

## **Agenda – Health and Social Care Committee**

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Meeting Venue:	For further information contact:
Hybrid – Committee Room 5, Ty Hywel and video conference via Zoom	Sarah Beasley Committee Clerk
Meeting date: 2 October 2025	0300 200 6565
Meeting time: 09.30	<a href="mailto:SeneddHealth@senedd.wales">SeneddHealth@senedd.wales</a>

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### **Private pre-meeting**

(9.00–9.30)

### **Public meeting**

(9.30–14:15)

#### **1 Introductions, apologies, substitutions, and declarations of interest**

(9.30)

#### **2 Inquiry into the future of general practice in Wales: evidence session 2**

(9.30–10:45)

(Pages 1 – 42)

Nia Boughton, Family medicine, Consultant Nurse – Royal College of Nursing Wales

Calum Higgins, Public Affairs and Policy Manager Wales – Chartered Society of Physiotherapy

Kim Willis, Clinical Lead Occupational Therapy Primary Care, Hywel Dda University Health Board – Royal College of Occupational Therapists.

Research brief

Paper 1 – Royal College of Nursing Wales

Paper 2 – Chartered Society of Physiotherapy

Paper 3 – Royal College of Occupational Therapists

### **Break**

(10:45 – 11.00)



**Senedd Cymru**  
**Welsh Parliament**

### **3 Inquiry into the future of general practice: evidence session 3**

(11:00–12:15)

(Pages 43 – 58)

Liz Hallett, Locality Prescribing Advisor and Lead Pharmacist for Aneurin Bevan University Health Board; Prisons and Care Homes – Royal Pharmaceutical Society Wales

Helen Davies, Principal Pharmacist, Primary Care: Medicines optimisation – Royal Pharmaceutical Society Wales

(Members of the Royal Pharmaceutical Society’s Welsh Pharmacy Board)

Steve Simmonds, Contractor Services Development Executive – Community Pharmacy Wales

Dai Williams, Community pharmacist – Community Pharmacy Wales Board member

Paper 4 – Royal Pharmaceutical Society Wales

Paper 4a – Letter from the Royal Pharmaceutical Society – Inquiry into the future of general practice in Wales

Paper 5 – Community Pharmacy Wales

### **Lunch**

(12:15 –13:00)

### **4 Inquiry into the future of general practice in Wales: evidence session 4**

(13:00–14:15)

Craige Wilson, Service Group Director for Primary Care and Deputy Chief Operating Officer

Sharon Miller, Associate Service Group Director for Primary Community and Therapies Service Group

Swansea Bay University Health Board

Paul Mears, Chief Executive

Dr David Andrews, Medical Director for Primary Care and Community Services

Cwm Taf Morgannwg University Health Board

Elaine Lorton, Director of Primary Care, Community and Mental Health Services

Powys Teaching Health Board

## **5 Paper(s) to note**

(14:15)

### **5.1 Submission from My Death, My Decision to assist the report on the Legislative Consent Memorandum for the Terminally Ill Adults (End of Life) Bill.**

(Pages 59 – 69)

### **5.2 Submission from Wales Humanists to assist with the report on the Legislative Consent Memorandum for the Terminally Ill Adults (End of Life) Bill.**

(Pages 70 – 79)

### **5.3 Letter from the Chair of Petitions Committee re Petition P-06-1505: Review the Carr Hill Formula in Wales – the funding system for primary care**

(Pages 80 – 81)

### **5.4 Letter to Chair of Petitions Committee re Petition P-06-1505: Review the Carr Hill Formula in Wales – the funding system for primary care**

(Page 82)

## **6 Motion under Standing Order 17.42 (vi) and (ix) to resolve to exclude the public from the remainder of the meeting**

(14.15)

## **Private Meeting**

(14.15–15.00)

**7 Inquiry into the future of general practice in Wales: consideration of evidence**

(14.15–14.20)

**8 Legislative Consent Memorandum for the Terminally Ill Adults (End of Life) Bill: consideration of draft report**

(14.20–14.50)

(Pages 83 – 111)

Paper 6 – Draft report: Legislative Consent Memorandum for the Terminally Ill Adults (End of Life) Bill

**9 Reviewing Committee effectiveness in the Sixth Senedd**

(14.50–15.00)

(Pages 112 – 114)

Paper 7 – Reviewing Committee effectiveness in the Sixth Senedd

# Agenda Item 2

Document is Restricted

**Cyflwynwyd yr ymateb i ymgynghoriad y [Pwyllgor Iechyd a Gofal Cymdeithasol](#) ar [dyfodol ymarfer cyffredinol yng Nghymru](#)**

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

**GP15 : Ymateb gan: Coleg Nyrsio Brenhinol Cymru | Response from:  
Royal College of Nursing**

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## **The Royal College of Nursing Wales response to the Health and Social Care Committee inquiry into ‘The future of general practice in Wales’**

### **Introduction**

The Royal College of Nursing is the professional body nurses, midwives, health visitors and nursing students, with around 30,500 members in Wales. Two thirds of our members work outside the acute hospital environment in the community, including working in general practice and primary care. The RCN is a major contributor to nursing practice, standards of care, and public policy as it affects health and nursing. The RCN represents nurses and nursing, promotes excellence in practice and shapes health policies.

The Terms of Reference for this Inquiry focus specifically on general practice and the workforce employed by these employers. However, general practice services exist in a broader context of primary care, community and social care services.

It is the view of the RCN that planning for primary care services needs to consider services both within and out with the GMS contract. Primary Care Nurses possess the exact skills and attributes required to meet modern patient need and drive forward this transformation.

Registered Nurses and health care support workers are employed by GPs. There is a wide range of qualifications, experience and job roles undertaken by registered nurses employed by GPs. Registered Nurses can be qualified as Nurse Practitioners, independent prescribers, Nurse Specialists and Consultant Nurses.

Primary Care Nursing presents a credible solution to upscale both health prevention and long-term condition optimisation agendas, improving access, supporting the care closer to home agenda and improving quality of life for the people of Wales in doing so.

Within the GP surgery it is often the Registered Nurse that will see, advise and treat people appropriately. Registered nurses, depending on their level of qualification can undertake a huge range of assessments and interventions, immunisation and vaccination, the management of long-term conditions and cervical cytology. Registered Nurses can treat small injuries, assist with minor operations done under local anaesthetic, lead patient care in managing long-term conditions and smoking cessation, run vaccination programmes, and more.

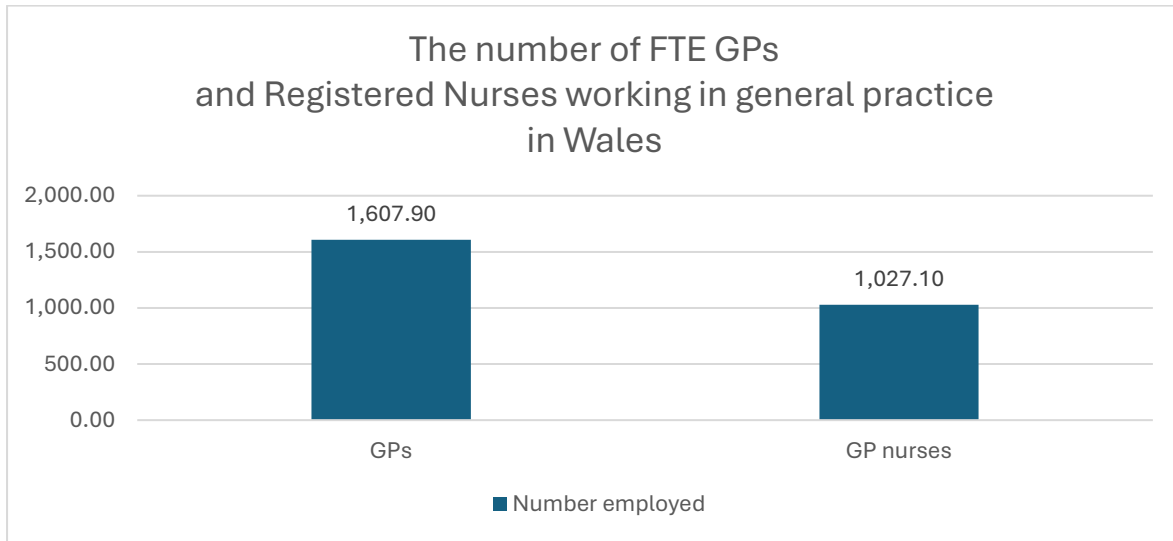
### **GP Nursing workforce**

There are 1,027.1 FTE registered nurses working in general practices in Wales, in comparison to 1,607.9 GPs (both figures are as of 30 September 2024).<sup>1</sup>

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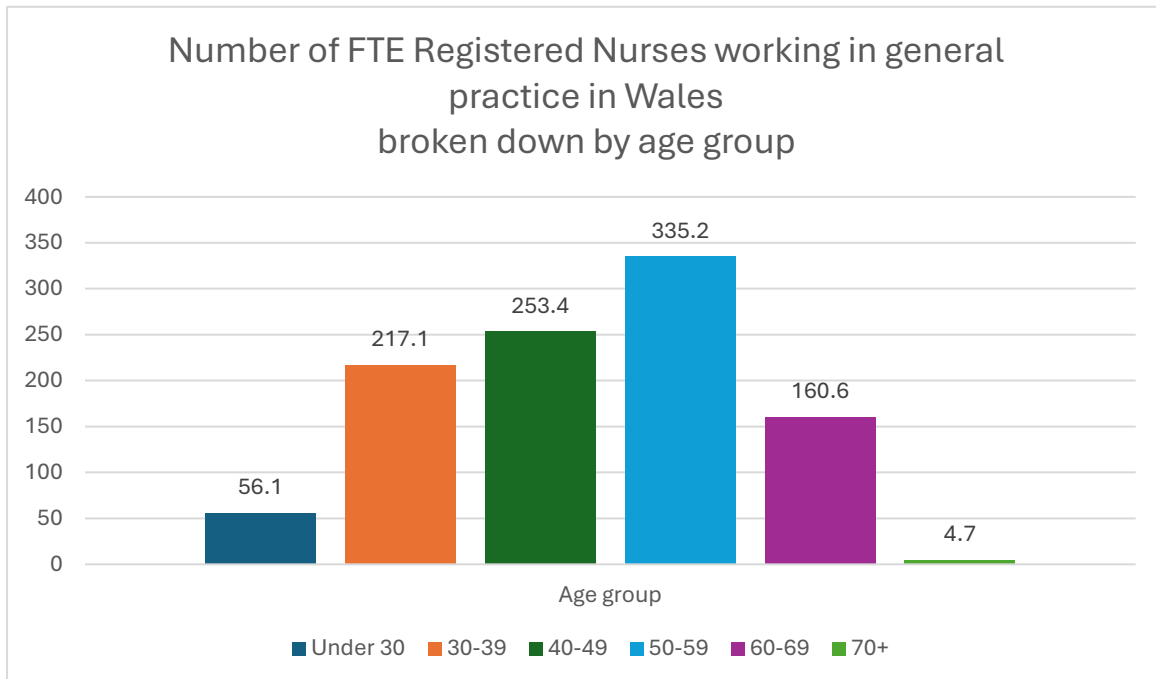
<sup>1</sup> StatsWales: <https://statswales.gov.wales/Catalogue/Health-and-Social-Care/General-Medical-Services/General-practice-workforce>

**Table 1** <sup>2</sup>



The age profile of nurses working in GP settings is concerning. Almost half (48.7%) are at least 50 years old and 16.1% are aged 60 or older. Most of the remainder are between 30 and 49 years old (45.8%), with just 5.5% aged 29 or younger. This age profile is concerning because nurses approaching (or older than) 55 are more likely to be considering leaving the workforce as they near retirement age. (Figures as of September 2024).

**Table 2** <sup>3</sup>



<sup>2</sup> StatsWales: <https://statswales.gov.wales/Catalogue/Health-and-Social-Care/General-Medical-Services/General-practice-workforce>

<sup>3</sup> StatsWales: <https://statswales.gov.wales/Catalogue/Health-and-Social-Care/General-Medical-Services/General-practice-workforce/widerpracticestaffheadcount-by-age-localhealthboard>

The Welsh Government should therefore ensure that nursing in GP settings is seen as an attractive career option for newly qualified nurses.

Health Education and Improvement Wales (HEIW) is responsible for commissioning nursing student programme places at universities. HEIW's Education and Training Plan (ETP) 2025-26 shows that only 21 places for the post registration General Practice Nursing Foundation Programme have been commissioned for 2025-26, even though HEIW had originally requested Welsh Government funding to commission 50 places.<sup>4</sup> In order to ensure resilient primary care services in Wales that are fit for the future, more postgraduate student places must be commissioned.

Another barrier to ensuring an effective nursing education for nursing students in primary care is the lack of placements in GP surgeries. One reason for this is because GPs require payment for allowing a nursing student to have an education placement at the surgery. This is not equitable when other parts of the NHS and independent health and social care do not receive a payment for placements. The Welsh Government, through HEIW, should ensure a consistent policy position regarding placement tariffs.

Wales requires significant investment in the development of an educational pipeline of highly competent Primary Care Nurses and an onwards postgraduate career framework. It is important that all primary care registered nurses have access to HEIW's Professional Framework for Enhanced, Advanced and Consultant Clinical Practice.<sup>5</sup>

To achieve this, funding is needed to support not only the direct provision of education but also the associated backfill to ensure uptake of courses. Nursing student placements must be funded in parity with the other professions (Pharmacy and Medicine) and should be developed alongside these. For example, the HEIW Nursing Workforce strategy emphasises the public health role of nursing, so new opportunities in nursing education in primary care are needed to fulfil this.

### **The role of the Registered Nurse in general practice**

Primary Care Nurses and advanced health practitioners undertook 22,000 appointments each working day in 2023 – 2024, with 88% of these being attributable to long term conditions management and a further 11% to urgent care needs.<sup>6</sup> It would be normal to see nurses in primary care settings being responsible for leading up to 99% of diabetes care and 86% of respiratory care.

For example, all individuals could be offered a comprehensive appointment with a registered nurse working in general practice or other Primary Care Nurse every 10 years, which would ensure a minimum level of interaction between patients and registered nurses working in general practice. These appointments would involve a two-way conversation between patient

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<sup>4</sup> HEIW, Education and Training Plan (ETP) 2025-26, p. 31: <https://heiw.nhs.wales/et-2025-26/>

<sup>5</sup> HEIW, Professional Framework for Enhanced, Advanced and Consultant Clinical Practice: [Professional Framework for Enhanced, Advanced and Consultant Clinical Practice - HEIW](#)

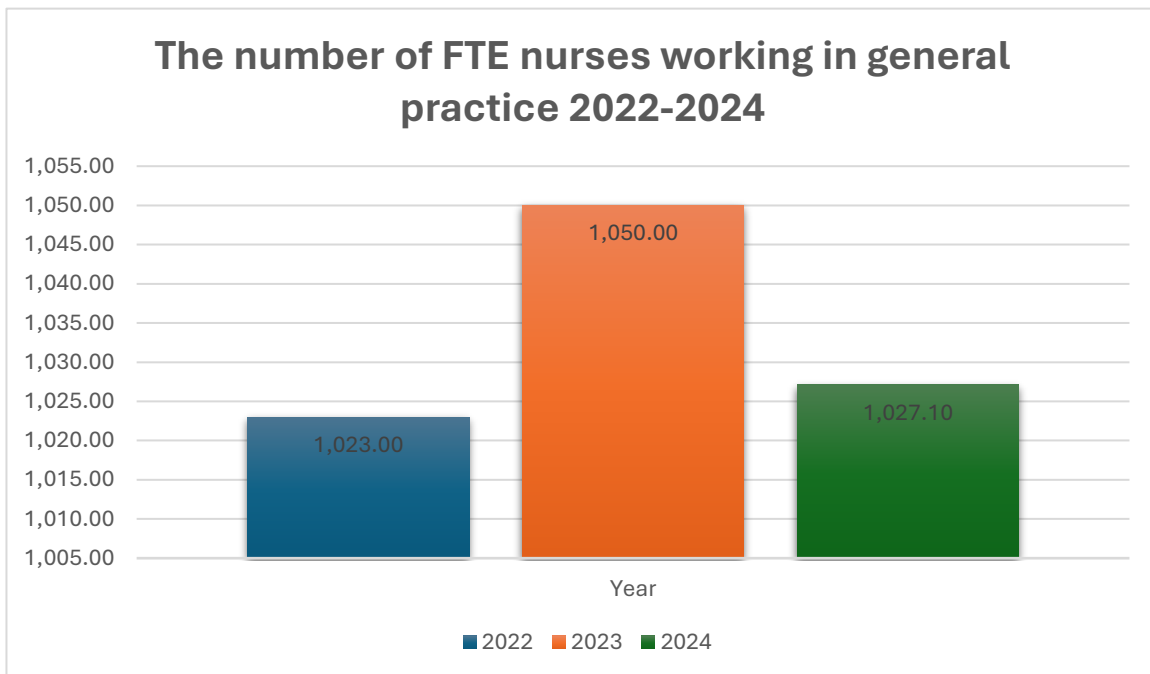
<sup>6</sup> [General practice activity: April 2023 to March 2024 \[HTML\] | GOV.WALES](#)

and nurse, where the patient’s health needs would be assessed holistically, thus ensuring that sufficient attention is placed on mental health as well as physical health. This illustrates the potential of primary care nursing to improving the overall health of the population.

