Report of the JHOSC Primary Care Access and Estates Working Group

Working Group Membership: Cllr Jane Hanna (Chair), City Cllr Louise Upton, Cllr Gareth Epps (until appointed to Cabinet in May 2026), Cllr Paul-Austin Sargent, Cllr Ron Batstone, District Cllr Katherine Keats-Rohan. District Cllr David Rogers.

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

Report to:

- Nick Broughton- Chief Executive, Thames Valley ICB.
- Julie Dandridge- Strategic Lead for Primary Care for Oxfordshire.
- Daniel Leveson- Director of Places & Communities, Thames Valley Integrated Care Board.

Report Contents:

EXECUTIVE SUMMARY:

1. The Oxfordshire Joint Health Overview and Scrutiny Committee (JHOSC) established the Primary Care Access and Estates Working Group following its scrutiny of GP services in September 2025, where members identified significant concerns relating to GP access, workforce sustainability, primary care estate constraints and the impact of housing growth on local services. The Working Group was tasked with undertaking a detailed review of the structural factors affecting general practice across Oxfordshire and developing evidence-based recommendations for the Thames Valley Integrated Care Board (ICB).

2. The Working Group report follows on continued scrutiny sessions since a previous workshop in October 2022 Agenda for Oxfordshire Joint Health Overview & Scrutiny Committee on Thursday, 24 November 2022, 10.00 am | Oxfordshire County Council which led to recommendations and action to tackle long-standing concerns resulting in:

   - The creation of a dedicated GP estates role within the Integrated Care Board (ICB).
   - Didcot Great Western Park being prioritised for ICB capital funding for a new GP estate.
   - Formal correspondence from the Committee to the Secretary of State for Health and Social Care, calling for primary care estate to be delivered ahead of major housing developments in Oxfordshire, alongside action on national workforce shortages.

3. A formal scrutiny item in September 2025 clearly identified the need for a 2026 inquiry to examine serious ongoing concerns about general practice through multiple lenses, including workforce, estates, patient experience, planning policy, infrastructure delivery and national NHS reforms. Evidence was gathered through a series of dedicated sessions with the Thames Valley ICB, the Buckinghamshire, Oxfordshire and Berkshire West Local Medical Committee (LMC), Healthwatch Oxfordshire, South Oxfordshire and Vale of White Horse District Council officers, and practising clinicians. The Working Group also reviewed extensive datasets covering GP appointment activity, patient list growth, workforce trends, patient survey results for every GP Practice in Oxfordshire. National policy and academic literature were also consulted. Three case studies of Didcot, Bicester and Wallingford were examined to properly understand the structural issues underpinning vital provision of GP estate.

   Summary of the Inquiry's Main Findings:

   - **Sustained and increased demand -** Oxfordshire's primary care system is experiencing sustained and increasing demand that is structural rather than temporary. Most practices are working very hard at exceptionally high levels of appointments. The structural problem is that public need and demand is outstripping the available service leading to patients experiencing insufficient or inequitable access.

- **Complex causes of demand -** Growth in demand for primary care is being driven by multiple interconnected factors including: housing and population growth, ageing demographics, increasing multimorbidity, rising mental health needs, greater public expectations, service shifts from hospitals into communities, and broader societal change all creating increasing complexity. GP services cannot be understood through appointment numbers alone. Access is shaped by the interaction between workforce capacity, workload intensity, primary care estate provision, patient demographics, digital exclusion, continuity of care and wider NHS system pressures. Crucially, the evidence suggests that no single intervention will be sufficient to address these pressures; rather, a coordinated and integrated response will be required if general practice is to continue meeting the needs of Oxfordshire's growing and changing population.

- **Structural imbalances and access pressures -** Structural imbalance and access pressures are unevenly distributed. This problem is most acute in areas of rural Oxfordshire that have experienced the highest housing growth and population increases or populations with additional access barriers. Patient experience evidence examined by the Working Group further highlighted substantial inequalities with people experiencing particular challenges in accessing timely care in communities that have and are experiencing rapid housing growth, rural communities and digitally excluded residents. The Working Group concluded that reducing inequalities in access should be a central objective of any future improvement programme.

- **Limited resilience -** GP practices are operating close to their limits; with little headroom to absorb additional demand, service change or workforce attrition. This helps explain why relatively small disruptions— such as staff absence, delayed estate development, or interface failures elsewhere in the system—can have disproportionate effects on patient access.

