GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

VACANT PRACTICE PANEL MEETING

Date and Time of Meeting:	Friday 31st October 2025, 9:00am-10:30am
Venue:	By Microsoft Teams

Present:	**Rhian Bond (Chair)** – Assistant Director of Primary Care (RB) **Dr Ernesto Jones** – Clinical Director – Primary Care & Community Services (EJ) **Samuel Dentten** – Deputy Regional Director - Llais (SD) **Leanda Wynn** – Engagement Office – Llais (LW) **Dr Sophie Bennett** – Medical Director of the Local Medical Committee (SB) **Anna Swinfield** – Head of GMS Sustainability (AS) **Amanda Whiting** – Head of GMS & Community Pharmacy (Contracts & Performance) (AW) **Victoria Edwards** – Service Transformation Lead (Carmarthenshire) (VE) **Leon Popham** – Senior Finance Business Partner (LP) [redacted] – Primary Care Administrative Officer (RBE)
Apologies:	**Sarah Perry** – General Manager, Carmarthenshire Systems

Item	Welcome, introductions and apologies for absence	Action
1	RB welcomed all to the meeting and the group individually introduced themselves. RB noted the apologies that had been received.	

2	**Declarations of interest**	
	No declarations of interest were received.	

3	**Revised Terms of Reference**	
	AS advised members that the Terms of Reference were agreed at the last Primary Care Contract Review Group (PCCRG). AS confirmed the meeting to be quorate and advised that the purpose of the meeting is to make a recommendation. SB referenced the last PCCRG meeting where it was decided that all the Health Board Managed Practices would be reviewed on an annual basis and queried whether this process would still be going ahead. RB clarified that separate conversations around Meddygfa'r Sarn had already taken place and advised that the proposed process of annually reviewing the Managed Practices would be brought to a later PCCRG meeting. RB confirmed that the Terms of Reference were agreed by the Board in the latter part of 2024 as being appropriate and in line with national guidance.	

4	**Options for consideration**	
	<u>**Background**</u> AS took members through the detail of the paper providing background information and an overview of the current situation, highlighting that: • Meddygfa'r Sarn has been a Health Board Managed Practice since 2017 due to sustainability concerns in the Amman Gwendraeth Cluster at that point in time.	

- Closer links between Meddygfa'r Sarn and Meddygfa Minafon have been developed, with a lot of shared staff roles between the Practices.
- AS highlighted that no staff engagement has taken place, emphasising the importance of keeping confidentiality until a decision has been made.

AS spoke on the demographic information of Meddygfa'r Sarn and highlighted the following points:

- Most of Meddygfa'r Sarn's population live in Pontyates itself.
- Some patients in Pontyates are registered with Practices in Pontyberem.
- Meddygfa'r Sarn's patient list size is 4,300, making it the smallest of the Managed Practices and the smallest Practice in the Amman Gwendraeth Cluster. For reference, AS noted that the average Health Board patient list size is 8,500.
- The whole of Meddygfa'r Sarn's boundary is covered by other Practices in the Cluster.
- The patient list size has grown since it became a Health Board Managed Practice and has now stabilised.
- The age and sex demographic is typical for the Cluster.
- There are no care homes in the Practice area, along with there being no community staff based at the Practice.
- There are Community Pharmacies in Pontyates and Pontyberem.
- Public transportation is limited.

AS spoke on Meddygfa'r Sarn's workforce, highlighting the following points:

- There is no GP Clinical Lead in post, along with no salaried GPs.
- The medical workforce is entirely GP Locum dependent.
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- The Practice actively participates in the weekly clinical team meetings that take place with Meddygfa Minafon and are overseen by Dr Ernesto Jones.

Speaking on the premises, AS highlighted the following points:

- The Practice operates from one building that is located at the bottom of the hill in Pontyates.
- In 2022, improvements suggested by Infection, Prevention and Control (IP&C) were made to the building.
- The premises is small for its list size of 4,400 patients.
- There are very high rates of occupation in all the clinical rooms.
- The Practice is very prone to flooding, and there have been instances of the building being surrounded by water in the past.
- The premises is owned by and is occupied by the Health Board under a TIR lease which expired in 2020 and has been extended until October 2026.
- The rent for the building totals at £23,000 per annum.
- There are three consultation rooms that are occupied by two GPs and another member of the Multidisciplinary Team (MDT).
- There are offices for the Medicines Management team and Service Delivery Manager.
- Work was undertaken in 2022 to improve the waiting area.
- The lack of space at Meddygfa'r Sarn constricts what Cluster services the Practice can host.