Learning disability nurses work in various settings, including in primary care. One of the “Desired Outcome” identified as part of the Welsh Government’s 2018 report, *Learning Disability Improving Lives Programme* was “To reduce health inequalities for people with a learning disability and reduce avoidable and premature deaths through early intervention, prevention & accessible services” (p. 19).<sup>7</sup> It is very disappointing that, seven years on, this has not been achieved.

2024 saw a decline in the number of registered nurses working in general practice compared to the previous year:

**Table 3<sup>8</sup>**



Advanced Nurse Practitioner posts are needed across Wales to strengthen primary care teams and to deliver more timely services for the public. The Welsh Government should encourage, potentially through the GMS contract, GP employers to achieve this. Alternatively, there could be nurse-led services as part of the GMS contract or Advanced Nurse Practitioners that are directly employed by NHS Wales.

<sup>7</sup> Welsh Government 2018, Learning Disability Improving Lives Programme: [learning-disability-improving-lives-programme-june-2018.pdf](https://www.welsh.gov.uk/learning-disability-improving-lives-programme-june-2018.pdf)

<sup>8</sup> Source: StatsWales: <https://statswales.gov.wales/Catalogue/Health-and-Social-Care/General-Medical-Services/General-practice-workforce/number-of-wider-practice-staff-employed-in-general-practices>

RCN Wales believes that services must be delivered based on the needs of the population, and this includes Welsh language provision.

To ensure that there are enough registered nurses working in primary care, it is vital that we educate the next generation of primary care nurses. HEIW – following advice from the RCN and other royal colleges as well as from primary care clusters – should therefore increase specialist primary care education and nursing student placements.

## **Primary care clusters**

GP practices work in “clusters” to develop services across a geographical area. There are currently 64 clusters in Wales. GP practices work together through this cluster model to ensure consistency in care and support smooth communication between GPs, registered nurses working in general practice and the wider community workforce, including District Nurses.

Registered nurses, both those employed in GP practices and indeed those in community nursing services, need to be included in strategic planning undertaken by primary care clusters. To ensure that this is the case, it should be required that there is a registered nurse on every cluster board.

Clusters have a responsibility to ensure that professional development opportunities are available to those working within them, including registered nurses working in general practice and Healthcare Support Workers, not only to enable essential revalidation, but also as a way of upskilling the primary care workforce and thus reducing the demand on GPs.

Recent research evidence has shown that attendance at cluster meetings by registered nurses working in general practice is very low. Funds directed towards enabling registered nurses working in general practice and nursing teams to be released to attend cluster meetings will help foster a whole system approach and help tackle the current perception of ‘GP’ cluster networks. This would also promote access to training and education opportunities for the workforce.

The Welsh Government either needs to provide the funding to enable registered nurses working in general practice and Healthcare Support Workers to be released (and to pay for the necessary backfilling) or the GP practices themselves need to fund their release.

Leadership and strategic planning in primary care needs cannot be exclusively from a medical perspective. Holistic health prevention and tackling health inequalities require a broad range of health professional interventions. The Welsh Government needs to set some ambitious objectives around the number of nurses and other health professionals taking up leadership roles within their practices, clusters and at a pan-cluster level. In addition, The Welsh Government could consider opening-up GMS contracts so that nurses (for example, consultant nurses) can bid to provide primary care services as independent contractors.

### *An integrated system*

GP services can be difficult for people to access. Most GP services now offer telephone appointments and some face-to-face appointments. However, different practices have different ways of working. Many GP practices, for example, only allow patients to make an appointment if they have had a prior telephone consultation. In order to get that telephone conversation, the

individual needs to ring at 8am and hope to get one of the few slots that are available. GP appointments are normally only available during 9am-5pm on a weekday. Out of hours primary care services are extremely variable across Wales. Very few GP services offer an out of hours visit. The public does have access to nurse-led advice from the 111 service, but if the issue requires a visual assessment, or an immediate treatment such as a prescribed pain killer, the only available suitable service for people to be referred to is the A&E department. This is also an issue for care homes and for people living at home but receiving care from the community nursing team.

Primary care services as a whole need a redesign to serve the community 24/7. If, for example, nurse practitioners with independent prescribing were available in community nursing teams in care homes, and running out of hours services, this would reduce unnecessary hospital admissions and pressure on the ambulance service.

Another problem is the lack of communication between primary care services and secondary care services, which often leaves patients having to re-explain their symptoms, conditions or needs to each service which they encounter.

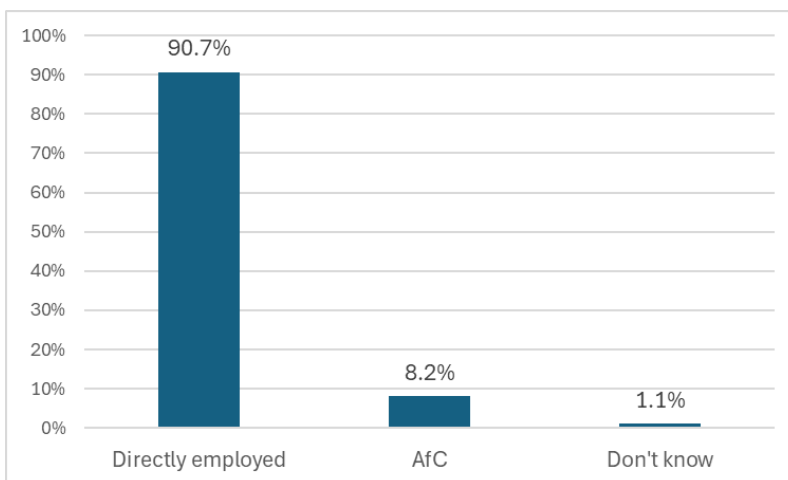
To address this issue, RCN Wales believes that the Welsh Government should help foster an integrated referral system, where communication is seamless between general practices and other health services that a patient may need to access.

### The views of registered nurses working in general practice in Wales

In early 2025, the Royal College of Nursing conducted a survey of registered nurses working in general practices working in Wales and across the UK.

There were 527 respondents in Wales, with employed directly by their practice (90.7%), with a further 8.2% employed on Agenda for Change (AfC) contracts.

**Table 4 – Wales**



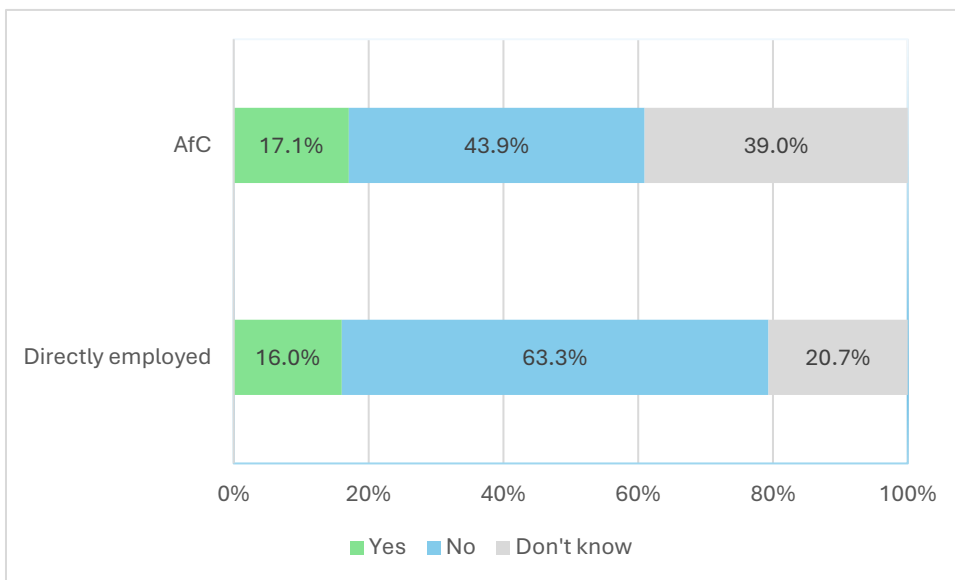
Of the respondents employed on AfC contracts, 82.9% stated they had received the 5.5% pay uplift for 2024/25. 17.1% said they had not received the uplift. Local health boards should ensure that registered nurses working in general practice employed on AfC contracts receive the uplift that were promised to them as a matter of urgency. RCN Wales calls on the Welsh Government to take a strong directional lead to ensure that this happens.

Worryingly, of those directly employed by primary care practices, 75.4% of nurses in Wales said that that their employer had not spoken to them about this year’s pay award.

Respondents who are directly employed appear to be more negative than those on AfC contracts about transparency, with over six in ten stating their employer is not transparent about how their funding is calculated and the funding that they receive from the Welsh Government:

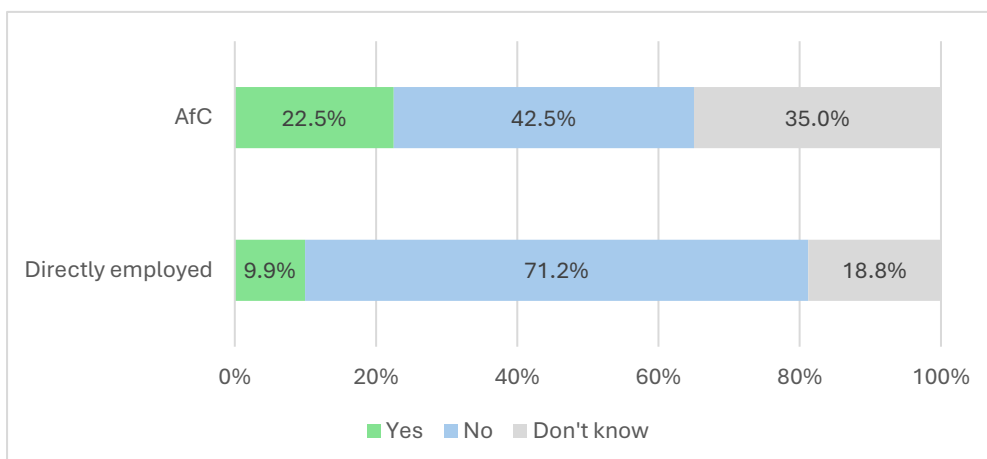
**Table 5 – Wales**

**“Has your employer been transparent about the funding they receive from government?”**



**Table 6 – Wales**

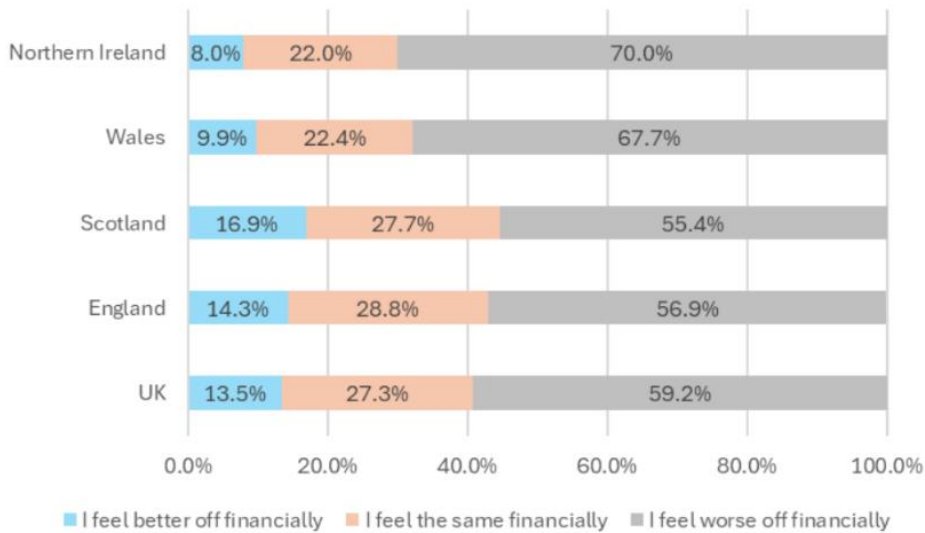
**“Has your employer been transparent about how your pay is calculated?”**



The survey results also showed that, of the four UK nations, Wales had the second highest proportion of registered nurses working in general practice who said that they felt that they were worse off financially this year than they were five years ago, and the second lowest proportion of registered nurses working in general practice who said that they felt that they were better off financially this year than they were five years ago:

**Table 7 – UK comparison**

**“Thinking about your finances today, and your finances five years ago - do you feel better or worse off financially?”**



Unless registered nurses working in general practice feel valued at work, and unless they feel financially secure in their roles, they will leave GP settings. It is therefore crucial that employers are transparent with registered nurses working in general practice about their pay and that these nurses are not kept in the dark. Registered nurses working for GP employers should be put on terms equivalent to Agenda for Change.

**Directly Employed NHS Wales Nurse Practitioners**

Nursing as a profession is not just about caring for those who are unwell, it is also about promoting good health. Not only are registered nurses essential when it comes to treating and preventing ill-health, but they also play a key role in fostering good health.

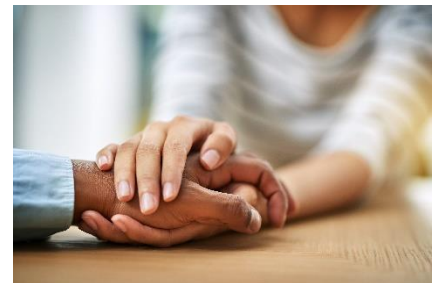
Because registered nurses witness the impact of health inequalities on the health of both patients for whom they provide care and the wider population, they have a clear stake in the direct and underlying causes of ill health. Nurses carry out direct interventions for individuals and families; assess need and help ensure that the right services are commissioned; make sure vulnerable groups are prioritised; provide leadership; support community empowerment; and advocate for change.

Where there is a shortage of general practice services, or where there is a particular local need to tackle health inequalities, primary care clusters should consider employing primary care practitioners to meet local need. Such practitioners could include nurse practitioners who can independently prescribe. There is already a precedent for creating accessible health services in the community; community health services and sexual health services are present examples of this. In addition, the Welsh Government could consider opening-up GMS contracts so that nurses and other health professionals can bid to provide primary care services as independent contractors (as GP employers currently do).

