them were not working and I asked the health board to come and fix them and nothing happens. So I go to the local electrical shop, buy fluorescent tubes, get the step ladder out and change them…..that's not really a job for the GP, but it emphasises the total neglect that there has been for premises, whether they're owned by the GPs or whether they're owned by the health boards."

GP

86. One participant cited an example of a general practice currently operating out of a portacabin, which was initially intended as a temporary solution but has been in use for over a decade.

87. Health board rental income has not increased for many years and does not match rental costs. As a result there is no incentive to spend on the premises.

"We've had 20 years of arguments [with the health board] about buildings and trying to get the room we need….Our particular problem is that we're doing the health board a favour because we're

providing a service in health board run buildings, which are inadequate and there's no incentive for them to rebuild and put us somewhere else."

GP

88. Disparities in access to infrastructure and resources within general practice, particularly affecting practices in deprived areas were discussed: *"..it all depends where you are in Wales."* Some suggested that general practice estates should adhere to a standard quality of premises.

89. When local general practices close, services often move away from areas with the greatest patient need, lacking adequate infrastructure like bus services. This issue is especially prevalent in deprived areas of Wales.

90. The provision of services in close proximity to patients should be a priority. However, the inability to expand general practice premises restricts the development of patient services, including the potential of incorporating multidisciplinary teams.

"If we're looking at primary care under one roof, then the estate's not fit for purpose. We're all wanting to help primary care, do preventative sessions and get in before it becomes a crisis, but if we're not physically there it's a struggle."

General Practice Pharmacist

91. A number of GPs expressed their frustration at not having the physical space to offer training provision for students, junior doctors and clinicians wanting primary care training, as they highlighted the palpable consequences of the issue.

"We're very proud of our teaching and training. So if we can't offer the space, we can't get those students, we can't get the trainees in. So it's a vicious cycle then."

GP

92. The multidisciplinary team and the practices seeking to accommodate the team on the premises also experience similar frustration.

Multidisciplinary team

93. Highly skilled healthcare professionals in specialised areas who can offer their expertise, alongside the appropriate utilisation of team members' skills, are some of the principal advantages of the multidisciplinary team(MDT) in general practice. This ensures both efficiency and effectiveness in patient care.

> *"An MDT setting when used appropriately is excellent. You all learn from each other and it's a really good learning environment because you can all add something different. It's a prudent approach to healthcare."*
>
> *General Practice Pharmacist*
>
> *"You cannot underestimate being able to wrap around a patient and having your MDT all on the same page....you can pick up on things that could help and make a difference."*
>
> *Occupational Therapist*

94. The importance of the MDT in managing patient waiting times, sharing of workload and decision making was also highlighted by some participants.

95. Some service users conveyed their appreciation of the support they receive from the multidisciplinary team and regret how some special clinics are no longer available.

> *"Special clinics were a really good way of learning and understanding....I miss them because they were useful."*
>
> *TPAS participant*

96. Opportunities to develop and further the role of the multidisciplinary team were suggested by some participants, such as use of 'hot clinics' – opportunities to discuss individual cases.

97. Allocating a pharmacist to each practice would substantially improve GP workload and potentially patient experience too.

"If each practice could be allocated a pharmacist....it would save the NHS millions in Wales. It would be much safer, there'd be less patients in hospital because a lot of the illnesses are iatrogenic caused by the drugs that they're on, either taking too many or side effects. It would be expensive, but would be paid back in no time."

GP

"If I knew it's something the pharmacist could do, I'd rather go straight to the pharmacist. This helps the system too."

Carer

98. Some allied healthcare professionals highlighted the need for clarity and better understanding of their roles within general practice and how they can best support the GP.

"One of the best things I've ever done as an occupational therapist is working within the primary care zone. But, being able to demonstrate it in a way that's meaningful is difficult."

Occupational Therapist

99. Challenging factors of the multidisciplinary team were also addressed, such as the potential fragmentation of care, sharing of information, supervision and devaluing professional core expertise.

"We are very proud of what we're good at and should not have to be something that we're not just to fill an economic gap."

General Practice Pharmacist

"I know where my boundaries are, I just hope that everybody else knows where their boundaries are as well."

