Cyflwynwyd yr ymateb i ymgynghoriad y Pwyllgor Iechyd a Gofal Cymdeithasol ar ddyfodol meddygaeth deulu yng Nghymru

This response was submitted to the Health and Social Care Committee on the future of general practice in Wales

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Cymru Wales

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

21 October 2025

Estates

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

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

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

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

Digital Infrastructure Deficits: Poor internet connectivity and outdated IT infrastructure - especially in rural practices, limits the ability to use digital tools such as e-prescribing, remote monitoring, and online consultations.

Ownership and Liability Risks: The shift from GP-owned to leasehold premises has not eliminated risks particularly regarding escalating service charges. Owner-occupiers face "*last person standing*" liabilities, despite the Welsh Health Circular[1] policy instruction for health boards to provide support in these circumstances, which can leave a single partner with full financial and operational responsibility.

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

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

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

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

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

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

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

Multi-disciplinary teams (MDTs)

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

Several systemic and operational barriers limit the effectiveness of MDTs:

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

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

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

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

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

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

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

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

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

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

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