## Recommendations:

### ACTION 1 – Primary care services that are responsive to local need

- The Welsh Government should ensure that primary care services are delivered based on the needs of the population across 24 hours, 7 days a week.
- The Welsh Government could also consider opening-up GMS contracts so that nurses (for example, consultant nurses) can bid to provide primary care services as independent contractors.
- The Welsh Government should help foster an integrated referral system, where communication is seamless between general practices and other health services that a patient may need to access.



### ACTION 2 – Invest in ANPs to reduce pressure on GPs

- Adequate numbers of Advanced Nurse Practitioner posts are needed across Wales to strengthen primary care teams and deliver more timely services for the public.
- The Welsh Government should encourage, potentially through the GMS contract, GP employers to achieve this. Alternatively, there could be nurse-led services as part of the GMS contract or Advanced Nurse Practitioners that are directly employed by NHS Wales.



### **ACTION 3 – Invest in primary care education**

- HEIW – following advice from the RCN and other royal colleges as well as from primary care clusters – should increase specialist primary care education and nursing student placements, including strengthening Welsh language provision.



#### **Coleg Brenhinol Nyrsio Cymru – Royal College of Nursing Wales**

The RCN is the world’s largest professional body and trade union for nursing staff, representing over half a million members, including nurses, midwives, health visitors and nursing students, with around 30,500 members in Wales. The majority of RCN members work in the NHS with around a quarter working in the independent sector. The RCN works locally, nationally and internationally to promote standards of care and the interests of patients and nurses, and of nursing as a profession. The RCN is a UK-wide organisation, with its own National Boards for Wales, Scotland and Northern Ireland. The RCN is a major contributor to nursing practice, standards of care, and public policy as it affects health and nursing. The RCN represents nurses and nursing, promotes excellence in practice and shapes health policies.

**Cyflwynwyd yr ymateb i ymgynghoriad y [Pwyllgor Iechyd a Gofal Cymdeithasol](#) ar [dyfodol ymarfer cyffredinol yng Nghymru](#)**

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

**GP50: Ymateb gan: Cymdeithas Siartredig Ffisiotherapi | Response from: Chartered Society of Physiotherapy**

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Date 28/03/25

Dear Colleague

**Re: Inquiry into general practice**

## Introduction

The CSP welcomes this opportunity to offer comments on the Inquiry into general practice. The consultation and our response compliments the principles in ‘A Healthier Wales’ and, the stated aim of the Welsh Government, to develop a long-term high level workforce strategy in partnership with the NHS and local government, the voluntary and independent sectors as well as regulators, professional bodies and education providers.

## Comments from the CSP

### Overview

We welcome the inquiry and its overall aims. Our aims are reflective of the aims that are articulated in “Healthier Wales”, and how we can help achieve the aims in the strategy together with the Physiotherapy workforce. We welcome that our aims are covered by the areas you have highlighted. In particular we are interested in workforce developments in Primary Care, sustainability of funding, and the growth of the multidisciplinary team;

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.

Our workforce input has direct effect on 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;

Our particular interest is in the area of workforce development:

- workforce planning,
- retention staff workload and wellbeing,
- and the growth of the multidisciplinary team.

### **First Contact Practitioners**

Physiotherapists are playing a leading role in the development of First Contact Practitioner role in primary care. FCPs are increasingly part of the team alongside a GP, providing first contact roles and advanced MSK services for patients in primary care. In line with “Healthier Wales” FCPs are already part of the changing primary and community care settings:

*“Primary and community care will offer a wider range of professionally-led services and support. Within a local area, clusters of GPs, nurses and other professionals in the community, such as dentists, community pharmacists and optometrists, will work closely with an expanded range of professionals, including physiotherapists”<sup>1</sup>*

FCP development has been at a slow pace in recent years, with several issues around sustainability of funding and training opportunities. On a yearly basis we hear of transformation and cluster funding ending, which results in GP clusters and Health Boards entering negotiations to continue FCP services. While all agree FCP services are worthwhile and make savings for the healthcare system overall, the primary and secondary care budgets negotiate to offload these services to each other. This is not sustainable in the long run, and will cause issues in attracting and retaining a skilled workforce who offer a convenient and prudent pathway for patients.

We are hearing that there may be changes to the way FCPs are deployed in pathways, in particular to their “first contact” role. It’s vital we do not lose the skills acquired by these practitioners in any changes made, and that we still offer the same access to their services in any developed system.

We would like to thank the committee for engaging with our FCP colleagues during the private stakeholder session earlier in the year, and hope they can see the value of these colleagues in the primary care system.

### **The policy behind FCP development**

First Contact Practice aligns with the Welsh Governments stated priorities, and meets the projected population needs.

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<sup>1</sup> <https://gov.wales/sites/default/files/publications/2019-10/a-healthier-wales-action-plan.pdf> , page 10

## 1. The overarching strategy

[A healthier Wales: long term plan for health and social care](#) is the overarching strategy for Health in Wales, which has several aims where FCP complements the Government's goals. These are:

- **A whole system approach to health and social care.** It will be a 'wellness' system, which aims to support and anticipate health needs, to prevent illness, and to reduce the impact of poor health. FCP does this by a preventative service being deployed in primary care, focussed on wellness of an individual rather than the need for referral.
- **An equitable system which achieves equal health outcomes for all.** FCP does this by ensuring equitable access to an MSK service in primary care, in the community, closer to the patient.
- **Services which are seamless, delivered as close to home as possible.** This aim is the key driver for FCP development. The strategy states: *"Primary and community care will offer a wider range of professionally-led services and support. Within a local area, clusters of GPs, nurses and other professionals in the community, such as dentists, community pharmacists and optometrists, will work closely with an expanded range of professionals, including **physiotherapists**, occupational therapists, paramedics, audiologists and social workers as a seamless health and well-being service focussed on prevention and early intervention...Every contact is an opportunity to support someone to better maintain or improve their own health and wellbeing, which will often mean looking beyond their immediate symptoms or needs."*

## 2. Strategic [Workforce Plan for Primary Care 2024/25-2029/30](#)

This plan outlines what the Welsh Government and HEIW will action over the next 5 years. Action 8 is: *Embed the new framework for [enhanced, advanced and consultant practice](#) to increase the number of people working in enhanced, advanced and extended roles within primary care settings.* While the plan does not state FCP by name, it supports developing the workforce into enhanced, advances and extended roles, which includes FCP.

The plan also states they will *"ensure a supply of the workforce that is able to meet growing demand within primary care as a result of demographic challenges and the impact of an increase in long-term conditions, support the delivery of a prudent healthcare model by facilitating a growth in extended, advanced and consultant level skills"*

## 3. Allied Health Professions Framework

[This framework](#) sets out the strategic response to A Healthier Wales (2018) from the Allied Health Professions. It describes the challenges that need to be addressed, the value that Allied Health Professionals (AHPs) offer and the actions needed to help maximise their value and impact. This AHP framework mirrors A Healthier Wales (2018) and uses the internationally recognised Quadruple Aim as an organising concept to describe the changes required based on these principles. This will result in AHPs working in partnership with citizens to achieve longer, healthier and happier lives through: 1. Improving population health outcomes 2. Enhancing the quality of

and access to AHPs 3. Securing higher value from AHPs through transformation 4. Inspiring a vibrant AHP workforce

The AHP framework states: *AHPs' person-directed, enabling and recovery-focused interventions will need to be more widely available in public health, primary and community care. Direct access, self-referral and **First Contact Practitioner models require development to meet demand.***

The Core principles in the document include **Accessibility and responsiveness**. The document states: *Being **first contact practitioners** with a strong presence in health and social care, the independent and third sector; easily accessible 24/7 where appropriate and working outside traditional professional boundaries; being flexible, responsive and collaborative responding to people's needs over the whole life course.*

The Primary Care Model for Wales sets the agenda for deploying the AHP workforce in multi-professional teams that integrate health and social care services. It also provides the structure for AHPs to be accessible via direct self-referral or as First Contact Practitioners and to act as Advanced Practitioners.

Under Securing higher value from AHPs through transformation, the document states:

AHPs in Wales are committed to delivering value based health and care to citizens, and ensuring that they continually develop and work to the top of their personal professional license. This includes: Acting as First Contact Practitioners where this is most appropriate.

#### **4. Primary Care Model for Wales**

The Primary Care Model for Wales (PCMW) is a model for Primary and Community Care, developed as a whole system approach to sustainable and accessible local health and wellbeing care. Focusing on place-based care, care closer to home and multi-professional working. It describes how care will be delivered locally, now and in the future, as part of a whole-system approach to deliver *A healthier Wales*.

The Primary Care model focuses on accelerated primary care cluster development (ACD)s. Included in this are a range of desired "outcomes". ACD2 is "a wider range of services delivered across a cluster, meeting population priorities and need".

#### **5. MSK Framework**

The MSK framework outlines the work of the MSK clinical network for Wales. While FCP is not directly mentioned, advanced roles and principles are outlined which FCP fits. **The principles for MSK Care are:**

• **Partnership working** • **Prevention and public health** • **Personalised care** • **Pathways of care (see dedicated section)** • **Productivity and performance**

**Under training, the framework reads:**

*There is a need to prepare the multiprofessional workforce to meet both current and future clinical demand. Whilst training programmes and career pathways are clearly mapped out in secondary care subspecialties and general practice, the multiprofessional team in primary and community*

care currently has no formal established programmes and pathways. The establishment of these, aligned to the enhanced, advanced and consultant practice framework, in partnership with HEIW will be a priority for the Strategic Clinical Network. These programmes will need to consider the changing needs of the person living with a MSK condition and be focussed on the principles outlined in this framework.

## **6. Other policies where FCP aligns with Government priorities.**

### **Value Based Care**

In Wales, [value-based care is underpinned by Prudent Healthcare](#), first launched as a philosophy and a policy in January 2014. Its key principles of coproduction, equity, intervening gently effectively (and only as much as we need to) and reducing unwarranted variation (including under and over-treatment) are all key to achieving value for our patients and citizens across a whole system of health and social care.

Under the [Prevention Based Health and Care Framework](#) FCP can be described as a preventative measure in primary care.

### **Our challenges in General Practice**

Having outlined the policy supporting FCP roles in General Practice/Primary Care, it's clear they play a role in developing preventative, accessible, and value based services alongside GPs. However, they face challenges in sustainability of funding.

When transformation or cluster funding ends, FCPs find themselves in the middle of budget negotiations between health boards and GP clusters. While GPs value FCPs in their surgery, the external funding for the FCP roles.

There are strong business cases for FCP retention, however short term funding cycles has created a stall in investment in these services. We would recommend the committee explore this role as part of making a recommendation for a wider MDT investment strategy in primary care. We want to ensure the skills quired by FCPs are not lost by a lack clarity about their future or funding.

### **About the CSP and Physiotherapy**

The Chartered Society of Physiotherapy is the professional, educational and trade union body for the UK's 58,000 chartered physiotherapists, physiotherapy students and support workers. The CSP represents 2,400 members in Wales.

Physiotherapists use manual therapy, therapeutic exercise and rehabilitative approaches to restore, maintain and improve movement and activity. Physiotherapists and their teams work with a wide range of population groups (including children, those of working age and older people); across sectors; and in hospital, community and workplace settings. Physiotherapists facilitate early intervention, support self management and promote independence, helping to prevent episodes of ill health and disability developing into chronic conditions.

Physiotherapy delivers high quality, innovative services in accessible, responsive and timely ways. It is founded on an increasingly strong evidence base, an evolving scope of practice, clinical leadership and person centred professionalism. As an adaptable, engaged workforce, physiotherapy teams have the skills to address healthcare priorities, meet individual needs and to develop and deliver services in clinically and cost effective ways.

Calum Higgins

**CSP Public Affairs and Policy Officer for Wales**



**Cyflwynwyd yr ymateb i ymgynghoriad y [Pwyllgor Iechyd a Gofal Cymdeithasol](#) ar [dyfodol ymarfer cyffredinol yng Nghymru](#)**

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

**GP39 : Ymateb gan: Coleg Brenhinoly Therapyddion Galwedigaethol  
| Response from: Royal College of Occupational Therapists**

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## Inquiry into the future of general practice in Wales

### About us

We're RCOT, the Royal College of Occupational Therapists. We've championed the profession and the people behind it for over 80 years; and today, we are thriving with over 35,000 members. Then and now, we're here to help achieve life-changing breakthroughs for our members, for the people they support and for society as a whole. Occupational therapists in Scotland work in the NHS, Local Authority social care services, housing, schools, prisons, care homes, voluntary and independent sectors, and vocational and employment rehabilitation services.

Occupational therapy helps you live your best life at home, at work – and everywhere else. It's about being able to do the things you want and have to do. That could mean helping you overcome challenges learning at school, going to work, playing sport or simply doing the dishes. Everything is focused on increasing independence and wellbeing.

It's science-based, health and social care profession that's regulated by the Health and Care Professions Council.

An occupational therapist helps people of all ages overcome challenges completing everyday tasks or activities – what we call 'occupations'. Occupational therapists see beyond diagnoses and limitations to hopes and aspirations. They look at relationships between the activities you do every day – your occupations – alongside the challenges you face and your environment.

Then, they create a plan of goals and adjustments targeted at achieving a specific set of activities. The plan is practical, realistic and personal to you as an individual, to help you achieve the breakthroughs you need to elevate your everyday life.

This support can give people a renewed sense of purpose. It can also open up new opportunities and change the way people feel about the future.

### RCOT response 28/03/2025

- **The funding model for general practice and current financial pressures.**

The funding model for general practice is a key challenge for occupational therapists (OTs) and other allied health professionals (AHPs). Generally, primary and community services needs greater resources.

Fragility of funding for OT posts in Wales is holding back progress and transformational funding has a shelf life. We can prove the value we bring to general practice but there is no way to mainstream this, and our temporary funding is often removed. There is little continuity planning when people leave roles and there isn't clarity about who takes on ongoing funding.

Our health and care systems in Wales are not mature enough to consider whole system approaches. For example, primary care colleagues feel that funding should move to provide more upstream services, while core services think primary care should be investing in this themselves.

For OTs, the answer to this funding tension is likely to be somewhere in the middle, as we provide benefit to both parts of the system, for example, having some primary care and some core investment. Pan-Cluster Planning Groups (PCPGs) may be the place to make these decisions but in some areas, they are not mature enough to do this.

As an alternative, significant investment for OTs in general practice could be overseen and managed through Health Board occupational therapy leadership, or through Cluster AHP/ OT leadership, to ensure clinical governance and supervision.

We believe OTs should be colocated in primary care practices, with each practice having access to an advanced occupational therapist (AOT) for at least one session per 5000 population. Alongside this, we need infrastructure that links this AOT to teams of occupational therapists based in community wellbeing hubs, and community resource centres.

Currently, most OT roles in general practice are funded by the local health board rather than by the individual surgeries. This provides the benefit that the OTs remain aligned to the larger local OT teams, with access to supervision, mandatory training and standard NHS pay, terms and conditions.

- The efficacy of different models for managing general practice,

The efficacy of different management models in general practice has not been established. To solve this, we need to measure value better and incorporate it into decisions about management.

For example, sometimes staff may be providing low value input in secondary care, but could offer much higher value, preventative work in primary care. However, this needs stronger measurement of value to prove and feed into management decisions.

Alongside this, clarity of vision is key. We believe the Welsh government's vision for primary care is clear, but it does not always translate into targets and strategic planning.

In addition, we need to consider how we coordinate and manage care for individuals with the most complex needs in primary and community care. If we get it right for them, we get systems right for all.

- The suitability and maintenance of general practice estates and access to digital technology;

Our members have found that a significant barrier to facilitating multi-professional primary care teams is lack of space. GP practices are often overcrowded and adding OTs to the workforce can be challenging because of this.