Advanced Nurse Practitioner

Digital technology

100. Digital technology possesses the potential to revolutionise ways of working within general practice and significantly enhance patient experience and continuity of care. However, the current digital infrastructure impedes the realisation of this potential.

101. Innovation to streamline digital technology systems, improve integration between systems and provide access on a need to know basis to make safe and appropriate decisions, would hugely impact ways of working and workload as well as patient outcomes.

> *"The IT infrastructure in Wales is appalling.....but I really do think that Wales could crack this and show the world what an integrated health service should look like....You would not believe how many hours that would save everyone."*
>
> *GP*

102. All participants expressed significant concern and frustration regarding the barriers presented by digital technology that they encounter on a daily basis.

103. One participant explained that the coding system used in Wales is different to the system used in England and Scotland.

> *"There are huge amounts of innovation happening in the UK which could really transform the way that we do things and it is barred to us in Wales."*
>
> *General Practice Manager*

104. Another participant questioned why Wales is not using the TPP system used by many countries, including England. This would improve communication within Wales and beyond.

105. Another participant referenced a database developed by the Royal College of General Practitioners and Oxford University that assesses practices which voluntarily contribute data. This tool enables a detailed analysis of specific practices and their patient populations to identify valuable insights into service needs. This type of database would be invaluable in Wales.

> *"We've got a database that's unused and untapped and would be invaluable for directing services."*
>
> *GP*

106. Participants explained the barriers of having to manage their workload with outdated computer systems, poor internet connection in many rural areas and no access to wifi in some practices.

> *"I don't always have access to working printers, which obviously then causes more time because you're having to scribble down all the details instead of just printing off a sheet."*
>
> *GP*

107. Many practices are currently either using the EMIS system or in the process of transitioning from Vision to EMIS. While some face challenges such as inadequate training, lack of funding to support the transition, and access issues during the transfer, participants generally view the 'new' system favourably.

108. Participants described the potential of e-prescribing as a transformative development. However, they emphasised that adequate funding is necessary for its implementation and expressed concerns regarding the duration required for its rollout. E-prescribing has been common practice in England for over ten years.

109. One participant highlighted the use of the askmyGP app at the local general practice and its significant impact on alleviating the 8:00am telephone rush.

110. Current and potential use and benefits of using AI were discussed, such as Heidi Health (for transcription of notes) and Klinik (online triage system). However, there was apprehension regarding security, accuracy and the effect on personal communication with the patient.

Patient experience and trust

111. Many service users relayed their positive experiences of general practice, the quality of care and the empathetic support they receive.

"I have a GP who is very supportive of my needs and very understanding of my caring role and how that impacts my life. Sometimes she will ring me, without me having an appointment, to check in on me."

Carer

"We've been very fortunate here, since our son was born the surgery has prioritised us as a family, and we're getting excellent support."

Carer

"Everyone in the practice does care and are very caring, I'm treated well and they do everything they can to help. It's just that initial step of getting the appointment."

Carer

Barriers

112. However, many barriers were also highlighted throughout the engagement programme including:

Accessibility barriers

113. The most common barrier is the requirement in most practices to book appointments on the telephone with all service users referring to the 8am rush. Although, one participant noted a significant improvement after the practice introduced two daily appointments slot sat 0800 and 1330.

"When I phoned 111 in the evening, I was told to make an appointment to see the GP in the morning. But, I phoned 111 in the first place because I couldn't get a GP appointment.....It's no wonder that people go to A&E."

BAWSO participant

114. To improve the patient experience of people living with disabilities and additional needs alternative methods of booking appointments are needed.

> *"It's been so bad with me trying to access my healthcare that my husband now is my named contact. So when the GP surgery needs to contact me, they ring my husband. I'm very lucky that I have a supportive great husband, but a lot of disabled women do not."*
>
> *Service user*

115. Policies and procedures for getting and attending appointments often become disabling barriers, especially for those who can't use the phone or travel independently.

> *"More needs to be done to embed the social model of disability…There are so many barriers that are disabling in themselves a lot of the time when you're trying to thrive as a disabled person and maintain as much health as you can."*
>
> *Service user*

116. Embedding allied healthcare professional services within general practice would enhance accessibility, particularly in rural areas. One participant mentioned that she has to travel over twenty miles to attend a physiotherapy appointment, incurring a cost of £50 each way, due to the lack of public transport.

