REPORT OF: THE JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE (HOSC):

General Practice Access and Estates in Oxfordshire

Report by: Dr Omid Nouri, Health Scrutiny Officer, Oxfordshire County Council

Report to:
- Julie Dandridge (Strategic Lead for Primary Care across Oxfordshire).
- Matthew Tait (BOB ICB Chief Delivery Officer).
- Dr Michelle Brennan (GP and Chair of the Oxfordshire GP Leadership Group).
- Rachel Jeacock (Primary Care Lead).

INTRODUCTION AND OVERVIEW

1. The Joint Health and Overview Scrutiny Committee considered a report on General Practice (GP) access and estates in Oxfordshire during its public meeting on 11 September 2025. The report provided a summary of GP services activity and some steps being taken to improve access to primary care for residents.

2. The Committee would like to thank Julie Dandridge (Strategic Lead for Primary Care across Oxfordshire); Matthew Tait (BOB ICB Chief Delivery Officer); Dr Michelle Brennan (GP and Chair of the Oxfordshire GP Leadership Group); and Rachel Jeacock (Primary Care Lead) for attending the meeting and answering questions from the Committee in relation to GP services. The Committee also wishes to thank Veronica Barry (Executive Director, Healthwatch Oxfordshire) and Peter Burke (Chair, Thames Valley Faculty Board, Royal College of General Practitioners) for their attendance and participation in the discussion.

3. The topic of GP services is of significant interest and concern by the HOSC given that it has a constitutional remit over health and healthcare services as a whole, and this includes the initiatives taken by the NHS to Council to not only deliver primary care services promptly and efficiently, but to explore how to address rising demand for these services through exploring Estate expansion.

4. Upon commissioning the report from the Buckinghamshire, Oxfordshire, and Berkshire West Integrated Care Board (BOB ICB) for this item, some of the insights the Committee sought to receive were as follows:

   - Details on appointment availability and timeliness.

   - The mechanisms in place to ensure equitable access for patients who struggle with digital or telephone systems.

- How patient experience and feedback was being monitored, and what such feedback is indication as to the nature of GP services.

- The impacts of barriers to recruiting newly qualified GPs under the Additional Roles Reimbursement Scheme.

- Details on the timelines and expected impacts of the new surgery in Great Western Park and the Bicester Health Centre expansion?

- How the ICB is prioritising estate improvement projects given capital and space constraints?

SUMMARY

5. During the 05 June 2025 meeting, the Strategic Lead for Primary Care highlighted progress through new approaches and increased GP recruitment. She acknowledged persistent challenges with primary care estates, such as inadequate premises and limited funding, though some expansion projects were in progress. The Strategic Lead also stressed that strengthening general practice was key to future neighbourhood health plans, with further improvements still needed.

6. The Chair of Thames Valley Faculty Board echoed concerns about estate resources, referencing the Ten-Year Health plan and Leng review. He stressed prevention, evidence-based screening, and the vital role of primary care amid rising demand and insufficient GP growth in Oxfordshire.

7. It was discussed as to how widely the Modern General Practice Model had been adopted across Oxfordshire’s 64 practices. Officers indicated that the model had been implemented as a national programme, not by local GP choice, and that practices had adopted omni-channel access, though the communication to patients about these changes could have been improved.

8. While the patient survey showed above average ease of contacting practices by phone, some practices had as low as 21% reporting easy access, indicating wide variation. The Strategic Lead for Primary Care explained that the ICB supported practices with lower scores by deploying a team to help improve access, sharing successful approaches from higher-performing practices, and introducing cloud-based telephony systems to better manage call queues and reduce complaints about long waits.

9. The discussion also revolved around the ICB’s approach to prioritising estate improvement projects, including the role of the Community Infrastructure Levy (CIL). It was explained that the ICB generally responded to all planning applications notified by councils and was successful in securing developer contributions, particularly in South and Vale, but faced challenges in spending these funds due to capital and revenue constraints. The use of CIL was highlighted as offering greater flexibility and the ability to accumulate and use funds upfront, with ongoing efforts to expand its use in West Oxfordshire and Cherwell. The urgency of population growth and the need for timely release of

funding, especially for projects like Great Western Park, were acknowledged, with the current delays attributed to NHS bureaucratic processes rather than lack of funds.