Primary care needs equity of environment and resources for its estates and locations. With improved primary care facilities, general practices could be anchor institutes. This is important for good care but also for in-person staff communication, team building and staff health and wellbeing.

For example, where OTs have been provided with rooms to work in, it has facilitated closer working relationships with the primary care multi-disciplinary team (MDT), enabled them to promote the OT role, increasing quality of referral and patient safety netting.

We believe significant investment in expanding cluster primary care estates is required. However, it frequently falls into the grey area of whether estates should be primary care funded, or core funded.

Ideally, funding needs to follow decision making about functions that are required from services, so estates can develop to deliver this. Expansion of estates should include consulting rooms, alongside wellbeing hubs that also have consultation space and room for therapeutic group work/group clinics for patients.

There may be potential in new models of care to consider how community and primary care link better together. For example, it would be useful to explore if co-location in the same estate is required all the time, or is integration better achieved with the right model of care and optimised communication.

Improved digital infrastructure is also required. Some GP surgeries have given permission to OTs to access their electronic records, though some of the surgeries have been much more guarded about this.

This has reduced the OTs ability to carry out holistic assessments with patients. For example, they have not been able to access info about existing input from other team members or find a patient's full medical history.

This inefficiency wastes extra time in the assessment needing to ask about this and relies on patient recall. It also limits collaboration, as the OTs cannot share their assessment findings with the wider team.

Patient electronic records need to be shared across primary and secondary care. In addition, the expansion of e-consults, attend anywhere or virtual consultations is also required to increase patient choice and improve efficiency.

- 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;

We want to expand the number of occupational therapists in primary care clusters and pan cluster planning. We want to see an OT in every primary care cluster and network across Wales with a focus on prevention. This is so everyone can benefit from earlier intervention and prevention by occupational therapists in primary and community care.

Occupational therapists are central to new national models of integrated care being developed by the Regional Integration Funds. Models that prove effective need to be identified, upscaled and receive stable funding.

Currently only about 37 out of 69 clusters have some type of access to OT. There are about 390 GP surgeries in Wales but only about 65 occupational therapists.

RCOT want to ensure occupational therapy roles are fully funded and facilitate sustainable growth as our workforce grows. We want investment in future roles to be based on proven benefits/value.

For example, the value of occupational therapists to the wider system such as secondary care needs to be understood so that costs and benefits can be shared. We must focus on ensuring the roles work for primary and community care but understand their wider impact.

There needs to be a pipeline for the occupational therapy primary and community care workforce with funding for training and development. This will include for primary care skills that can only be learnt in primary care.

Pre-registration training placements for occupational therapists in primary care must be supported to expose the future workforce to careers in primary care.

Supervision can ensure capability and safety, provide necessary governance and develop the workforce in primary care. It must be resourced and planned, alongside sufficient support and time for continued professional development (CPD) as a regulatory requirement.

Although workforce challenges exist, there is also opportunity. Some areas have successfully recruited and retained OT staff to primary care services. These need to be allowed to develop, grow and be showcased. This will help to embed MDT expansion and improve retention.

Financial stability is crucial in terms of workforce development. Short term pots of money mean we lose the trust of staff, and we see regression as funding is withdrawn so people lose hope which then reduces wellbeing.

Conflict in the system needs to be managed. There are often services and organisations competing with different priorities, making workforce planning a challenge and further impacting on recruitment.

Thinking could be expanded about how we use the existing workforce, focusing on what is truly unique about qualified OT provision and making better use of support staff. Fear about this means OTs fall back on reductionist explanations of their roles which usually focus on equipment provision when the role is much wider. OTs should be able to focus on prevention, rehabilitation and self-management as these are our core skills.

Investment into OT training places needs a significant increase, to fulfil the ambition of the AHP Framework to offer upstream intervention, harnessing a bio-psycho-social, rather than a medical model of care.

OTs can particularly offer support to general practice for those patients with long term comorbidities and common mental health conditions, through supported self-management and harnessing community assets.

Commissioning of OT training places is an ongoing issue: how to ensure parity across Wales, and this has not been achieved yet. Whilst the current level of training places for OT in Wales has increased, it remains inadequate to fulfil current demand, let alone an increase in service provision, that moves away from medical models of care.

The Occupational Therapy School at Bangor closed in recent years, and deprived Wales of an accelerated route of training for postgraduates. This meant losing the opportunity to develop mature

and academically proficient staff, who may have become future leaders. The loss of this school also impacted on recruitment for the mid Wales areas, such as the West of BCUHB, Powys, and Hywel Dda Health Boards.

Workforce training schools should teach health and care students how to address mental health and cognitive concerns. This should include positive psychological strategies, such as motivational interviewing, cognitive behavioural therapy and solution focused approaches.

This would help the workforce deal with mental health concerns in every clinical setting across primary and community care. It would help to address the high prevalence of mental health comorbidity that impacts on the self-management of physical conditions, while helping to destigmatise mental health needs.

Investment in the infra-structure of OT Teams is required to secure recruitment and retention of an OT workforce that can support general practice. Such infrastructure is needed to afford professional clinical identity, knowledge and skills, ongoing CPD. This type of support equips staff in maintaining evidenced based CPD, development into leadership roles, and to safeguard the wellbeing of staff facing complex and distressing cases.

Some OTs are reporting that they feel isolated when working in the GP surgeries, as they are often put in a room on their own. They often don't see any of the team as the GPs are in another surgery or are in their clinic rooms. As a result, the OTs prefer to work from the central OT office, where they can engage in group supervision which improves morale.

- **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;**

MDT development is key to this: Teams need to work properly to manage complexity and risk. Without this, patients bounce through the system as they are referred around to try and get their needs met. Current systems do not always facilitate a true MDT. More thought is needed about systems that support MDT working and better understanding the benefits of an MDT approach to care.

The reality is also that demand in general practice is outstripping supply which can lead to poor patient experience. For patients with linear or straight forwards needs, their experience can be good, but the system struggles with complex patients.

For patients using more than one service, their experience is often uncoordinated and fragmented. There are dead ends or processes that require multiple assessments that encourage bounce rather than targeted access.

Investment in multiple specialist services that meet specific needs has proliferated, meaning there are more referral pathways and more complexity that is now counterproductive. GPs used to be the coordinators of care but now cannot, due to time and multiple access routes. For example, GPs cannot even see all the ways people can access services, let alone monitor them all. Community Rehab Teams are meant to resolve but, in some areas, this has not been achieved.

This leads to difficulties with equitability and quality of service. The fragmentation and complexity make it hard to navigate and measure. There are different services called the same thing in different areas but with a different function, or services with the same function called different things.

All this impacts on patient trust. There may be trust in individuals and local services, but more widely there is a deficit in systemic trust.

Patchy, time limited funding means a postcode lottery for quality OT in primary care that could help people make lifestyle and self-management changes which reduces the burden on the NHS downstream.

As the incidence of dementia, long-term conditions, frailty and mental health issues increase, access to consistent, sufficient and recurring funding for OTs in general practice would mitigate against variances in service provision. It would also harness the considerable contribution that OTs can add to multi-professional teams in general practice.

- Opportunities to improve general practice to make it fit for the future and take a more preventative approach to care

RCOT supports the ongoing policy drive for an MDT approach in primary and community care across Wales. For the value of OT roles to be felt and successfully embedded, there needs to be sufficient staffing levels (density of staff per patient population).

OTs bring benefits to patient populations, support primary care teams to manage demand and meet local need, as well as reducing the ongoing demands on secondary care and other sectors.

Occupational therapists add proven value and capacity across the primary and community care system. They enable better integration with pathways across sectors. They facilitate partnerships between primary, secondary and community care services and VCSE sectors. There should be local flexibility to decide how to implement OT in primary care, in partnership with community providers. It should consider local population needs, existing staffing levels in the primary care workforce and across the system.

The whole primary and community care workforce should value and understand the importance of everyday activity. This is a measure of both the impact of illness, injury and disability on peoples' everyday lives and a useful measure of the impact of primary care interventions.

Changes are needed with the current targets which mostly focus on hospital admission/flow etc. This means operational leads are held to account to these targets in a way that requires their focus.

This is not true for primary and community transformation. Community transformation will impact these measures, but targets need to reflect that this is a longer term, less direct link, otherwise the focus remains on actions that have more immediate impact. Measuring prevention work in the community and the development of integrated community teams could also be included.

A shift in culture in general practice is needed so shared decisions are embedded into primary care. Too often the person is not really involved in their care. It needs to develop from an "I will fix you" culture to a "these are the options, what works for you?" culture.

System complexity needs more attention, focusing on core elements of community delivery, embedding the CRT and clusters, understanding the roles of each to gain consistency and agreed pathways.

General practice could transform with larger multi-professional teams with appropriate estates and accommodation, alongside colocation and partnerships. OTs need to have a regular and routine presence in such teams to realise the vision laid out in the AHP framework and All Wales Rehabilitation Framework.

Links with local authorities and third sector partners would facilitate easy access for the public to health, social care, benefits, housing, the National Exercise Referral scheme, and social enterprises.

Commissioning to third sector organisations and social enterprises needs to be delivered with longer timeframes. It is detrimental to service users, and all partners for commissioning arrangements to change annually or biannually.

Some OT primary care services get a consistent flow of referrals from GPs in particular integrated health communities. Working closely with GP practices facilitates smoother patient flow and they are seen much quicker due to the collaboration which exists.

In some general practice services, patients are sent patient related experience measures (PREMs) which ensures the OTs get feedback following their intervention. This enables them to make necessary changes to the OT offer.

Other early intervention OT services have taken an upstream approach, by promoting health, wellbeing and self-care for patients. In response to a GP questionnaire which asked them to identify patients they need more support with, initial OT interventions focused on housebound individuals. These services now see those with heart failure to promote self-care which will prevent / slow down admissions into secondary care services.

By taking a collaborative approach, with OTs working in surgeries and being more accessible to all, they can prevent problems occurring by individuals been seen at the right time and in the right place. This approach should reduce demand on already squeezed GPs.

For more information, evidence and resources about the OT role in primary care, please go to:  
[Occupational therapy in primary care - RCOT](#)

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# Agenda Item 3

Cyflwynwyd yr ymateb i ymgynghoriad y [Pwyllgor Iechyd a Gofal Cymdeithasol](#) ar [dyfodol ymarfer cyffredinol yng Nghymru](#)

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

**GP60 : Ymateb gan: Cymdeithas Fferyllol Frenhinol Cymru | Response from: Royal Pharmaceutical Society Wales**

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Dear Russell,

**RE: RPS Consultation Response: Inquiry into the future of general practice in Wales**

Thank you for the opportunity to contribute to the committee's inquiry on this important issue. Over the past decade or so the role of pharmacists within general practice has evolved significantly. They are now a central part of multidisciplinary teams in practices across Wales. Pharmacists are typically employed in one of two roles:

- **Cluster pharmacists:** Employed by the Health Board on behalf of the cluster, working across a group of practices.
- **Practice-based pharmacists:** Directly employed by and working within an individual GP practice.

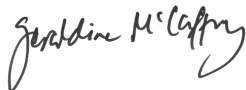
In both roles, patients and the wider healthcare team benefit from pharmacists' expertise in medicines and prescribing. The specific responsibilities of pharmacists can vary across practices and clusters, depending on local needs, but generally include:

- Reviewing patients with complex medication regimens, ensuring safety, efficacy, and cost-efficiency.
- Supporting patients with chronic conditions.
- Assisting patients with medication adherence.
- Leading condition-specific clinics.
- Acting as the primary point of contact for all medicine-related queries.
- Conducting medicines audits and providing education.

Our response below is structured to align to the inquiry's terms of reference. To help inform our response, we issued a survey to our members working in general practice focused on the themes in the terms of reference.

We hope these insights will be helpful and would be glad to provide further information at an evidence session.

Kind regards



Dr Geraldine McCaffrey  
Chair, the Royal Pharmaceutical Society's Welsh Pharmacy Board



Patron:  
**His Majesty King Charles III**

Chief Executive:  
**Paul Bennett FRPharms**

President:  
**Prof. Claire Anderson FRPharms**

England Board Chair:  
**Tase Oputu MRPharms MFRPSII**

Scotland Board Chair:  
**Andrew Carruthers MRPharms**

Wales Board Chair:  
**Dr. Geraldine MCCaffrey MRPharms**

## 1. Challenges threatening the sustainability of general practice, including:

### a) the funding model for general practice and current financial pressures,

We understand that the committee will be examining the broader funding model and financial pressures affecting general practice. However, our survey revealed several key themes regarding the funding of pharmacists working within general practice that we believe are important to highlight.

#### Long-term cluster funding

While cluster funding has been a valuable model for supporting the integration of pharmacists, its increasingly conditional nature has raised concerns about the long-term sustainability of this resource. Several survey respondents highlighted that, although cluster funding has been beneficial, it is not guaranteed and may be challenging to maintain over time.

#### Funding for pharmacists at different career stages

Our survey highlighted concerns that in some cases, practices struggle to balance competing financial demands and the need for pharmacist expertise. As a result, they may:

- a) be unable to employ a pharmacist with the required experience, or
- b) fail to provide the professional support needed for a less experienced pharmacist.

In such situations, a less experienced pharmacist could be placed in a position where they are asked to work independently without adequate support, leading to a high level of responsibility but limited professional oversight.

One respondent reflected that:

*“When I moved to the surgery I was already practicing at an advanced level having been supported to do that in my previous post. If I had come to the post without that, experience I would not have been able to substitute for GP work without additional support or training”.*

In summary, adequate funding and workforce planning is needed to ensure practices can afford experienced pharmacists or provide proper support for less experienced pharmacists.

#### Funding of more pharmacy roles

There were also comments suggesting that pharmacists could have a more significant role in improving general practice care if there was more investment in other pharmacy staff, such as employing pharmacy technicians to support the workload and enable pharmacists to take on more clinical duties. At present, due to financial constraints in some practices,



pharmacists are not empowered to work at the top of their license and are mostly involved in reactive problem-solving rather than proactive care.

## **b) Working Environments; physical spaces, facilities and digital infrastructure**

### Physical Space

Several respondents to our survey reported that physical space in their general practice is a major concern. A common issue is the lack of clinical rooms, which can result in pharmacists having to share spaces with other healthcare professionals or deliver consultations in less-than-ideal environments. In some cases, pharmacists are forced to work from home or use non-clinical spaces, such as meeting or tea rooms, for telephone consultations.

Several respondents mentioned the difficulties posed by working in older buildings, with issues like dampness, cramped spaces, poor temperature control, and the challenge of maintaining cleanliness.

On the positive side, some respondents reported that their practices have more suitable physical spaces with sufficient room. It must be noted that these were typically in newer buildings.

The availability of suitable equipment was also raised, with some pharmacists having to negotiate for basic office furniture or equipment.

### Digital Infrastructure

The development of the first-ever Shared Medicines Record for patients in Wales and the introduction of the Primary Care Electronic Prescription Service currently in development and being rolled out as part of DHCW 'digital medicines programme' is very welcome. Undoubtedly, they will lead to improved patient experience and safety and there was widespread optimism around their implementation in our survey.

However, many respondents to our survey noted that there is still a need for ongoing investment in digital solutions to improve efficiency and better integrate with clinical systems. One respondent emphasised that:

*“In 2025, efficient health care cannot be delivered without digital solutions, which are increasingly expected by patients (for e.g. self-booking, texting, remote consulting, online communications/advice). These digital solutions are becoming a necessity to deliver the GMS contract at often considerable expense to practices”.*

- 2. 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;**



## Workload

The responses to our survey about workload for pharmacists in general practice paint a worrying picture. When asked to describe their current workload, responses included; “high”, “*incredibly high and unsustainable*”, “excessive” and “enormous”.

In some cases, the workload is so high that they have no option but to catch up during protected learning time or personal time.