117. Although positive about allied healthcare professional services and support, the limited access to GPs was a concern for many service users.

> *"No disrespect to the nurse, she's wonderful, but she's not a doctor and they don't delve deeper into other issues."*
>
> *TPAS participant*

118. Extending appointments and general practice hours was recommended by service users to improve accessibility.

> *"There's more to the person than just the condition, but applying that is very, very difficult due to appointment time constraints and the resources available."*

Service user

119. Challenges with accessing medication because of ways of ordering, shortage of or receiving wrong medication were highlighted.

> *“Some weeks I've had to go to the surgery three times to get prescriptions right, and the surgery is ten miles away. The only positive is that the prescriptions are free.”*
>
> *TPAS participant*
>
> *“I’m diabetic, and I’ve been told to order my prescription online, but when I go online I need a code that I haven’t been given…so I’m confused what I should do.”*
>
> *BAWSO participant*

Language barriers

120. Many service users emphasised that it is of utmost importance to their patient experience that they are able to communicate and engage in conversations in Welsh, particularly when they are at their most vulnerable.

> *"If I have to translate for the healthcare staff, that takes away one of the strongest things about our son, which is his ability to communicate."*
>
> *Carer*

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

> *"I get my letter and it says please phone, so even before you get through the door, the barriers are in place. I can't phone to make an appointment."*
>
> *Deaf community participant*

122. Some service users expressed concerns that dispersed and trafficked people are not able to access general practice upon arrival in Wales because of language barriers. Others welcomed the benefits of using language line to improve accessibility and communication, especially for vulnerable general practice service users.

> *"It is a challenge to make an appointment at eight o'clock in the morning, but it's even more of a challenge when you have a language barrier too."*
>
> *BAWSO participant*

Digital barriers

123. Many service users expressed their frustration about the lack of opportunities to utilise digital technology in general practice. For example, very few were able to access and use the NHS app to book appointments and see their results.

124. Some participants felt confident and satisfied using digital communication with their general practice, for example the ability to send images of their ailments. Others stressed the importance of traditional, face-to-face clinical care.

125. Digital exclusion remains a significant barrier for some service users. For example, one practice requires patients to use econsult as the only option to make an appointment. Those without digital access are advised to seek assistance from family and friends to schedule their appointments.

126. The reliance on calling patients' names aloud in waiting rooms, resulting in deaf patients missing their turn was another example.

127. Participants suggested simple solutions, such as text message notifications or visual display screens, to make the system more accessible:

> *"Most people have phones. Why not send a text message when you're being called for your appointment? Simple things make all the difference."*
>
> *Deaf community participant*

128. GPs also suggested ways to enhance continuous digital communication with patients to reassure them and improve their experience.

> *"The moment the referral goes off, there should be something sent to the patient to know that they're on the list, just to avoid confusion; maybe they should get told the current waiting time is X amount of weeks, because otherwise they're wondering, are they on the list. It's these things that are stressful for patients."*
>
> *GP*

Public satisfaction

129. The implementation of patient forums and co-production to make meaningful changes were recommended to improve patient experience and public satisfaction.

> *"We know primary care and general practice is under so much pressure but if you route it back to coproduction....if you're constantly talking with and engaging with and listening to ideas from your patients, changes could be made...we want the NHS to thrive."*
>
> *Service user*

130. One GP highlighted the need for transparency in surveys to improve public satisfaction and trust in general practice.

> *"In some of the more deprived areas, they're not able to read and write well and that's why there are less complaints in writing, because they're not able to articulate themselves in the same way.....it leads to a disproportionate response where disadvantaged people get disadvantaged again."*
>
> *GP*

131. To better patient service and satisfaction GPs and general practice workforce emphasised the need for an enhanced focus on prevention services suggesting a regular health check for certain ages and conditions. This could

improve health literacy and encourage patients to take ownership of their health conditions.

> *"We need to provide people with the option to practically manage their health and not waiting for things to go wrong before they engage with their general practices."*
>
> *Occupational Therapist*

3. Ways forward

In this section, we present a collection of ideas suggested by participants during the engagement sessions. These ideas represent diverse perspectives aimed at improving the current situation.