10. The Committee noted the Director of Public Health's emphasis that rising primary care demand was a national issue, with population growth outstripping GP capacity, especially in Didcot. They highlighted the need for neighbourhood health centres, expanded roles for other clinicians, and clear communication with the public to help manage demand and create additional GP capacity.

KEY POINTS OF OBSERVATION:

11. This section highlights three key observations and points that the Committee has in relation to GP access and estates in Oxfordshire. These three key points of observation have been used to determine the recommendations being made by the Committee which are outlined below:

    Reporting on access equity: Equitable access to primary care is a foundational principle of the NHS, underpinning its mission to provide high-quality healthcare to all, regardless of background or circumstance. In recent years, the landscape of general practice has undergone significant transformation, driven by digital innovation, demographic change, and evolving patient expectations. Against this backdrop, the Committee is recommending that the ICB develop regular reporting on access equity, specifically addressing digital exclusion, rural access, and variation in appointment availability between practices. This recommendation is not only timely but essential for safeguarding the fairness and effectiveness of primary care provision.

    Regular reporting on access equity serves several critical functions. First, it provides transparency and accountability, enabling both the public and policymakers in Oxfordshire to scrutinise how well the health system is meeting its obligations. Second, it can allow for the identification of disparities and the targeting of interventions where they are most needed throughout the County. Third, it supports continuous improvement, enabling the Oxfordshire system to adapt to changing needs and circumstances.

    The Committee understands that, while Oxfordshire performs well compared to national averages in terms of appointment availability and patient satisfaction, these aggregate figures can mask significant variation at the local level. For example, the report received by the Committee for this item notes that 88% of patients in Oxfordshire are seen within two weeks of contacting their practice, compared to 86% nationally, and 55.5% have same-day appointments. However, these averages do not reveal whether certain groups—such as those living in rural areas, those with limited digital access, or those registered at specific practices—face greater barriers to care.

Furthermore, the digital transformation of primary care, accelerated by the COVID-19 pandemic, has brought many benefits, including greater convenience and efficiency. The Committee notes the rollout of online consultation tools and the NHS App, which allow patients to book appointments and manage prescriptions remotely. However, not all patients are able to benefit equally from these innovations. Digital exclusion—defined as the inability to access or use digital technologies—remains a significant barrier for older adults, people with disabilities, those in deprived areas, and some ethnic minority groups.

Academic research underscores the risks of digital exclusion. A 2022 study in the *British Journal of General Practice* found that patients who were older, less affluent, or had lower levels of education were less likely to use online consultation systems, potentially exacerbating health inequalities[1]. Similarly, the King's Fund (2021) has warned that the shift to digital-first primary care could leave behind those who lack internet access or digital literacy[2].

Other areas have recognised this challenge and taken steps to address it. In Greater Manchester, for example, the Health and Social Care Partnership has implemented a "Digital Inclusion Programme" that provides training and support to patients who struggle with technology, ensuring that digital transformation does not come at the expense of equity[3]. Regular reporting on digital exclusion in Oxfordshire would enable the ICB to monitor the extent of the problem, evaluate the effectiveness of interventions, and ensure that alternative access channels—such as telephone and face-to-face appointments—remain available.

Furthermore, Oxfordshire's geography encompasses both urban centres and rural communities, each with distinct healthcare needs and challenges. The report submitted to the Committee notes that practice mergers and branch closures, such as the closure of Hedena Health's Marston Pharmacy site, can affect local access, particularly for those in remote areas. Rural patients may face longer travel times, limited public transport, and fewer healthcare options, all of which can impede timely access to care.