- AS reported that a routine health and safety audit had recently been conducted. The audit identified necessary works required on the premises to meet compliance standards.
- An issue that has been flagged repeatedly is the Practice does not have a staff room. AS explained that an arrangement is in place whereby the Practice Manager vacates [redacted] office at lunch time to allow staff to use that space during lunchtime.
- AS confirmed that there is parking to the front and the rear of the Practice.
- AS stated, that the Practice has made the switch from Vision to Emis.

AS invited any questions from members on premises or workforce.

AS confirmed that the absence of a Clinical Lead and salaried GP was due to a combination of factors, including the departure of the previous Clinical Lead earlier in the year and limited interest in salaried posts, although an advert for an interim Clinical Lead had recently closed. SB asked about the presence of Locums, to which AS responded that there was a regular team of Locums providing continuity. SB acknowledged this and queried whether Locums were taking on responsibilities such as reviewing results and correspondence. AS confirmed that these tasks were managed within the Practice, supported by an experienced Practice Manager. AS commented that the oversight and the day-to-day management by the Service Delivery Manager is good. EJ added that the regular Locums had developed strong relationships with the Practice and were undertaking additional administrative duties typically expected of salaried GPs, including managing complex issues. SB noted that the Locums were effectively functioning as salaried GPs due to their ongoing involvement and comprehensive engagement with the Practice. EJ agreed, highlighting the continuity and satisfaction among the Locums, who were familiar with the patients and the Practice environment. AS noted, that some Locums are working across other Health Board Managed Practices including Meddygfa Minafon and Ashgrove Medical Centre.

The following business issues were highlighted to the group by AS:

- Meddygfa'r Sarn total cost for 2024/25 was £1.013 million, with projected costs rising to £1.078 million.
- Total projected pay-related expenditure was £1.149 million.
- 49% of pay-related costs were attributed to Locum GP sessions.
- No forecasted expenditure was allocated for salaried GPs.
- Additional pay costs included administrative, clerical, pharmacy, and nursing teams.
- Non-pay costs were primarily premises-related, including rent and associated expenses totalling £51K.
- Office-related costs amounted to £6K.

SB queried who the Physician Assistant has supervision from. EJ explained that he was currently stepping in as interim GP lead for Meddygfa Minafon and Meddygfa'r Sarn, providing oversight and maintaining regular contact with the teams, including occasional links with the salaried GP at Meddygfa Minafon. SB [redacted]. SB emphasised the need for clear day-to-day oversight and continuity to protect both the GPs and the Health Board. EJ agreed, noting that the PA had been in post for approximately three years and was very experienced, and that discussions were ongoing regarding the scope of practice considering the Leng Review. SB reiterated the importance of assurance given the complexity of the issue.

AS noted, that the core, Supplementary Services and Cluster Services were listed further down in the documentation. She confirmed that a Contract Assurance Framework (CAF) visit was scheduled for the following month, assessed as requiring a full visit based primarily on the CGPSAT responses. AS outlined that the visit would cover areas including performance data, PADRs compliance, and ESR-related matters. She mentioned the presence of sickness within the team, including long-term cases, and stated that the Practice had self-assessed as stable at escalation level 2. Regarding patient engagement, AS reported that the Practice had participated in the contractually required National Patient Experience Survey earlier in the year, receiving an overall rating of 8.02 out of 10, with generally positive feedback and praise for staff, though some comments highlighted a lack of continuity with GPs. Most respondents felt appointment wait times were reasonable. AS added that Managed Practices were involved in the Civica pilot for year-round online feedback, although response rates had been slow to date.