These responses are very much in line with the results of our 2024 pharmacy workforce wellbeing survey, where the Wales-specific results revealed that a worrying 88% of pharmacy team members are at high risk of burnout. Key contributing factors including inadequate staffing (73%), lack of work-life balance (46%), financial pressures (45%), and insufficient protected learning time (49%).

## Retention and recruiting

The biggest challenges in recruiting and retaining pharmacists in general practice, according to the responses in our survey, centre around several key factors:

1. Workload and Burnout:

Linked to the section above, a significant challenge is the high volume of work and the risk of burnout. The lack of support and peer review due to the isolation of the role contributes to the difficulty in managing the workload.

2. Financial and Career Concerns:

Many pharmacists cited a lack of alignment with the Agenda for Change pay scales, which are offered to hospital colleagues, as a deterrent. This, coupled with a lack of clear career progression and opportunities for professional development in general practice, can make the role less attractive.

3. Integration and Recognition:

The role of pharmacists is sometimes not fully understood or respected within general practices, with some GPs and practice managers not recognizing the value pharmacists can bring to the team. This lack of integration and possible unclear expectations further complicates recruitment and retention.

4. Training and Development:

The lack of training, professional supervision, and career development opportunities was highlighted as a barrier. Pharmacists in general practice



often lack access to protected learning time and the ability to develop into advanced clinical practitioners, which limits their long-term professional satisfaction and career growth.

### Multidisciplinary working

Our survey results painted a mixed picture of multidisciplinary team (MDT) working in general practice. On the positive side, many respondents reported that MDT working is effective in their practice, with good communication, understanding of roles, and collaborative discussions. Daily catch-ups, regular team meetings, and clear recognition of individual team members' skills and competencies were highlighted as positive aspects.

On the other hand, several respondents pointed out challenges that hinder the effectiveness of MDT working. A recurring issue is the lack of understanding or awareness of the pharmacist's role within the team. This includes misunderstandings about the level of training pharmacists have undergone and their ability to manage chronic disease or take on specific clinical tasks.

Some respondents also felt that the allocation of patients to the most appropriate healthcare professional is not always done effectively, with other staff members, like receptionists, not fully recognizing what pharmacists can do. In addition, some pharmacists reported that their skills were not being fully harnessed within the team, with much of their time spent on administrative tasks or dealing with supply issues rather than contributing to chronic disease management or specialised clinics.

To improve MDT effectiveness, there should be greater education and communication about the pharmacist's role and skills within the general practice team. Enhanced collaboration, such as case-sharing meetings or interdisciplinary learning sessions, could also help foster stronger working relationships and ensure that patients are allocated to the most appropriate professional.

### **3. 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;**

A recurring theme in the responses as to what would improve patient experience was for an increase in the number of pharmacists and support staff, as well as better funding under the General Medical Services (GMS) contract. A key issue identified is the current lack of adequate cover, with some practices only having one pharmacist for a large patient base, such as one for every 10,000 patients.

A key benefit of increasing the number of pharmacists working in general practice would be to ensure that all patients with comorbidities and complex medication regimens who are at high risk of adverse reactions would be able to receive regular pharmacist-led medication reviews. Increasing the number of such reviews would have a number of benefits including:

- Ensuring that patients avoid harm get the maximum benefits from their medicines.



- Reducing the number of medicines-related hospital admissions (they account for around 11% of unplanned adult hospital admissions, rising to 18% in some hospitals).
- Improving medicine optimisation, promoting best-value prescribing, and supporting appropriate deprescribing to reduce waste.

Additionally, providing protected time for peer support sessions and promoting collaborative working between pharmacy teams (including technicians and junior pharmacists) could help expand the scope of practice and improve the overall patient experience.

#### Patients understanding of role of pharmacists

A recurring theme in our survey that needs highlighting is that patients' understanding of the role of pharmacists in general practice is varied. In some practices, patients are familiar with and appreciate the role of pharmacists, particularly when they have had long-term exposure to their services. In these cases, patients often prefer to consult with a pharmacist for medication-related issues.

However, for many patients, there is still a lack of awareness about what pharmacists do in a general practice setting. Some patients continue to see pharmacists as part of community pharmacy or as professionals primarily brought into general practice as 'cost-saving measure', rather than understanding the full scope of their clinical responsibilities.

To improve patient understanding, greater efforts are needed to promote the pharmacist's role within general practice. This could include clearer communication about the services provided and public education campaigns to ensure patients recognise pharmacists as integral members of the healthcare team.

We would envisage that other professionals such as nurses and allied health professionals face similar challenges.

#### **4. Opportunities to improve general practice to make it fit for the future and take a more preventative approach to care.**

The sections above covering the other parts of the inquiry's terms of reference has touched on the opportunities related to pharmacists and medicines use that can improve general practice to make it fit for the future. These opportunities are summarised below:

- **Medication Reviews and Chronic Disease Management:** Increasing and building greater capacity the number of pharmacists would allow for more proactive medication reviews, particularly for patients with complex medication regimens or diagnosed with chronic conditions. This would help prevent adverse reactions, optimize medication use, and reduce hospital admissions related to medications.



- **Pharmacist-Led Clinics:** Pharmacists could run more condition-specific clinics (e.g., for diabetes, hypertension, or respiratory conditions), focusing on prevention through education, early intervention, and medication management.
- **Pharmacy Support Staff:** Investing in pharmacy technicians and support staff would free up pharmacists to focus more on preventative, patient-facing roles rather than administrative or reactive tasks.
- **Clearer Role Recognition with the MDT:** Educating other healthcare professionals on the pharmacist's role in general practice—particularly in prevention, chronic disease management, and medication optimization—would lead to more effective team-based care.
- **Raising Awareness of Pharmacists' Role among the public:** Linked to the point above, educating patients on the benefits of consulting with pharmacists for medication management and chronic disease support will lead to improved pharmacist-patient dynamics and will help alleviate the burden on GPs and improve
- **Adequate Physical Space and Equipment:** Ensuring that pharmacists have access to appropriate clinical spaces and equipment is essential for providing high-quality care.
- **Protecting Learning Time and Peer Support:** Ensuring that pharmacists have access to protected time for learning and peer support will help reduce burnout and increase job satisfaction. This is especially important as the workload in general practice increases.
- **Continued Investment in Digital Solutions:** Ongoing investment in digital tools like the Shared Medicines Record and electronic prescription services will improve the efficiency of care delivery, reduce medication errors, and enhance coordination across teams.

## 5. Community Pharmacy

It is important to note that community pharmacy faces many of the same challenges as general practice, particularly in terms of funding, workforce pressures, and the need for clearer career pathways and support.

We encourage the committee to consider undertaking a similar inquiry into community pharmacy in the future. Such an inquiry would help highlight the key issues facing this essential sector, which is integral to the delivery of healthcare services in Wales, and ensure that it receives the support needed to thrive alongside general practice.



September 26

Peter Fox MS  
Chair, Health and Social Care Committee

Dear Peter,

**RE: Inquiry into the future of general practice in Wales**

Dear Chair,

As you will know next Thursday my colleagues Liz Hallett and Helen Davies, members of the Royal Pharmaceutical Society's (RPS) Welsh Pharmacy Board, will be giving evidence to the Committee as part of your inquiry into the future of general practice in Wales. I am writing ahead of that session to inform you of important new work which I believe will be of direct relevance to the Committee's deliberations.

At the *Pharmacy: Delivering a Healthier Wales* Conference, held on 25 September, the Cabinet Secretary for Health and Social Care, Jeremy Miles MS, announced that the Welsh Government has commissioned the RPS to lead an independent review of the role of pharmacy professionals working in and for general practice in Wales.

This review will examine how pharmacists, pharmacy technicians and wider pharmacy teams are currently working in and alongside general practice and will make evidence-based recommendations to maximise their impact in improving patient care, safety and outcomes.

Over the last decade we have seen a rapid expansion in the number of pharmacy professionals delivering direct patient care in general medical practice. We estimate that more than 7% of pharmacists and 4% of pharmacy technicians in Wales now work in this sector. This growth presents significant opportunities for improving the prescribing and use of medicines, leading to better health outcomes and a reduction in medicines-related harm and waste. However, there remain considerable challenges, with wide variation in roles and impact across Wales. An independent review will help



Patron:  
**His Majesty King Charles III**

Chief Executive:  
**Paul Bennett FRPharms**

President:  
**Prof. Claire Anderson FRPharms**

England Board Chair:  
**Tase Oputu MRPharms MFRPSII**

Scotland Board Chair:  
**Andrew Carruthers MRPharms**

Wales Board Chair:  
**Dr. Geraldine MCCaffrey MRPharms**

identify how best to support consistency, maximise expertise, and inform future policy development.

The key deliverable of the review will be a report to Welsh Government covering the following objectives:

- Map Current Pharmacy Workforce, Roles and Activities.
- Assess Alignment with NHS Wales Priorities and Unique Skillsets of Pharmacy Professionals.
- Identify Facilitators and Barriers to the Delivery of Pharmaceutical Care.
- Identify Best Practice and Innovation.
- Evaluate Leadership and Governance Structures
- Support System-Wide Integration
- Make Evidence-Based Recommendations

The review will take place over a seven-month period, with a final report submitted to Welsh Government. Given the timescales, it is unlikely the report will be published before the end of this Senedd term. We will, however, ensure that the successor Committee in the next Senedd is fully informed of its findings.

I hope the Committee finds this update helpful in the context of your current inquiry. The RPS is committed to supporting the Committee's work, and we look forward to contributing to the discussion next week.

Yours sincerely,



Elen Jones  
Director for Wales, Royal Pharmaceutical Society



**Cyflwynwyd yr ymateb i ymgynghoriad y [Pwyllgor Iechyd a Gofal Cymdeithasol](#) ar [dyfodol ymarfer cyffredinol yng Nghymru](#)**

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

**GP07 : Ymateb gan: Fferylliaeth Gymunedol Cymru |Response from: Community Pharmacy Wales**

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## Community Pharmacy Wales response to the Health and Social Care Committee

### **Inquiry into the future of general practice in Wales**

Date: February 2025

Contact Details  
Russell Goodway  
Chief Executive  
Community Pharmacy Wales  
3<sup>rd</sup> Floor, Caspian Point 2  
Caspian Way  
CARDIFF, CF10 4DQ



## Part 1: Introduction

Community Pharmacy Wales (CPW) represent community pharmacy on NHS matters and seeks to ensure that the best possible services, provided by pharmacy contractors in Wales, are available through NHS Wales. It is the body recognised by the Welsh Government in accordance with *Sections 83 and 85 National Health Service (Wales) Act 2006* as 'representative of persons providing pharmaceutical services'.

Community Pharmacy Wales are the only organisation that represents every community pharmacy in Wales. It works with Government and its agencies, such as local Health Boards, to protect and develop high quality community pharmacy-based NHS services and to shape the community pharmacy contract and its associated regulations, to achieve the highest standards of public health and the best possible patient outcomes. There are around 700 community pharmacies in Wales and these are located in high streets, town centres and villages across Wales as well as in the major metropolitan centres and edge of town retail parks.

In addition to the dispensing of prescriptions, Welsh community pharmacies provide a broad range of patient services on behalf of NHS Wales. These face-to-face NHS Wales services, available from qualified pharmacists and Pharmacy Technicians include, Pharmacist Independent Prescribing Services, contraception services, Discharge Medicines Reviews, Smoking Cessation, Influenza Vaccination, Palliative Care Medicines Supply, Emergency Supply, Substance Misuse and the Common Ailments services.

CPW are pleased to have the opportunity to respond to this important consultation. Together with our GP colleagues, community pharmacies represent one of the key pillars of primary care. The evolution of the community pharmacy contract in Wales has resulted in the community pharmacy network delivering a significant increase in clinical consultations, managing the treatment of common ailments and prescribing for many conditions.

The expansion of our clinical role, endorsed by Welsh Government, has resulted in us working in closer partnership with local GP practices and taking a significant amount of workload away from GPs, to provide headroom for them to deal with more complex consultations.

The introduction of independent prescribing has resulted in one third of all community pharmacies providing a prescribing service. This will increase significantly, as pharmacists who qualify from next year, will do so with a prescribing qualification. Within a few years it is likely that all community pharmacies will offer a prescribing service.



**This change, where primary care in Wales will have around 700 new prescribers is a simply massive opportunity if grasped by the committee or could be a huge lost opportunity if it does not do so.**

CPW proposed the following addition to the Terms of Reference for the inquiry and was disappointed that it was not taken up:-

*To explore the relationship and degree of integration of general practice with local community pharmacy practices, with the objective of improving the delivery of services to local patients and reducing administrative burden.*

The Health and Social Care Committee is holding an inquiry into the future of general practice in Wales, including consideration of:

- 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.**

The observations below relate to the considerations highlighted in bold type in particular equitable access to care and the effective management of patients.

## Part 2: areas for the committee to consider

**Removing the majority of workload associated with repeat medication:** NHS Wales is making a significant investment into the digital transfer of prescriptions from the GP practice to the community pharmacy. This presents an opportunity for the committee to leverage this investment by moving the supply of regular medication for stable patients completely to the community



pharmacy, releasing a significant amount of time in GP practices and immeasurably improving convenience for patients. For example; a stable patient currently obtains a prescription, signed by a GP, to take to a pharmacy at a regular interval to obtain their medication. This is somewhat archaic and inconvenient for all involved. CPW believe this labour-intensive process could be changed significantly for example: A GP sees a patient and after a review decides that the patient will be reviewed again in 12-months' time. The GP sends an electronic prescription to the pharmacy authorising the supply of medicines for the next 12 months. The pharmacy then supplies medicines to the patient at an interval that is convenient to the patient without the further involvement of the GP practice. This opportunity will be there to grasp in the next 12 months.

**Long-term conditions:** in a similar vein a community pharmacist with a prescribing qualification has the potential to take over the routine management of patients with long-term conditions such as asthma and diabetes. This is a clear this is an opportunity to more effectively manage patients.

**Other opportunities for the committee to consider:** There are many other aspects which the CPW board believe the committee should consider:-

- A more joined up service that incentivises GPs to refer to community pharmacy where appropriate and a formal digital referral system the other way.
- Wider primary care integration to improve the patient experience.
- The alignment of incentives and contractual arrangements.
- Seek to reduce duplication – where pharmacies are providing similar services to those in GP practices.
- Digital interoperability to streamline activity.
- Defining and communicating to the public where care should be provided, e.g. common ailments should not be treated in a GP practice.

### Part 3: Conclusion

CPW feel that there is a golden opportunity presented by both this inquiry and the significant changes in community pharmacy to more effectively manage patients in primary care and to integrate GP and community pharmacy practices.

CPW agree that the content of this response can be made public.

CPW welcome communication in either English or Welsh.

For acknowledgement and further Contact:



The Face and Voice of Community Pharmacies in Wales. Page 4  
Wyneb a Llais Fferyllwyr Cymunedol yng Nghymru

21/03/2025

Russell Goodway  
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# Agenda Item 5.1

MY DEATH, MY DECISION 



**Terminally Ill Adults (End of Life) Bill**

**Legislative Consent Motion**

**Senedd Health and Social Care Committee Call for Evidence**

# My Death, My Decision

**26th August 2025**

Pack Page 59

# Response from My Death, My Decision (MDMD)

## Summary

My Death, My Decision is a grassroots organisation that campaigns for laws across the United Kingdom to allow those who are terminally ill or intolerably suffering from incurable conditions the option of a legal, safe, and compassionate assisted death.

### **My Death, My Decision (MDMD) supports a Legislative Consent Motion for the Terminally Ill Adults (End of Life) Bill.**

As an organisation, we focus on the individual's experience and aim to ensure that any legislation on assisted dying has that person's journey at its heart.