Nationally, rural access to primary care has been a persistent concern. The National Centre for Rural Health and Care (2023) highlights that rural GP practices often struggle with recruitment and retention, leading to reduced appointment availability and increased pressure on remaining staff[4]. In Lincolnshire, for example, the local ICB has developed a "Rural Access Dashboard" that tracks appointment availability, travel distances,

[1] Green, M.A., et al. (2022). "Digital exclusion and access to general practice: a cross-sectional survey." British Journal of General Practice.
[2] King's Fund (2021). "Digital transformation in primary care: risks and opportunities."
[3] Improving health and care in Greater Manchester | Greater Manchester Integrated Care Partnership
[4] National Centre for Rural Health and Care (2023). "Rural Health Inequalities in England."

and patient satisfaction by postcode, enabling targeted investment in mobile clinics and telemedicine solutions.

Academic literature supports the need for granular, location-specific data. A systematic review by Farmer et al. (2016) in BMC Health Services Research found that rural residents in England were more likely to report difficulties accessing GP services, and that regular monitoring was essential for identifying and addressing these disparities. By developing regular reporting on rural access, the Oxfordshire ICB can ensure that resources are allocated fairly and that rural communities are not left behind.

While Oxfordshire's overall performance on appointment availability is commendable, the JHOSC report acknowledges that there is variation between practices. Factors such as staffing levels, premises, management practices, and patient demographics can all influence how quickly and easily patients can secure appointments. Without regular, practice-level reporting, these differences may go unnoticed, leading to pockets of unmet need and frustration.

Other regions have demonstrated the value of benchmarking and transparency. In London, NHS North-West London publishes quarterly "Access Equity Reports" that compare appointment availability, waiting times, and patient satisfaction across practices. This has enabled the identification of outliers and the sharing of best practices, driving improvements across the board.

Academic studies reinforce the importance of monitoring variation. Roland et al. (2019) in the Journal of Health Services Research & Policy argue that regular, comparative reporting is essential for quality improvement, enabling commissioners and providers to learn from high-performing practices and support those that are struggling.

Policy Alignment and Future Directions

The NHS's "Fit for the Future – 10 Year Health Plan for England" (2025) places equity at the heart of its vision for neighbourhood health teams and personalised care. Regular reporting on access equity aligns with national policy and supports the ICB's statutory duty to cooperate with local authorities on health matters. It also complements existing data sources, such as the GP Patient Survey and Friends and Family Test, by providing more granular, actionable insights.

To implement this recommendation effectively, the ICB should develop standardised metrics for digital access, rural provision, and appointment variation, report at regular intervals, and engage stakeholders in interpreting the data and co-designing solutions. This approach will not only enhance transparency and accountability but also support evidence-based decision-making and continuous improvement.

Conclusion

In summary, the recommendation for the ICB to develop regular reporting on access equity across Oxfordshire is justified by the need to ensure that all residents—regardless of digital literacy, geographic location, or practice affiliation—can access timely and appropriate primary care. Drawing on evidence from Oxfordshire, national examples, and academic research, it is clear that regular, transparent reporting is essential for identifying disparities, targeting interventions, and promoting fairness and quality in primary care provision. By embracing this recommendation, Oxfordshire can lead the way in delivering truly equitable healthcare, aligned with both local needs and national ambitions.

Recommendation 1: *For the ICB to develop regular reporting on access equity across Oxfordshire, including digital exclusion, rural access, and variation in appointment availability between practices.*

Rollout plan and evaluation of Modern General Practice model: The Modern General Practice Model (MGPM), as outlined in the HOSC paper, is a conceptual and operational shift in how primary care is delivered. Introduced in 2024, it aims to better align capacity with patient need, improve the experience of care, and enhance the working environment for general practice staff. Its core components include optimising contact channels (telephone, online, in-person), structured information gathering at first contact, care navigation to prioritise need, better allocation of capacity across multidisciplinary teams, and building capability in data use and digital tools.

While the model is ambitious and well-intentioned, its success depends on consistent implementation and rigorous evaluation. Without a clear rollout plan and metrics to assess progress, the risk is that Modern General Practice could become a fragmented initiative with potentially uneven impact across Oxfordshire's diverse communities. A rollout plan provides clarity on how, when, and where the Modern General Practice model will be implemented. It ensures that practices are supported with the necessary resources, training, and infrastructure to adopt the model effectively. The HOSC paper notes that the ICB is working with practices to support implementation, including funding and incentives, but lacks detail on timelines, milestones, or geographic prioritisation.