Assessment

AS advised, there are four options to consider and these are:

1. **Standalone Managed Practice –** AS explained that this is what the Practice is now, opting for this would maintain the status quo. AS stated, this option would involve continuing to operate from the same premises. This option would not involve a significant engagement effort. AS noted, that recruitment of GPs would be necessary and expressed hope that the current process to appoint a fixed-term GP Clinical Lead would be successful. However, AS highlighted risks associated with this option, including its lack of innovation and vision for improvement, and its commitment to maintaining problematic premises. She pointed out that the Practice remained small, serving only 4,500 patients, and that the lease had expired in 2020, with the Health Board currently holding over. AS concluded that this issue would need to be addressed if the status quo option were pursued.

2. **Merger with Meddygfa Minafon –** AS stated that this option would provide continuity for the staff and patients. However, the longer-term issues concerning the premises and workforce would need to be addressed. AS outlined that the proposed approach would involve a managed dispersal of the entire patient list to form a single, larger Practice, with all staff retained, which she emphasised as a key priority. She noted that while this would not eliminate existing premises issues, the larger Practice would need to be accommodated across the Meddygfa Minafon site, with options to retain either both Trimsaran and Sarn sites or just one, due to ongoing space pressures. AS explained that maintaining two or three buildings was under consideration. AS commented that this option would allow for standardisation of care across a broader patient list of approximately 13,000, making it the largest Managed Practice in the area. She highlighted the opportunity to engage with the community and potentially shift towards a more Meddygfa Minafon led model. The merger would also enable a more integrated workforce, improving efficiency, as current cross-site roles were not fully combined. AS acknowledged that the main risks associated with merging with Meddygfa Minafon related to

premises and workforce, and that any site closures would require careful engagement and consideration. She added that a larger Practice would demand further investment in the already pressured Meddygfa Minafon premises and anticipated that patient travel concerns would arise if services were relocated or sites closed. AS confirmed that, due to its size and role as an anchor site for workforce, Meddygfa Minafon would be considered the main site in the proposed merger, with Sarn and Trimsaran potentially operating as branch sites depending on final decisions. SB acknowledged this arrangement. RB added that Meddygfa Minafon would require significant redevelopment, as it was not currently fit for purpose in terms of premises. VE asked about staffing capacity at Meddygfa Minafon considering the proposed merger and the additional 4,000 patients it would bring. AS responded that there was currently only one part-time salaried GP at Meddygfa Minafon but expressed optimism about recruitment prospects there compared to Meddygfa'r Sarn, noting that filling the Clinical Lead post was a priority before further recruitment could proceed. She agreed with RB's point that combining patients and staff across the existing or reduced number of buildings would be challenging due to space constraints.

3. **Managed dispersal -** AS explained that the patient dispersal would be based on geographical proximity, using postcodes to determine the nearest Practice, whether Independent Contractor or Managed. She noted that this method had been used in previous dispersals and confirmed that at least one neighbouring Practice, Coalbrook Surgery, had expressed interest in expanding its list size due to concerns about its current scale and long-term sustainability. This option would involve TUPE transfer of existing staff and help mitigate workforce and premises risks for the Health Board. AS stated, that postcode modelling had been conducted to assess the impact, with approximately 2,900 patients expected to be dispersed to Coalbrook Surgery, 960 to Meddygfa Minafon (increasing their list from 8,500 to 9,500), 300 to Ashgrove, and 81 to more outlying Practices. SB asked for clarification on Coalbrook Surgery's willingness to grow its list by around 4,000 patients, to which AS confirmed they were aware and supportive, having held three meetings with them. She added that Coalbrook Surgery had previously shown interest in the Cross Hands and Tumble tender in 2024 and had expressed a desire to recruit, become a training Practice, and expand their premises, with NWSSP Specialist Estates Service colleagues having visited in the summer and RB meeting with them more recently to discuss their ambitions. RB confirmed that Coalbrook Surgery currently has two GPs nearing retirement who remain engaged with the Practice, alongside two younger male GP partners. A female GP partner and a female salaried GP were also due to join the team. RB noted that the Practice had made significant progress in acquiring the adjacent building to support physical expansion and had engaged in discussions about growing both their premises and patient population. She highlighted their enthusiasm for development and sustainability, including exploring training status and one of the younger GPs taking on dermatology responsibilities previously handled by a retiring GP. However, RB made clear that the Practice intended to remain a single-site Practice. AS noted, that one of the