We are firmly committed to proposing an evidence-based law that would balance individual choice alongside robust safeguards for the most vulnerable.

We have submitted evidence to legislative work in Scotland, Jersey, the Isle of Man, and the Republic of Ireland as well as the UK Parliament Health and Social Care Committee's inquiry into assisted dying. We also submitted evidence to the Westminster Terminally Ill Adults Bill Committee. We provided oral evidence to the Nuffield Council of Bioethics Citizens' Jury on Assisted Dying, and have presented evidence to other legislatures.

## Our views on LCM relevant clauses

This evidence is presented in response to the Senedd Health and Social Care Committee's call for evidence in the letter to stakeholders. However, since then, we recognise that the supplementary Legislative Consent Motion has been laid following changes to the Bill at Report Stage. We will address those changes as part of our evidence. Where merely the clause number has changed, we will reference this at the start of each section.

### **Clause 37: Guidance about the operation of the Act (Now Clause 40)**

*Clause 37 of the Bill requires the Chief Medical Officer (CMO) for Wales to prepare and publish guidance about the operation of the Act. Before making guidance, the CMO must consult with relevant individuals and groups, including people with learning disabilities, and ensure the guidance is practical and accessible.*

*Following Report Stage of the Bill, changes were made to this clause, which now sits in the Bill as Clause 40. This requires Welsh Ministers to issue guidance relating to the operation of the Act in Wales, about matters within devolved competence. The Welsh Ministers must consult*

*with specified persons before issuing guidance, including the Chief Medical Officer for Wales. This clause imposes requirements on the Welsh Ministers to publish any guidance they issue and to have regard to specified matters when preparing guidance.*

**Q1: What are your views on these proposals?**

We strongly support the requirement that Welsh Ministers prepare and publish practical, accessible guidance following consultation with the Chief Medical Officer (CMO) for Wales and relevant individuals and groups, including people with learning disabilities and those with protected characteristics. This requirement is essential to ensure safe, effective, and inclusive implementation.

**Q2: Are these proposals sufficient to ensure that the CMO can effectively oversee implementation?**

Under the revised Bill, the responsibility for preparing guidance now lies with Welsh Ministers and the Secretary of State, not the CMO for Wales. However, we firmly support that the CMO for Wales must be consulted when guidance is being designed.

We would recommend ensuring the CMO for Wales has a leading role in developing the guidance, including through convening medical networks. We would also recommend explicitly including the following in the guidance:

- Standardised clinical pathways for assessments and eligibility decisions,
- Guidance for clinicians in rural or resource-limited settings,
- Information-sharing protocols between services and regulators.

**Q3: Do the proposals provide sufficient safeguards to protect vulnerable individuals?**

Yes. Ensuring consultation with people with learning disabilities strengthens protections and inclusivity. Mandatory training on domestic abuse further adds to this, and could be explicitly referenced in the guidance. The legislation is also strong on safeguarding professionals who wish to 'opt-out'.

International evidence further suggests that well-drafted guidance underpins safety:

- In Victoria, Australia such guidance led to clear safeguards and consistent delivery. A detailed review found assisted dying operating safely and compassionately, with improvements across system preparedness, workforce capability, and public support
- In Oregon, the low usage rates and high palliative care involvement suggest robust regulation and responsible practice. Over 25 years, only around 0.8% of total deaths were via assisted dying, with strong hospice integration and no evidence of misuse.

**Recommendation:** In preparing guidance, as well as engaging with relevant demographic groups and professional bodies, Welsh Ministers should engage with the Disability Advisory Board appointed by the Voluntary Assisted Dying Commissioner.

**Clause 39(1),(2),(5) and (6): Voluntary Assisted Dying Services: Wales (Now Clause 42)**

*Clause 39 allows the Welsh Ministers to make regulations to support how voluntary assisted dying services work in practice in Wales. These regulations can be tailored to different situations (such as hospitals or care homes), and may include technical or transitional arrangements.*

**Q4: What are your views on enabling Welsh Ministers to regulate the structure, management, and delivery of services?**

The absence of an operational model yet is a challenge, as is considering how services may be delivered within a Welsh context. However, the regulations are clear on defining who makes the regulations and who approves them. We consider they are robust in enabling Welsh Ministers to develop services in line with Wales's health system priorities and tailored for different settings, helping to address different experiences for e.g hospitals, care homes, rural communities.

**Q5: How will these regulations (if approved) impact current palliative care practices in Wales?**

The specification and commissioning framework for hospices (due to go live in April 2026) will provide a valuable standard to allow assisted dying to complement and enhance palliative care services.

We welcome the view that delivery of palliative care should be seen independently of assisted dying, with no case for diversion of funding from such a critical health service.

Further, we expect these regulations to complement and enhance palliative care. International experience suggests assisted dying laws often lead to improvements in palliative care, as outlined by the 14-month inquiry into assisted dying by the UK Parliament's Health and Social Care Committee. Some examples are below:

- In **Victoria**, [81% of assisted dying participants were already receiving palliative care](#); the law led to deeper integration and earlier end-of-life conversations. Many died in their preferred setting, including home or care facilities.
- In **Canada**, the use of palliative care has [risen by almost 10%](#) across the population, which researchers say is almost certainly the fastest rate of growth of palliative care in Canadian history.
- In **Colorado**, [84.9% of participants were in hospice care when they died](#), reinforcing the linkage between assisted dying and palliative services.
- In **Quebec**, a right to palliative care was mandated, which prompted more investment and earlier conversations about end-of-life care. [75% of participants received palliative care](#). (A further 14.7% did not require palliative care, and 2.3% had care available but did not access it.) Assisted dying services are often delivered by palliative care physicians in Quebec, leading to a holistic and patient-centred model.
- Provision of palliative care also improved in **Oregon**, with some hospitals reporting a [20% increase in referrals](#) in the first 18 months after the assisted dying vote, following changes to healthcare plan eligibility as a result of the vote. From 1998-2020, [on average 91% of those requesting an assisted death were enrolled in palliative care](#), rising to 92% in 2022. People who request assisted dying are more

likely to be in hospice and to have enrolled earlier than the average terminally ill patient.

- [The Nuffield Trust](#) examined 15 jurisdictions where assisted dying is legal and found that 75% or more people accessing assisted dying were reported to be receiving palliative care in 2023.

Regardless, it is important to note that palliative care sadly cannot relieve pain for all. In 2024, the [Office of Health Economics](#) found that, across the UK, over 7,000 people per year die with no pain relief in their last three months, even with the highest possible levels of palliative care.

One consequence is that, each year, a significant number of people with terminal illnesses try to take their own lives in ways that are often violent, unpredictable, and distressing. A study by the [Office of National Statistics](#) found that adults diagnosed with a terminal illness are twice as likely to die by suicide. Legal assisted dying would remove the need for these distressing attempts.

Therefore, the option of an assisted death is crucial to many, even those who do have good palliative care.

Furthermore, just having the option of an assisted death can have a positive impact on those facing the end of life.

In countries with assisted dying laws, people who are eligible are greatly comforted by this being available if they need it, even if they do not opt for it themselves. As philosophy [Professor Ben Coburn writes](#), *'In the face of ill health and decline, it can be transformative for someone to know that they have a (potentially) acceptable escape, even if – suitably empowered and encouraged by that knowledge – they choose not to take it.'*

Similarly, a [British Medical Association briefing](#) states, *'The existence of legislation allowing assisted dying brings reassurance and peace of mind for many people with terminal illness and their loved ones, even though only a small percentage actually use it when the time comes.'*

The availability of legal assisted dying, in those societies where it exists, helps far more people than the few who ultimately opt for it. For many sufferers, having a 'backup plan' that is under their control substantially eases the anxiety they experience regarding the potentially uncontrolled pain and indignity of terminal and progressive illnesses. In this regard, access to assisted dying is complementary to palliative care.

**Recommendation:** Welsh regulations should ensure seamless integration between assisted dying and palliative care, as well as shared training.

**Recommendation:** As there will be reviews of palliative care by the Secretary of State at both 12 months and five years after the Act passing, the Welsh Government should contribute to those reviews to ensure the Welsh palliative care experience is properly reflected.

## **Clause 45: Monitoring by Commissioner (Now Clause 49)**

*Clause 45 requires the Voluntary Assisted Dying Commissioner (appointed by the Prime Minister) to monitor the operation of the Act, investigate and report to an appropriate national authority on any matter connected with the operation of the Act which the appropriate national authority refers to the Commissioner, and submit an annual report to each appropriate national authority on the operation of the Act.*

### **Q6(a): What are your views on allowing Welsh Ministers to refer matters to the Commissioner?**

The legislation has been strengthened by moving the responsibility from the CMO to the Commissioner. We support that Welsh Ministers may refer matters to the Commissioner. It ensures devolved oversight, giving Welsh Ministers a voice in monitoring the service and responding to Welsh-specific concerns, without undermining the UK-wide nature of the Commissioner role.

### **Q6(b): What are your views on requiring the Commissioner to consult the CMO for Wales in annual reports?**

This is a necessary and welcome provision. It ensures that Welsh-specific experiences, service models, and population needs are reflected in national oversight.

### **Q6(c): What are your views on requiring Welsh Ministers to publish and respond to the Commissioner's annual report?**

We support this as a transparency and accountability measure. It aligns with good governance principles and ensures that the Senedd and the public are kept informed of how the Act is working in practice in Wales. This also supports the Welsh Ministers in continuing to deliver on their obligations that the legislation remains workable.

## **Clause 47(4): Provision of Information in English and Welsh (Now Clause 51: Provision about the Welsh language)**

*Clause 47 requires any service, report, declaration or certificate of eligibility provided under the Act to a person seeking assistance to end their own life must be in the persons first language, if that language is English or Welsh and, if neither of those languages is their first language, must be in their preferred language of English or Welsh.*

*Following Report Stage of the Bill, changes were made to this clause, which now sits in the Bill as Clause 51. This places a duty on the Welsh Ministers to make provisions to ensure that those wishing to communicate in Welsh are able to do so, including for all written reports. This clause also requires consultation between the Secretary of State and the Welsh Ministers before the Secretary of State makes regulations about the form of documents, such as the declarations or final statements, to be available in Welsh.*

### **Q7(a): Do you agree that services and documents must be provided in a person's first language if English or Welsh, and otherwise in their preferred language of English or Welsh?**

Yes. We fully support these provisions to ensure informed consent and equitable access. It

reflects, for example, the Welsh Language Measure 2011, in which the NHS in Wales has a statutory duty to deliver services to the public in both Welsh and English. Language should never be a barrier to exercising one's legal rights at the end of life.

**Q7(b): What are your views on requiring Senedd approval for any Welsh-language-related regulations?**

This is appropriate. It aligns with Wales's devolved language policy and ensures democratic legitimacy.

**Clause 50(1), (2), (5) and (6): Regulations (Now Clause 54)**

*Clause 39 allows the Welsh Ministers to make regulations to support how voluntary assisted dying services work in practice. Clause 50 provides that such regulations must be approved by the Senedd before they can take effect.*

**Q8: What are your views on the proposed procedure for regulations, and whether it provides appropriate Senedd oversight?**

We support this. Senedd approval for regulations is a proportionate and necessary safeguard given the ethical importance of the issue and the need to ensure consistency across the devolved health system. It also ensures that public and stakeholder voices can continue to be reflected as regulations evolve. This could be enhanced with public consultation.

We would recommend that any preparatory work gets underway as soon as possible to ensure development of Welsh regulations does not fall behind those being prepared in the UK Parliament and, subsequently, that access for Welsh residents is not delayed. This is particularly important in the context of a new Senedd in 2026, with new members potentially approaching this legislation for the first time. Work must be done to ensure all new MSs have the information and tools they need to take the legislation forward in Wales, if it does become law in Westminster.

As far as possible, the Welsh Government may wish to coordinate with the UK Government to reduce burdens on Welsh residents (particularly in border communities) should regulations evolve in a way that makes access to assisted dying substantially different in Wales than England. For example, if Welsh NHS regulations are not passed by the Senedd, this could lead to an unjust system where those living in Wales may only be able to access an assisted death through private provision, whilst those in England could get access through the NHS. That would mean only those who can afford private care in Wales would have meaningful control at the end of life, while others are denied the compassion and dignity they deserve, unless they are able to travel over the border to England. With average incomes in Wales lower than in England and Scotland, the development of a "private only" model in Wales could further broaden existing health inequalities.

We must ensure that terminally ill people who are already facing substantial hardship do not have to navigate additional complexity in carrying out their end of life wishes.

**Recommendation:** Though there is no statutory requirement to do so, Welsh Ministers should also consider a public consultation on the necessary regulations to ensure they are both robust and would allow the service to be delivered in the least burdensome way for those seeking an assisted death.

**Recommendation:** Commence preparatory work to ensure a Welsh perspective is captured to better inform the development of the draft regulations, e.g. usual assessments and public consultation in line with work already undertaken by Westminster. This should be completed as soon as possible to ensure the new Senedd members elected in May 2026 are well informed to carry out their duty to take the legislation forward in Wales.

### **Clause 54(6), (8) and (9): Commencement (Now Clause 58)**

*Clause 54 deals with the commencement of the Act.*

*Following Report Stage of the Bill, changes were made to this clause, which now sits in the Bill as Clause 58.*

#### **Q9: What are your views on allowing Welsh Ministers to decide commencement dates (subject to Senedd approval)?**

We agree with this proposal. It allows Wales to ensure systems are in place - including workforce training, public awareness, translation of materials, and referral pathways - before the law is operational. This supports safe and consistent delivery.

We recognise the concern over the system change is real and significant. This is further underlined by the current lack of an operational model and possible capacity concerns in the NHS to bring the legislation forward.

However, we would urge the swiftest possible progress, recognising that the four-year implementation period in the Bill is a backstop and not a goal. Every month without implementation is a month where terminally ill people do not have the choice they deserve.

It is important to note that no other jurisdiction in the world has taken longer than three years to implement a democratically passed assisted dying law, and only one has taken longer than 19 months, and that was Oregon, due to legal challenges.

Some of the autonomous regions in Spain established a working law just three months after the national parliament passed assisted dying legislation, including oversight panels similar to the model proposed in this Bill – Spain being the only other jurisdiction to have this model. Regional implementation timelines of the panels varied between three months and a year.

More locally, approved proposals in Jersey include an implementation period of 18 months, and of two years in the Isle of Man.

Extensive training, guidance and codes of practice already exist internationally, in jurisdictions with very similar legislation. We can safely draw from it to reduce an unnecessarily long implementation period.

**Q10: Is the procedure appropriate?**

Yes, requiring Senedd approval ensures that readiness is scrutinised and democratically accountable.

**Q11: What are your views on the implications of different start dates in England and Wales?**

We are concerned that staggered start dates could cause some public confusion, particularly for those living in border communities. We recommend proactive coordination between the UK and Welsh Governments with efforts to align commencement dates, if possible, and clear communication for patients and professionals on when and where the law applies.

**Recommendation:** Welsh Government should develop joint public messaging strategies and referral protocols with UK Government colleagues and NHS England to ensure clarity across borders.

## Conclusion

*My Death, My Decision* supports the Legislative Consent Memorandum and the devolved provisions it outlines. We believe the proposals:

- Provide appropriate oversight and regulatory powers to Welsh Ministers,
- Respect the Welsh health and language context,
- Embed strong safeguards and transparency,
- Align with international best practice on assisted dying.

More broadly, we strongly support the case for assisted dying through a clear, legal framework in Wales. It is an affirmation of clear and positive values that are capable of being shared by people of all different backgrounds and beliefs:

- **Dignity:** Passing the Bill will give terminally ill adults the choice and dignity of a compassionate death within the law. People with terminal illnesses will gain peace, knowing that if their suffering becomes too great, they have a choice.
- **Autonomy:** It's your death, it should be your decision. Just as you already have a right to refuse treatment, no one else should have the right to stop you from choosing a safe and painless death.
- **Compassion:** We all participate in the suffering of those we love. A clear law will allow families to focus on quality time together that will never come again instead of distress.