This lack of specificity is problematic given the variation in practice size, staffing, and patient demographics across Oxfordshire. For example, practices range from serving 3,300 to over 42,000 patients, and some operate in converted houses or outdated buildings with limited capacity for expansion. A rollout plan would allow the ICB to tailor support to local contexts, ensuring that smaller or rural practices are not left behind.

Nationally, NHS Greater Manchester's "Primary Care Blueprint" offers a useful precedent. It outlines phased implementation of digital triage, workforce expansion, and patient engagement strategies, with clear

timelines and responsibilities. Such structured planning has enabled more consistent adoption and better outcomes across the region.[5]

Equally critical is the development of an evaluation framework to assess the impact of Modern General Practice. The paper submitted to the Committee provides some data on appointment volumes and patient satisfaction, noting that 88% of patients are seen within two weeks and 55.5% receive same-day appointments. However, these metrics alone do not capture the full picture of patient experience, staff wellbeing, or service efficiency. An evaluation framework should ideally include:

- *Patient Experience Metrics:* Beyond appointment speed, measures should include ease of access across channels, continuity of care, and satisfaction with care navigation. The GP Patient Survey and Friends and Family Test offer useful starting points, but more granular, practice-level data is needed (and this should be made as accessible and transparent as possible).

- *Staff Wellbeing Indicators:* The success of Modern General Practice hinges on the morale and resilience of staff. Metrics such as workload distribution, burnout rates, and job satisfaction should be tracked. Research by West et al. (2020) in the *British Medical Journal* highlights the link between staff wellbeing and patient outcomes, underscoring the need for systematic monitoring[6].

- *Service Efficiency Measures:* These should include utilisation of multidisciplinary teams, reduction in unnecessary GP appointments, and improvements in triage accuracy. The *Health Foundation's 2022 report* on "Efficiency in Primary Care" recommends using data dashboards to monitor these metrics in real time[7].

In London, NHS North Central London ICB has implemented a "Primary Care Outcomes Framework" that tracks these dimensions across practices. This has enabled targeted support and shared learning, improving both patient and staff outcomes.

Furthermore, publishing a rollout and evaluation framework also supports equity. The paper submitted to the Committee acknowledges that while Oxfordshire performs well on average, there is variation between practices. Without transparent reporting, disparities in access and quality may persist. Moreover, the shift to digital-first care risks excluding patients who lack internet access or digital literacy—a concern echoed in Healthwatch Oxfordshire's June 2025 report, which found that some patients face significant barriers to navigating new systems. Academic literature reinforces this point. A study by Green et al. (2022) in the *British Journal of General Practice* found that digital

[5] Greater Manchester Primary Care Blueprint
[6] Time for a rebalance: psychological and emotional well-being in the healthcare workforce as the foundation for patient safety | BMJ Quality & Safety
[7] Access to and delivery of general practice services - Health Foundation.pdf

exclusion disproportionately affects older adults, those with disabilities, and people in deprived areas[8]. An evaluation framework must therefore include equity metrics, such as digital access rates and outcomes by demographic group.

Moreover, publishing a rollout and evaluation framework enhances transparency and public trust. Patients and stakeholders need to understand how changes are being made, what impact they are having, and how concerns are being addressed. This is particularly important in a context where changes to access systems can be confusing or disruptive. The *King's Fund* (2021) emphasises that transformation in primary care must be co-designed with patients and communities, and that regular reporting is key to maintaining engagement and accountability[9]. By committing to publish its plans and progress, the ICB can demonstrate its responsiveness to public concerns and its commitment to continuous improvement.

Recommendation 2: *To publish a rollout plan and evaluation framework for the Modern General Practice model, including metrics for patient experience, staff wellbeing, and service efficiency.*

Progressing Great Western Park and Bicester Projects: Primary care is the bedrock of the NHS, and its infrastructure must evolve to meet the changing needs of communities. The report submitted to the Committee for this item acknowledges that many GP premises across Buckinghamshire, Oxfordshire, and Berkshire West (BOB) are outdated, often housed in converted residential buildings or older purpose-built surgeries that no longer meet modern healthcare standards. With 154 practices operating out of 223 sites, the report notes that "very few have room to expand," and many have "outgrown their existing space".