partners at Coalbrook Surgery currently works as a GP Locum in Meddygfa'r Sarn. She explained that the risks associated with dispersal would largely depend on the capacity of receiving Practices to absorb additional patients, with the greatest impact expected at Coalbrook Surgery and Meddygfa Minafon. AS emphasised that Meddygfa Minafon would need to accommodate a substantial number of patients, raising concerns about the building's ability to manage the increased demand. Legal advice had been sought regarding TUPE implications for staff in the event of a managed dispersal, and the guidance received indicated that TUPE-eligible staff would be allocated proportionally based on patient distribution. AS acknowledged that this process would require careful management and added that Independent Contractors affected by the dispersal would need to seek their own legal advice to fully understand their responsibilities, risks, and benefits under TUPE regulations.

4. **Procurement -** AS outlined the third option involving procurement under the new Welsh regulations, applicable to GMS or APMS contracts, noting that it would require careful navigation. AS acknowledged that premises would likely remain a challenge and that the financial viability of the model would need thorough assessment. AS highlighted the advantage of this option as it allows for an open and transparent process, allowing any interested party to bid, and confirmed that in addition to Coalbrook Surgery's interest in list growth, regular GP Locums had also expressed interest. She clarified that procurement differs from dispersal in that it is a voluntary process initiated by the bidder and would likely be more acceptable to patients if the existing premises remained open. AS cautioned that procurement under PSR Regulations would be competitive and would require close collaboration with procurement colleagues to ensure success. She noted that staff engagement would be necessary and could lead to insecurity and anxiety, requiring sensitive management. In the event of a successful contract award, TUPE would apply to all Meddygfa'r Sarn staff who spend the majority of their hours at the Practice. AS also acknowledged the risk that a contract awarded through procurement could later prove unsuccessful, a risk inherent in any procurement scenario. She concluded by stating that, given the current timeline, the aim would be to implement the chosen direction by 1 April 2026, leaving limited time for preparation.

5 Recommendation

AS introduced the recommendation phase of the discussion, explaining that the panel was asked to consider all four options and agree that Primary Care Contract Review Group (PCCRG) would act as the oversight group for implementation and management of the chosen recommendation. RB invited panel members to share their preferred option, and AS suggested using a process of elimination, as done previously.

RB began by questioning the viability of maintaining Meddygfa'r Sarn as a stand-alone Managed Practice, given the known risks around workforce and premises. AW responded that this was likely the least preferable option due to long-term risks to business and workforce sustainability. RB asked if anyone disagreed, and with no objections raised, it was agreed that maintaining Meddygfa'r Sarn in its current form would be ruled out.

RB asked the group whether merging with Meddygfa Minafon, considering the number of sites involved, Minafon, Sarn and Trimsaran, or a combination, was viewed as a viable or preferred option. SB responded that the option was viable and should not be discounted, noting that the next stage would involve a public consultation. RB clarified that next stage would be that the Health Board makes a recommendation to the Board on a preferred option and a public consultation would only occur once a preferred way forward had been agreed. She added that presenting multiple options during consultation could be disruptive and hinder decision-making, hence the importance of narrowing down to a single, publicly viable recommendation. LP supported this approach, noting that while financial modelling had been done for multiple scenarios (A, B, and C), further work was needed to understand each on its own merits. He suggested narrowing the options to allow more focused financial analysis, as each had its own pros and cons. VE expressed concern about the proposed merger with Meddygfa Minafon, particularly regarding staffing levels, noting that it would become the largest Managed Practice. She added that retaining all three premises would essentially maintain a stand-alone model and suggested that one site may need to be removed to achieve meaningful integration. RB acknowledged the point. AS reiterated that Meddygfa'r Sarn was a dated building that limited-service provision, and that Meddygfa Minafon was also in poor condition. She emphasised that merging without significant investment in Meddygfa Minafon premises would not be a viable solution and noted that the recent change in landlords could complicate discussions, making progress on premises improvements slow. RB concluded that option 2 should be retained for further consideration, specifically options 2B and 2C, considering the comments around premises and VE's suggestion.