The current situation for many people is indefensible:

- **Pain:** While most people die peacefully and naturally, a small but significant minority experience extreme suffering. The Office of Health Economics estimates that 20 people a day will die in pain, even with the best possible palliative care.
- **Inequality:** Only those with enough money to spare, as well as the physical ability to travel, are able to have assisted deaths abroad in Switzerland. More than one person a week ends their life abroad.
- **Suicide:** People who are diagnosed with a terminal condition are twice as likely to die by suicide, and those diagnosed with a neurodegenerative condition are 100x times more likely to do so. People are voluntarily stopping eating and drinking, leading to uncomfortable and prolonged dying.

Assisted dying internationally is safe, dignified and supported by the public:

- **Introduction of safeguards:** Coercion and abuse thrive in the darkness, in the absence of safeguards and scrutiny. Legalising this would introduce safety measures and checks.
- **Peaceful death:** The life-ending medication used by the Swiss centre DIGNITAS is dignified and peaceful. Their evidence to the [Terminally Ill Adults Bill Committee](#) said: 'Every patient ingesting [the] lethal dosage passed away, with no instances of regaining consciousness.'
- **Consistent public support:** Public opinion polls in jurisdictions where assisted dying is legal, including Australia, Oregon, Canada and Switzerland, show overwhelming public support.

We hope our contribution has been useful, and we would be pleased to offer further assistance or evidence to support the Committee's scrutiny.

# Agenda Item 5.2

**SENEDD HEALTH AND SOCIAL CARE  
COMMISSION AND LEGISLATION, JUSTICE AND  
CONSTITUTION COMMITTEE: ASSISTED DYING  
LEGISLATIVE CONSENT MEMORANDUM**



**Response from Wales Humanists,  
September 2025**

## **ABOUT WALES HUMANISTS**

Since 1896, we have worked for a society rooted in justice and human rights, empowering non-religious people to express their views and stand in solidarity with others. By bringing non-religious people together we help them develop their own views and an understanding of the world around them. Together with our partners Humanist Society Scotland, we speak for 150,000 members and supporters and around 130 members of the All-Party Parliamentary Humanist Group. Through our ceremonies, pastoral support, education services, and campaigning work, we advance free thinking and freedom of choice so everyone can live in a fair and equal society. Wales Humanists is a part of Humanists UK.

## **THE HUMANIST VIEW ON ASSISTED DYING**

Humanists defend the right of each individual to live by their own personal values, and the freedom to make decisions about their own life so long as this does not result in harm to others. Humanists do not share the attitudes to death and dying held by some religious believers, in particular that the manner and time of death are for a deity to decide, and that interference in the course of nature is unacceptable. We firmly uphold the right to life but we recognise that this right carries with it the right of each individual to make their own judgement about whether their life should be prolonged in the face of pointless suffering.

We recognise that any assisted dying law must contain strong safeguards and the international evidence from countries where assisted dying is legal shows that safeguards can be effective. We also believe that the choice of assisted dying should not be considered an alternative to palliative care, but should be offered together as in many other countries.

Wales Humanists strongly supports a change in the law to allow assisted dying for terminally ill adults as a compassionate, safe, and necessary reform. Current legislation is unsafe and unregulated, resulting in people dying each year through suicide, mercy killings, suicide pacts, the administration of excessive medication, or by travelling abroad to access assisted dying. Travelling overseas, often to Switzerland, places a significant financial burden on individuals and their families, costing on average £15,000 and effectively making a dignified death accessible only to those with the means to afford it.<sup>1</sup> This may disproportionately impact people in Wales in rural locations with limited travel options to Switzerland.

<sup>1</sup> Dignity in Dying, 'Cost of journey for assisted dying in Switzerland skyrockets, Sep 2023  
<https://www.dignityindying.org.uk/news/cost-of-journey-for-assisted-dying-in-switzerland-skyrockets-to-15k-intensifying-harm-caused-by-uk-ban/>



Legalised assisted dying would provide individuals with terminal illnesses the choice to end their lives with dignity and compassion, reducing unnecessary suffering while allowing families to focus on meaningful time together without fear of legal repercussions.

Evidence from over 30 jurisdictions, including Australia, Switzerland, Spain and Oregon, demonstrates that assisted dying can be safely regulated to protect vulnerable people while coexisting with high-quality palliative care. Robust safeguards should include written consent witnessed by an independent party, approval by two independent healthcare practitioners, mandatory waiting periods with flexibility for extreme suffering or imminent death, clear oversight by a specialised regulating body, and an implementation period for training, service setup, and public awareness.

Patients' autonomy must be respected, with decisions free from coercion, and healthcare providers should retain the right to conscientiously object without obstructing access.

Legalising assisted dying would also provide much-needed clarity for families who currently face fear of investigation when a loved one seeks assistance abroad or attempts to end their life. It aligns with public sentiment, with over 74% of the UK population supporting reform<sup>2</sup>. Wales Humanists considers that introducing assisted dying with clear safeguards ensures compassionate, safe and equitable access, respects individual autonomy, reduces unrelieved suffering, and provides a dignified option for those facing terminal illness.

## **Our views on LCM relevant clauses**

### **Clause 37: Guidance about the operation of the Act<sup>3</sup>**

#### **Q1: What are your views on these proposals?**

Wales Humanists strongly advocates that the Chief Medical Officer (CMO) for Wales issues practical and accessible guidance following consultations with the outlined persons, including persons with learning disabilities, persons who have protected characteristics, and other persons deemed appropriate by the Secretary of State. It is our position that these requirements are critical to safeguarding individuals and fostering inclusive, efficient and safe implementation procedures.

#### **Q2: Are these proposals sufficient to ensure that the CMO can effectively oversee implementation?**

Wales Humanists believes the proposals give the CMO sufficient authority and obligations. However, we strongly recommend incorporating the following proposals:

- Implement mandatory information-sharing protocols between services and regulators.

<sup>2</sup> Electoral Calculus, Assisted Dying MRP Poll, Oct 2025  
<https://humanists.uk/2024/10/16/new-poll-shows-every-constituency-backs-assisted-dying/>

<sup>3</sup> This is now under Clause 40.

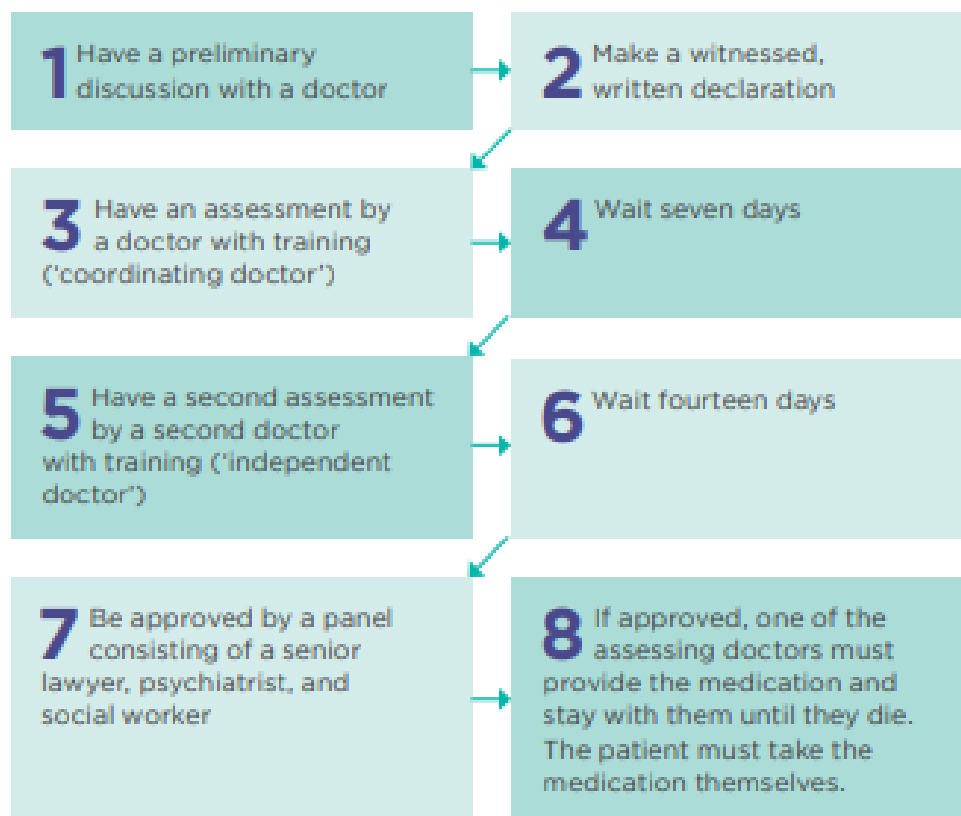


- Streamline clinical processes to ensure fairness in eligibility decisions.
- Consider incorporating a provision for grief and bereavement support to the next of kin and families of persons undergoing assisted dying. We strongly support this measure, noting that Australia's Department of Health's Centre for Evaluation and Research Evidence recommended a similar one in its review of their Voluntary Assisted Dying Act, which was accepted by the Government.<sup>4</sup>

**Q3: Do the proposals provide sufficient safeguards to protect vulnerable individuals?**

The process of applying and receiving assistance to die under the current proposals is rigorous and more than sufficient to protect anyone applying.

**In order to access an assisted death, a person must:**



Wales Humanists believe the proposals are sufficient to protect vulnerable individuals. Guaranteeing consultations with persons with learning disabilities and protected characteristics provides an

<sup>4</sup> Victoria Department of Health, Feb 2025 Voluntary Assisted Dying Five-Year Review  
<https://www.health.vic.gov.au/voluntary-assisted-dying/five-year-review>



essential inclusive layer to the proposed safeguards. Having listed the safeguards in the Bill below, it becomes clear that they are extensive and more than sufficient to protect vulnerable people.

The following safeguards are incorporated in the Bill:

1. The first declaration must be voluntary, free from pressure and coercion S.8(4)(b)(iv) and S.11(2)(e).
2. Making the ability to cancel your declaration, at any time, a requirement. S.8(4)(b)(v) and S.12(2)(e).
3. The ability to disqualify certain persons from acting as a witness as outlined in S.8(11) and S.52.
4. Criteria for the coordinating doctor to not be a relative, beneficiary, or a financially interested party S.8(6)(c) and S.8(6)(d).
5. Doctors must have training in capacity assessment, coercion, domestic abuse, autism/learning disabilities safeguards, and reasonable adjustments, regulated by the Secretary of State S.8(7-10) and S.11(9-10).
6. Identity verifications with two forms of proof of ID to the coordinating doctor and the witness mentioned in S.8(2)(c)(iii), as mentioned in S.9(2), alongside the ability of the Secretary of State to make provisions by regulations about the forms of proof of identity that are acceptable as mentioned in S.9(3).
7. Requirement for two independent assessments by different doctors, as enshrined in S.10 and S.11.
8. Mandatory reflection period of seven days before the second assessment, S.11(3).
9. Advising patients to inform their GP and consider speaking with their next of kin, S.12(2)(f-g).
10. Requirement for the assessing doctor to consult a registered medical practitioner who holds qualifications of the diagnosis and management of the illness in case of doubt about terminal illness or mental capacity S.12(5).
11. Obligation to record and share opinions between assessing doctors for transparency S.12(7).
12. If the independent doctor is not satisfied that all eligibility criteria are met (S.11)(2)(a-e), the person may request the coordinating doctor to refer them to another independent doctor for a further assessment, S.13(1-2).
13. If a new independent doctor disagrees with the first, both reports must be made available to later decision makers and to the Commissioner, S.13(3)(b-c).
14. The coordinating doctor may only make one referral for a second opinion, S.13(5).
15. If a doctor dies or is unable/unwilling to continue, a replacement doctor must meet the same requirements as the original coordinating doctor, S.13(6), S.14(2)(a), S.15(4).
16. The Assisted Dying Review Panel, consisting of a multidisciplinary panel consisting of a social worker, psychologist, and senior lawyer must be satisfied the declaration meets the requirements outlined in sections 8-12 and in S.17(2), as enshrined in S.17(2). This panel will be overseen by a former judge and a Government-appointed Voluntary Assisted Dying Commissioner. Meaning, one person's scrutiny has been replaced by several.



17. A person has the right to seek reconsideration of a refusal if there was an error of law, irrationality, or procedural unfairness, S.18(2).
18. The Commissioner must give written reasons for decisions on reconsideration, S.18(5).
19. A second declaration can only be made after a mandatory reflection of 14 days (or 48 hours if death is imminent) has ended, S.19(2).
20. The second declaration must be witnessed by both the coordinating doctor and an independent witness, who must see it being signed, S.19(3)(c).
21. The person must declare that they are acting voluntarily and without coercion, and that they understand that they may cancel the declaration at any time (S.19)(4)(b)(iii-iv).
22. The coordinating doctor may only witness if, immediately before the signing, they are satisfied that: the person is terminally ill; the person has the capacity to make a decision to end their own life; the person has a clear, settled and informed wish; and the person is acting voluntarily and free from pressure, S.19(5).
23. Persons disqualified under section 52 may not witness a declaration under S.19(3)(c)(ii), as enshrined in S19(9).
24. A declaration can be cancelled any time by the person, in any form of communication they ordinarily use, so long as it is communicated to the coordinating doctor, or any registered medical practitioner with the person's GP practice, S.20(1).
25. Cancellation is effective immediately when given, S.20(4).
26. A proxy may only sign if the person is unable to sign and has authorised them to do so, S.21(1).
27. The proxy must be satisfied that the person understands the nature and effect of the declaration, S.21(4)(a).
28. A proxy cannot act if disqualified under S.52, or if they acted as a witness to the first declaration when signing the second, S.21(4)(b-c).
29. The proxy must either have known the person for at least two years or fall within the categories specified in regulations made by the Secretary of State, S.21(5).
30. A qualifying person with a learning disability, mental disorder, autism, or substantial difficulty in understanding or communicating, must be supported by an independent advocate to ensure they can effectively engage with the Act, S.22(3-4).
31. Independent advocates must meet conditions, training, and approval requirements set out in regulations, S.22(2).
32. A new offence of 'Dishonesty, coercion or pressure' is introduced with offences liable to up to life imprisonment.

Wales Humanists considers the safeguards contained within the Bill to be sufficient for their intended purpose. Introducing additional safeguards risks creating unnecessary procedural burdens that could undermine the Bill's central aim: to provide terminally ill patients with autonomy and the ability to die with dignity.

Excessive procedural requirements would risk diverting a patient's limited time towards compliance, rather than allowing them to spend that time with loved ones. It is therefore important that Wales



adopts the safeguards and training provisions set out in the Bill to ensure parity of access to assisted dying between patients in England and Wales. Consistent and inclusive legal guidance is integral to promoting both safety and fairness. International experience supports this approach:

- In Australia, their guidance led to the successful implementation of their Voluntary Assisted Dying Act. Reviewing the operation of the Voluntary Assisted Dying Act's first four years, their Department of Health found that voluntary assisted dying is meeting its intended functionality, providing a compassionate and safe choice to eligible people. Feedback from families consistently highlighted the compassionate, person-centred approach, and the high levels of respect and practicality as a result of their robust safeguards.<sup>5</sup>

#### **Clause 39(1), (2), (5) and (6): Voluntary Assisted Dying Services: Wales<sup>6</sup>**

#### **Q4: What are your views on enabling Welsh Ministers to regulate the structure, management, and delivery of services?**

Wales Humanists supports the mentioned provisions. It enables NHS Wales to develop and tailor its services according to its own priorities, provided that this could be done by an Act of the Senedd Cymru.