In this context, the Great Western Park (Didcot) and Bicester Health Centre projects are not merely capital investments—they are essential responses to demographic pressures and service delivery challenges. Great Western Park is a rapidly growing residential area, and Bicester is one of Oxfordshire's key urban centres. Without timely expansion of primary care facilities in these locations, patients could face longer waits, reduced access, and increased pressure on neighbouring practices.

The Committee's call for an urgent update on the timeline of delivery is rooted in the principle of public accountability. It is pivotal that there are specific milestones, completion dates, or progress indicators. In the absence of such detail, stakeholders—including patients, councillors, and healthcare professionals—are left uncertain about when and how

[8] Implications of the changes to patient online records access in English primary care | British Journal of General Practice

[9] Shaping the future of digital technology in health and social care - Digital Collections - National Library of Medicine

these improvements will materialise. Any lack of clarity could be particularly concerning given the broader challenges facing the NHS estate. The report highlights constraints such as "lack of capital, high rental costs, and lack of suitable options," which make investment difficult. Without a published timeline, there is a risk that these projects may be delayed or deprioritised, despite their strategic importance.

The Committee understands that in August 2024, the ICB issued a letter to all Heads of Planning outlining the types of planning applications it should be consulted on and the use of Community Infrastructure Levy (CIL) funding to support primary care estate projects. The report submitted to the Committee confirms that healthcare has been allocated 20% of the infrastructure proportion of CIL funding from South Oxfordshire and Vale of White Horse District Councils, with contributions approved for extensions in Abingdon and Great Western Park. Given these commitments, it is essential that the ICB demonstrate how planning obligations are being translated into tangible infrastructure improvements. A written timeline update would show how developer contributions are being used, when construction will begin, and when new facilities will be operational.

Other regions have faced similar challenges and responded with structured, transparent estate planning. In North East London, the ICB has developed a "Primary Care Infrastructure Delivery Plan" that maps estate needs against population growth projections and includes detailed timelines for each project. This approach has enabled the region to secure additional capital funding and coordinate with local authorities more effectively[10].

Academic research also supports the need for proactive estate planning. A study by Imison et al. (2018) for the Nuffield Trust found that "poor premises are a barrier to service transformation" and that "investment in estate must be aligned with service redesign and population needs." The authors argue that without clear delivery plans, estate projects risk being reactive and fragmented, undermining their potential impact[11].

Recommendation 3: *To urgently progress and provide a written update on the timeline of delivery of the Great Western Park and Bicester Projects.*

Alternative funding models and design solutions for primary care estate expansion: Many practices across Oxfordshire have outgrown their existing premises, and traditional capital schemes are increasingly failing to deliver viable solutions. The Committee is aware that while developer contributions via Section 106 and the Community Infrastructure Levy (CIL) have been secured, bureaucratic delays and rigid funding mechanisms could also hinder timely deployment.

[10] Primary care transformation - NHS North East London

[11] Improving access and continuity in general practice | Nuffield Trust

This situation is not unique to Oxfordshire. Nationally, the NHS faces a historic backlog in estate maintenance and capital investment. According to the NHS Confederation, the NHS has had half the average rate of capital investment compared to other OECD (Organisation of Economic Cooperation and Development) countries since the 1970s, with over 27,000 clinical service incidents in the last five years linked to estate failures. The House of Lords Library also notes that reliance on general taxation and tight capital controls has limited the NHS's ability to invest strategically in infrastructure[12].

Across the UK, several alternative funding models and design approaches are being explored to overcome the limitations of traditional capital schemes:

- *Public-Private Partnerships (PPPs):* These have been used to deliver estate improvements through shared risk and investment. While controversial in some contexts, PPPs can offer flexibility and speed when structured transparently.

- *Modular and Rapid Build Solutions*: Organisations like Health Spaces have demonstrated that modular construction can reduce delivery times by up to 30%, offering cost-effective and scalable solutions for expanding capacity[13].