132. As documented in these findings, numerous suggested ways forward were proposed by the participants during discussions. This possibly reflects the nature and magnitude of the threat to the sustainability of general practice in Wales. Some of the main potential pathways for positive change are shared here to inspire further dialogue and consideration.

Funding model

1. Review Carr-Hill formula.

Funding

2. Review primary and secondary care funding disparity.

Workload

3. Extend appointments and surgery hours.

Burnout

4. Record and acknowledge time spent on administrative tasks to provide true reflection of workload.

Recruitment and retention

5. Extend duration of pilots and projects.

Negative narrative

6. Redefine and recognise role of general practice.

General practice estate

7. Review health board rental income for general practice estate.

Multidisciplinary team

8. Allocate a pharmacist to each general practice.

Digital technology

9. Streamline digital technology systems.

Patient experience and trust

10. Provide more opportunities for prevention services.

Annex 1: Focus group and interview questions

The following questions served as a flexible guide for the focus groups and interviews.

133. The focus groups and interviews were participant-led, allowing for an organic conversation flow. The questions were used to facilitate discussion based on the participants' responses and needs.

Questions for general practitioners

1. What are the main challenges threatening the sustainability of general practice?
2. How sustainable is the current funding model for general practice? What changes (if any) need to be implemented? What difference would this make?
3. What are the positives and/or negatives of multidisciplinary teams within general practice?
4. Is the general practice estate fit for purpose? Do you have access to the infrastructure and resources you need?
5. In your view, how can access to digital technology within general practice be improved? What difference would this make?
6. What practical actions need to be taken to improve GP workload and well-being? To what extent would these actions impact staff recruitment and retention?
7. Do you feel that you have access to effective training and continuing professional development?
8. In your view, how can public satisfaction and trust in general practice be improved?
9. What, (if anything) do you think needs to change in general practice to make it fit for the future?

Questions for general practice workforce

1. What are the main challenges/demands threating the sustainability of the general practice workforce?
2. How sustainable is the current funding model for general practice? What changes (if any) need to be implemented? What difference would this make?
3. Is the general practice estate fit for purpose? Do you have access to the infrastructure and resources you need? In your view, how can access to digital technology within general practice be improved? What difference would this make?
4. What are the positives and/or negatives of multidisciplinary teams within general practice?
5. What practical actions need to be taken to improve GP workforce workload and well-being? To what extent would these actions impact staff recruitment and retention?
6. Do you feel you're given enough support to enable effective training and continuing professional development?
7. In your view, how can public satisfaction and trust in general practice be improved?
8. What, (if anything) do you think needs to change in general practice to make it fit for the future?

Questions for general practice service users

1. What are the positives and/or negatives you've experienced while accessing general practice?
2. Have you received care from a health care professional working in general practice e.g. a nurse, physiotherapist, occupational therapist? What are the positives and/or negatives you've experienced while accessing care from health care professionals working in general practice? Do you feel able to access the health care professional who is most suitable to offer the care that you need?

3. Have you come across any good practice examples within general practice? (For example, a multi-disciplinary approach to support/treatment).
4. What are the main barriers, if any, you've faced whilst accessing support/treatment within general practice?
5. What practical actions do you think would help to improve the quality of care within general practice?
6. In your view, how can public satisfaction and trust in general practice be improved?
7. What, (if anything) do you think needs to change in general practice to make it fit for the future?

Annex 2: Partner Organisations

134. Thank you to the following for their support in sourcing participants for the focus groups and interviews.

- Black Association of Women Step Out (BAWSO)
- British Medical Association (BMA)
- Carers Outreach
- Carers Trust
- Chartered Society of Physiotherapists (CSP)
- Institute of General Practice Management (IGPM)
- LLAIS
- Royal College of General Practitioners (RCGP)
- Royal College of Occupational Therapists (RCOT)

- Royal College of Nursing (RCN)
- Royal Pharmaceutical Society (RPhS)
- Tenant Participation Advisory Service (TPAS)
- Views from the Deaf community were drawn from focus groups and interviews conducted for the British Sign Language (BSL) (Wales) Bill.