

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

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

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

Improvements Needed to the General Practice Estate in Wales

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

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 Many practices are operating from buildings that are outdated, inflexible, and no longer meet the demands of contemporary multidisciplinary care.

1.Space and Capacity

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

2. Safety and Security

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

3. Modernisation and Digital Readiness

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

4. Accessibility and Inclusion

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

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

5. Sustainability and Energy Efficiency

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

6. Flexibility for Future Models of Care

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

7. Tackling Inequality

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

Premises-Related Funding and Support Arrangements

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

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

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

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

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

Additional supportive measures could include:

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

Barriers to Effective Multidisciplinary Team Working in General Practice

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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