#### **Q5: How will these regulations (if approved) impact current palliative care practices in Wales?**

Wales Humanists welcomes the proposed regulations as we expect them to complement and enhance palliative care.

International evidence consistently shows that legalising assisted dying does not hinder palliative care, as shown in the following examples:

- In a recent article for the National Library of Medicine, Dr. Ben Colburn asserts that introducing legalised assisted dying does not hinder palliative care or cause it to deteriorate; rather, such deterioration would only occur due to a lack of Government support or funding cuts (Colburn, 2025).<sup>7</sup>
- Research by Bernheim et al. indicates that legalising assisted dying has not been shown to impede the development of palliative care. (Bernheim, J. L., et al., p.866, 2008).<sup>8</sup>
- Chambaere et al. concluded that concerns about palliative care being undermined by legislation in Belgium and the Netherlands are not supported by the evidence.

<sup>5</sup> Operation of Victoria's Voluntary Assisted Dying Act 2017 October 2024

<https://www.health.vic.gov.au/sites/default/files/2025-02/review-of-operation-voluntary-assisted-dying-act-2017-final-report.pdf>

<sup>6</sup> This is now under Clause 42.

<sup>7</sup> Palliative care-based arguments against assisted dying, Colburn, 2025:

<https://pmc.ncbi.nlm.nih.gov/articles/PMC11754995/>

<sup>8</sup> Bernheim, J. L., Deschepper, R., Distelmans, W., Mullie, A., Bilsen, J., & Deliens, L. (2008). Development of palliative care and legalisation of euthanasia: Antagonism or synergy?



- An Australian report examined the argument that assisted dying could stall the development of palliative care or weaken its culture of competent and compassionate practice, and likewise found no evidence to support this claim.<sup>9</sup>
- A 2018 report commissioned by Palliative Care Australia found that in jurisdictions with assisted dying, the palliative care sector has continued to advance. The Australian experience reflects this: Since Victoria introduced assisted dying in 2017, over \$1 billion in additional funding has been directed to palliative care nationwide, including a \$743 million increase in New South Wales, the most recent state to pass legislation<sup>10</sup>.
- The use of palliative care has risen by 10% in Canada, which is the fastest-growing rate of palliative care in its history.<sup>11</sup>

Given the evidence presented, it is necessary to consider the broader issue of unrelieved suffering at the end of life. Unrelieved suffering and the case for dying in dignity:

- Even under optimal care, it is not always possible to fully alleviate suffering.
- A recent report by OHE has confirmed that between 2019 and 2023, there has been a 15% increase of people dying in unrelieved pain, despite receiving the highest standards of palliative care in England.<sup>12</sup>
- Research by My Death, My Decision reveals that at least one British citizen per week travels to Switzerland seeking assisted dying.<sup>13</sup>
- Dignity in Dying recently published that the average cost to travel for assisted death purposes is around £15,000<sup>14</sup>. This cost is not only a financial burden to the average citizen, but it also makes dying with dignity and autonomy a luxury that only the wealthy can afford, adding unnecessary avoidable pain to persons and families that are already suffering enough.
- In a report by Compassion in Dying, they mention that 83% of people would rather prioritise their quality of life, over living longer.<sup>15</sup>

<sup>9</sup> Bernheim, J. L., et al. (2008), p.866.

<sup>10</sup> Palliative Care Australia, Experience Internationally Of The Legalisation Of Assisted Dying, October 2018 [https://palliativecare.org.au/wp-content/uploads/dlm\\_uploads/2018/12/Experience-internationally-of-the-legalisation-of-assisted-dying-on-the-palliative-care-sector-APEX-FINAL.pdf](https://palliativecare.org.au/wp-content/uploads/dlm_uploads/2018/12/Experience-internationally-of-the-legalisation-of-assisted-dying-on-the-palliative-care-sector-APEX-FINAL.pdf)

<sup>11</sup> Journal of Palliative Medicine, Medical Assistance in Dying and Palliative Care: Shared Trajectories, June 2023 <https://pubmed.ncbi.nlm.nih.gov/37428971/>

<sup>12</sup> Office of Health Economics, unrelieved pain, November 2024 <https://www.ohe.org/insights/20-people-a-day-die-in-unrelieved-pain-across-the-uk-at-the-end-of-their-ives/>

<sup>13</sup> Assisted Dying Coalition, Number of UK citizens going to Switzerland, Feb 2019 [https://humanists.uk/wp-content/uploads/2019-2-1-KM-Assisted-Dying-Briefing\\_-\\_Number-of-UK-citizens-going-to-Switzerland-to-see-an-assisted-death-1.pdf](https://humanists.uk/wp-content/uploads/2019-2-1-KM-Assisted-Dying-Briefing_-_Number-of-UK-citizens-going-to-Switzerland-to-see-an-assisted-death-1.pdf)

<sup>14</sup> Dignity in Dying, 'Cost of journey for assisted dying in Switzerland skyrockets, Sep 2023 <https://www.dignityindying.org.uk/why-we-need-change/travelling-to-dignitas-for-assisted-death/>

<sup>15</sup> Compassion in Dying, Rethinking the UK's approach to dying, July 2024 <https://cdn.compassionindying.org.uk/wp-content/uploads/rethinking-UKs-approach-dying-july-2024.pdf>



Clause 47 in the Bill also places a responsibility on the Secretary of State to publish and lay before Parliament, a report about the progress made after the period of one year after the Act has been ratified, and every six months thereafter until the sixth reporting period. This Clause places a legal obligation to provide a report that will openly assess the availability, quality and distribution of appropriate health services to persons with palliative care and end of life needs, ensuring that all practices will be subject to careful scrutiny. It is important to note that the specification and commissioning framework for hospices will provide an adequate standard aimed at enabling assisted dying to supplement and improve palliative care in April 2026.

The debate should not be framed as a choice between palliative care and assisted dying. Evidence from Victoria and Western Australia demonstrates that the two can and do coexist, with 80 to 95 percent of individuals who access voluntary assisted dying also receiving high-quality palliative care. Voluntary assisted dying therefore represents an additional compassionate option rather than a replacement.<sup>16</sup>

#### **Clause 45: Monitoring by Commissioner<sup>17</sup>**

##### **Q6(a): What are your views on allowing Welsh Ministers to refer matters to the Commissioner?**

Wales Humanists supports Welsh Ministers to refer matters to the Commissioner. It ensures devolved governance, enabling Welsh Ministers to contribute to monitoring the service and addressing Wales-specific concerns, while preserving the UK-wide remit of the Commissioner role.

##### **Q6(b): What are your views on requiring the Commissioner to consult the CMO for Wales in annual reports?**

Wales Humanists welcomes this provision and finds it necessary. It ensures the needs of the Welsh population are met and reflected in national governance.

##### **Q6(c): What are your views on requiring Welsh Ministers to publish and respond to the Commissioner's annual report?**

Wales Humanists sees this provision as necessary, as it fosters transparency, government accountability and promotes devolution by strengthening the role of Welsh Ministers.

#### **Clause 47(4): Provision of Information in English and Welsh<sup>18</sup>**

##### **Q7(a): Do you agree that services and documents must be provided in a person's first language if English or Welsh, and otherwise in their preferred language of English or Welsh?**

Wales Humanists wholeheartedly agrees with these provisions, as language should never be a barrier to exercising one's rights, especially when it comes to their right to autonomous and

<sup>16</sup> Go Gentle Australia, Written Evidence (ADY0184), Jan 2023  
[https://committees.parliament.uk/writtenevidence/116137/html/#\\_ftn6](https://committees.parliament.uk/writtenevidence/116137/html/#_ftn6)

<sup>17</sup> This is now under Clause 49.

<sup>18</sup> This is now under Clause 51.



dignified end-of-life options. We find these provisions essential to guaranteeing informed consent and equal access. In this regard, we find this approach is consistent with Language (Wales) Measure 2011 which places a statutory duty on NHS bodies in Wales to provide services in both Welsh and English.

**Q7(b): What are your views on requiring Senedd approval for any Welsh-language-related regulations?**

Wales Humanists believes this provision is appropriate and necessary as it aligns with Wales' devolved language policy.

**Clause 50(1), (2), (5) and (6): Regulations<sup>19</sup>**

**Q8: What are your views on the proposed procedure for regulations, and whether it provides appropriate Senedd oversight?**

Wales Humanists supports the proposed procedure for regulations and considers requiring Senedd approval. This measure helps ensure that any regulations affecting end-of-life care are consistent within the devolved health system and reflects the ethical significance of the decisions involved. We recommend that Welsh Ministers prioritise the development of regulations to prevent delays in access for Welsh residents.

Expedited preparatory work will help ensure that regulations are ready alongside those being developed in the UK Parliament, particularly important given that a new Senedd will be in place in 2026, with Members approaching this legislation for the first time. Providing them with timely information and resources will support informed decision making. It is also important that public consultation is considered during the development of these regulations. Engagement with patients, families, and healthcare professionals will help ensure that the rules are clear, practical, and do not place unnecessary burdens on those seeking assisted dying.

We emphasise the need to avoid inequalities between Wales and England. If Welsh regulations are not enacted, access to assisted dying may be restricted to private services, where available, meaning that only those able to afford it could exercise this vital choice. This would exacerbate existing health inequalities, as average incomes in Wales are lower than in England and Scotland, and risk denying terminally ill individuals the ability to make autonomous, dignified decisions at the end of life. Coordination with the UK Government can help minimise these disparities and ensure equitable access across jurisdictions.

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<sup>19</sup> This is now under Clause 54.



**Clause 54(6), (8) and (9): Commencement<sup>20</sup>**

**Q9: What are your views on allowing Welsh Ministers to decide commencement dates (subject to Senedd approval)?**

Wales Humanists support allowing Welsh Ministers to determine commencement dates, subject to Senedd approval. This approach ensures that all necessary systems are in place before the law becomes operational, including workforce training, public awareness, referral pathways, and the provision of materials in Welsh where requested. We recognise that establishing assisted dying services represents a significant system change and that capacity considerations in the NHS must be addressed. Expedited preparatory work is essential to avoid unnecessary delays and ensure that Welsh residents can access services as soon as it is safe and practicable to do so. Giving ministers discretion over commencement dates allows for careful planning while maintaining accountability through Senedd oversight, ensuring the law is implemented safely, consistently, and equitably across Wales.

**Q10: Is the procedure appropriate?**

Wales Humanists consider the procedure appropriate, as requiring Senedd approval guarantees that readiness is carefully examined and remains accountable to democratic oversight.

**Q11: What are your views on the implications of different start dates in England and Wales?**

Wales Humanists are concerned that differing start dates could create confusion, particularly for residents of communities situated between jurisdictions. We suggest the UK and Welsh Governments coordinate with the intention of aligning commencement dates, with efforts to establish efficient communication with both patients and professionals.

**Conclusion**

**Clause 40 - Guidance about the operation of the Act:**

Wales Humanists supports the CMO issuing practical, inclusive guidance following consultation with persons with learning disabilities, protected characteristics, and other relevant stakeholders. While the CMO has sufficient authority, we recommend information sharing, streamlined clinical processes, and grief support for families. The Bill's extensive safeguards including multidisciplinary panels, mandatory training, independent advocacy, voluntary and revocable declarations, strict eligibility and witness criteria, identity verification, and transparent record keeping are sufficient to protect vulnerable individuals while maintaining an efficient and practical framework for implementation.

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<sup>20</sup> This is now under Clause 58.



**Clause 42 - Voluntary Assisted Dying Services in Wales:**

Wales Humanists supports Welsh Ministers regulating the structure, management, and delivery of services to tailor care locally. Voluntary assisted dying is expected to complement rather than hinder palliative care, supported by international evidence from Australia, Belgium, the Netherlands, and Canada. Funding for voluntary assisted dying and palliative care must remain separate. Reporting requirements will ensure transparency, accountability, and equitable access, addressing unrelieved suffering and promoting dignity at the end of life.

**Clause 49 - Monitoring by Commissioner:**

Wales Humanists supports Welsh Ministers referring matters to the Commissioner and consultation with the Chief Medical Officer to ensure the needs of the Welsh population are represented. Publishing and responding to the Commissioner's annual report promotes transparency, accountability, and strengthens devolution.

**Clause 51 - Provision of Information in English and Welsh:**

Wales Humanists believes that services and documents should be provided in a person's first language or preferred language to guarantee informed consent and equal access. Senedd approval for language related regulations is appropriate and aligns with devolved language policy.

**Clause 54 - Regulations:**

Wales Humanists supports the proposed procedure for regulations with Senedd oversight to ensure consistency, ethical standards, and integration within the Welsh health system. Expedited preparation, public consultation, and coordination with the UK Government are recommended to prevent delays, reduce unnecessary burdens, and avoid inequities with England.

**Clause 58 - Commencement:**

Allowing Welsh Ministers to decide commencement dates, with Senedd approval, ensures readiness, workforce training, public awareness, referral pathways, and provision of Welsh language materials. Coordination with the UK Government is advised to avoid confusion from differing start dates and to ensure safe and equitable implementation.

**For more details, information, and evidence, contact Wales Humanists:**

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[humanists.uk](http://humanists.uk)



# Agenda Item 5.3

Y Pwyllgor Deisebau

## Petitions Committee

### Senedd Cymru

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### Welsh Parliament

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Peter Fox MS,

Chair, Health and Social Care Committee

CC: Jeremy Miles MS

Cabinet Secretary for Health and Social Care

Welsh Government

Tŷ Hywel

Cardiff Bay

CF99 1SN

23 July 2025

Dear Peter,

**Petition P-06-1505 Review the Carr Hill Formula in Wales - the funding system for primary care**

The Petitions Committee met on 14 July and considered the above petition, submitted by Matthew Jones.

Members noted the matter is under active scrutiny by the Health and Social Care Committee as part of its [inquiry into the future of general practice in Wales...](#)

It was agreed that I would write to you as Chair of the Committee to highlight the correspondence on this petition and ask for an update on the likely timescales for that inquiry work. The letter is copied to the Cabinet Secretary for Health and Social Care for awareness. Members agreed the petition would be kept open pending your response.

The full details of the Committee's consideration of the petition, including the correspondence and the actions agreed by the Committee can be found here: [P-06-1505 Review the Carr Hill Formula in Wales - the funding system for primary care...](#)

I would be grateful if you could send any response by e-mail to the clerking team at [petitions@senedd.wales](mailto:petitions@senedd.wales).



Yours sincerely

A handwritten signature in black ink that reads "Carolyn". The letters are cursive and fluid, with a large initial 'C'.

Carolyn Thomas MS  
Chair

Croesewir gohebiaeth yn Gymraeg neu Saesneg.

We welcome correspondence in Welsh or English.

# Agenda Item 5.4

Y Pwyllgor Iechyd a  
Social Cymdeithasol

## Health and Social Care Committee

Carolyn Thomas MS  
Chair  
Petitions Committee

18 September 2025

Dear Carolyn

Petition P-06-1505 Review the Carr Hill Formula in Wales - the funding system for primary care

Thank you for your letter of 23 July seeking an update on the timescales for our inquiry into the future of general practice in Wales.

In September 2024, the Committee held an initial stakeholder event involving GPs, practice staff, and other health professionals working in general practice, to help inform the terms of reference for the inquiry. A written consultation exercise ran from January to March 2025. This was followed by a roundtable event and formal evidence session with GPs, practice managers, and allied health professionals in July 2025.

Oral evidence sessions will continue through the autumn term, with a view to reporting in the new year.

Yours sincerely



Peter Fox MS  
Chair, Health and Social Care Committee

Croesewir gohebiaeth yn Gymraeg neu Saesneg. We welcome correspondence in Welsh or English.

**Senedd Cymru**

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# Agenda Item 8

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# Agenda Item 9

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