- *Flexible Leasing and Repurposing:* NHS Property Services and AHR Architects have promoted the repurposing of underutilised estate and flexible leasing arrangements to support community-based care and integrated service delivery[14].

- *Technology-Enabled Estate Optimisation:* The NHS Estate Optimisation Guide outlines how data-driven space utilisation can help identify and transform vacant or inefficient spaces, aligning estate use with clinical demand[15].

- *Neighbourhood Health Hubs*: The NHS Confederation's September 2025 briefing advocates for the development of neighbourhood health centres that co-locate services, reduce duplication, and improve access, particularly in underserved areas[16].

Furthermore, design innovation is equally critical. The NHS Estate Strategy and planning guidance stresses the importance of adaptable, sustainable, and patient-centred design that can evolve with changing service models. This includes:

[12] Reimagining estates funding | NHS Confederation / Long-term sustainability of the NHS: Options for systems and funding - House of Lords Library
[13] Healthcare Estates | NHS & Private Health | Health Spaces

[14] NHS Property Services | Using innovative technologies to optimise the NHS Estate
[15] NHS Property Services | Using innovative technologies to optimise the NHS Estate
[16] Transforming-NHS-estate-enable-neighourhood-health-service.pdf

- Multi-purpose spaces that accommodate different services.
- High-street drop-in centres for accessible care.
- Reconfigured offices for neighbourhood care delivery.
- Digital-ready infrastructure to support virtual consultations and AI-enabled diagnostics[17].

These approaches can not only improve patient experience and staff wellbeing but also enhance operational efficiency and long-term resilience.

Given these insights, the JHOSC's recommendation for the ICB to produce a plan for Oxfordshire is both pragmatic and strategic. Such a plan should:

- Map current estate pressures and future demand.
- Identify schemes deemed unviable under traditional models.
- Engage district valuers and local authorities in co-designing solutions.
- Explore alternative funding routes, including CIL, Section 106, PPPs, and modular builds.
- Align with national estate optimisation frameworks and the NHS 10-Year Plan.

This plan would not only unlock stalled projects but also position Oxfordshire as a leader in estate innovation, capable of delivering modern, equitable, and sustainable primary care infrastructure.

In essence, the recommendation for the ICB to collaborate with district valuers and local authorities to explore alternative funding models and design solutions is a necessary response to the systemic challenges facing NHS estate development. By producing a localised plan, Oxfordshire can overcome bureaucratic inertia, leverage innovative approaches, and ensure that its primary care estate is fit for the future. This is not just about buildings—it is about enabling better care, closer to home, for every resident.

Recommendation 4: *For the ICB to work with district valuers and local authorities to explore alternative funding models and design solutions for estate expansion where traditional schemes are deemed unviable. It is recommended that the ICB produces a plan for Oxfordshire.*

[17] Estate Strategy and Masterplanning | Medical Architecture

Legal Implications

12. Health Scrutiny powers set out in the Health and Social Care Act 2012 and the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 provide:
 Power to scrutinise health bodies and authorities in the local area
 Power to require members or officers of local health bodies to provide information and to attend health scrutiny meetings to answer questions
 Duty of NHS to consult scrutiny on major service changes and provide feedback n consultations.

13. Under s. 22 (1) Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 'A local authority may make reports and recommendations to a responsible person on any matter it has reviewed or scrutinised'.

14. The Health and Social Care Act 2012 and the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 provide that the committee may require a response from the responsible person to whom it has made the report or recommendation and that person must respond in writing within 28 days of the request.

15. The recommendations outlined in this report were agreed by the following members of the Committee:

Councillor Jane Hanna OBE – (Chair)
District Councillor Dorothy Walker (Deputy Chair)
Councillor Ron Batstone
Councillor Judith Edwards
Councillor Gareth Epps
Councillor Emma Garnett
District Councillor Paul Barrow
District Councillor Katharine Keats-Rohan
District Councillor Elizabeth Poskitt
City Councillor Louise Upton
Barbara Shaw

Annex 1 – Scrutiny Response Pro Forma

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