RB introduced option 3, managed list dispersal, and invited views on its viability. AW supported the option, noting that if a contractor was interested and it offered stability, it should be seriously considered. SB agreed, highlighting the positive engagement from Coalbrook Surgery and acknowledging that while the impact on other GMS Practices and Health Board-Managed Practices such as Meddygfa Minafon must be carefully considered, the interest and preparedness shown by Coalbrook Surgery made it a strong option for patients. VE concurred, adding that for patients, having a sustainable Practice with a known workforce outweighed concerns about travel, especially as many affected patients were already located outside the immediate area. RB thanked contributors and confirmed that managed dispersal remained under consideration.

RB introduced the option of procuring a new contract, noting that any new provider would be required to deliver services from the existing premises, which had already been identified as problematic. VE expressed concern that after completing the procurement process, a successful bidder might choose to merge the Practice anyway, thereby removing patient choice and undermining the original intent.

AS responded by highlighting the potential benefits of managed dispersal, suggesting it could improve outcomes for Meddygfa'r Sarn patients and strengthen sustainability within the Cluster, particularly benefiting Coalbrook Surgery. SB raised questions about the impact of current procurement regulations, asking whether the Health Board was legally required to procure and whether due diligence had been done to avoid legal challenges. RB confirmed that procurement rules still applied and that the process would involve testing the market, assessing bidders for governance and service suitability, and potentially deciding not to award a contract if no suitable provider emerged. She acknowledged the process was lengthy, disruptive, and

	required confidence in a positive outcome. RB also clarified that managed list dispersal remained a valid alternative under current regulations. RB then asked the group to consider ranking the four options, suggesting a tentative order of preference: option 3 (managed list dispersal), option 2 (merger with Meddygfa Minafon, with caveats), option 4 (procurement), and option 1 (status quo), and invited further views. EJ agreed, stating that procurement was complex and uncertain, while dispersal appeared to be the more feasible option. SD clarified that while he had remained quiet during the discussion, this should not be interpreted as agreement or disagreement with any of the recommendations being considered. He emphasised that it was important for the public to have their opportunity to contribute to future plans before any preferences were expressed, and that it would be inappropriate to speculate on public opinion at this stage. RB acknowledged this. RB moved the conversation forward, proposing that the group recommend pursuing a managed list dispersal as the primary option, contingent on continued engagement from the interested Practice and resolution of issues, particularly regarding the impact on Meddygfa Minafon in terms of staffing volume. She added that if the Board did not accept this recommendation, a secondary option would be to explore the future of Meddygfa'r Sarn and Meddygfa Minafon as a single Practice, which would require further work on premises, workforce, and site configuration. RB sought confirmation from the group that these were the options to be put forward to the Board, with managed dispersal as the preferred recommendation. AW raised concerns about option 2C, noting that including Meddygfa'r Sarn would result in similar challenges to option 1, and suggested that option 2B may be more viable. RB agreed, acknowledging that neither Trimsaran or Sarn offered ideal premises and that a review of the sites would be necessary. VE added that public backlash could arise depending on which site remained open, as Trimsaran was known as a branch site while Meddygfa'r Sarn operated as a standalone premises, making the rationale for closure complex. RB agreed that significant public engagement would be required to support any preferred model and emphasised the need for investment in all premises to ensure quality care. EJ asked why a merger was being considered over procurement, to which RB responded that a merger was simpler, within the Health Board's control, and did not require a formal procurement process, whereas procurement carried uncertainty about attracting suitable providers. She explained that if procurement failed, the fallback would be either a merger or list dispersal. RB expressed concern about the lack of clear feedback from the group and suggested a vote to determine the preferred option. AW, VE, and EJ all supported option 3 managed list dispersal. SB clarified that while unable to vote, they had shared their views. Based on the majority support, RB confirmed that the recommendation to the Board would be to pursue managed list dispersal, with a contingency plan to consider a joint practice between Meddygfa Minafon and Meddygfa'r Sarn if dispersal proved unfeasible. The group confirmed agreement with this outcome.	

6	**Any other business**	
	None.	