- **Workforce sustainability -** The inquiry also identified that while Oxfordshire has benefited from the growth of multidisciplinary primary care teams, increases in full-time equivalent GP capacity have not matched growth in demand. There are good examples of innovations that had improved access and reduced complaints. One practice however, had also changed to a limited liability organisation and indicated that any further pressures would require them to consider private practice. The evidence demonstrated that increasing workload intensity, pressures on continuity of care, and difficulties retaining experienced clinicians represent very real and significant short, medium and long-term risks for the future of general practice.

- **Administrative workload burden on GPs -** A recurring theme throughout the review was the impact of avoidable workload and administrative burden on general practice. Evidence from the Local Medical Committee (LMC), NHS partners, and national studies demonstrated that a significant proportion of GP capacity continues to be consumed by system-generated work originating elsewhere within the NHS. The Working Group concluded that reducing avoidable workload is critical if meaningful impact is to be achieved. Evidence from the Group's site visits was that there would be value in local leaders across

acute and primary care working on opportunities to rationalise and create efficiency through improved collaboration on avoidable workload. This was an important finding from the site visit to Hedena Health in Oxford City.

- **Constrained and outdated premises -** The Working Group found that across Oxfordshire, constrained or outdated premises are limiting practices' ability to recruit additional staff, expand services, and deliver new models of care; and that this emerged as the most critical concern of all. Workforce growth, appointment delivery, and service transformation are all constrained by the availability, suitability and timing of primary care infrastructure. Estate provision has failed to keep pace with population growth, changing models of care, and access pressures. The problem is acutely urgent across rural Oxfordshire, which has and is experiencing high housing and population growth.

- **Challenges generated by national restrictions -** The national context is crucial to understanding the range of funding, legislative and policy restrictions within which local leaders are able to operate to make improvements The Working Group's review suggests that many national contractual reforms are directionally positive and consistent with broader policy objectives around integration, prevention and multidisciplinary care. However, the Working Group found that contractual reform alone cannot resolve underlying pressures relating to workforce sustainability, estates capacity, housing growth, continuity of care and workload intensity. Whilst the Working Group found good practice supporting transformation and improvements to neighbourhood health (including tackling social determinants of health and prevention), funding was short-term and was restricted to a minority of GP practices. The future of general practice will depend not only on the contents of the national contract itself, but on how effectively local systems can be supported to be able to translate those contractual reforms into meaningful improvements for both patients and clinicians.

- **Limitations of planning legislation and policy on estate provision -** The Working Group found that the existing national framework for estates provision through planning legislation and policy is not fit for purpose. It is unable to deliver timely estate, constituting a major barrier to patient registration and critical workforce recruitment for primary care. Local leaders need urgent support in tackling the serious delays in providing necessary estate in the communities that have experienced high growth. Future planning for housing growth needs to align with reforms that make provision of health and care infrastructure and services happen at the same time as communities grow.

Case Studies

4. To explore these challenges in greater depth, the Working Group undertook detailed case study reviews of three major primary care estate projects:

- ***Great Western Park, Didcot*** examined the consequences of large-scale housing development occurring ahead of healthcare infrastructure delivery. The case study demonstrated how population growth can outpace primary care capacity and highlighted the complexity and longstanding challenges associated with funding,

planning and delivering new health infrastructure. It also demonstrated the severe impacts of this on the local population and primary care workforce. The Working Group concluded that Great Western Park illustrates the imperative of aligning healthcare delivery with housing growth from the outset. It reinforces the need for national and local changes to support earlier and more structured engagement between healthcare commissioners, planning authorities, developers and central government. Many of the challenges encountered at Great Western Park could have been mitigated through stronger strategic alignment between housing delivery, infrastructure planning and healthcare funding arrangements.

- ***Bicester Health Centre*** examined the impact of rapid population growth on existing primary care facilities and demonstrated how estate constraints can limit workforce expansion and appointment capacity. The Working Group found that the project illustrates the direct relationship between estate capacity and patient access, particularly in fast-growing communities. The quality, size and functionality of primary care premises directly influence how many patients can be seen, how quickly they can be seen, and which services can be provided locally.

- ***Wallingford Medical Practice*** focused on the long-term challenge of future-proofing healthcare infrastructure generally. The evidence demonstrated that incremental estate expansion can eventually become insufficient, requiring more fundamental redevelopment solutions. The case study highlighted how demographic change, population growth and changing models of care are creating pressures that many existing practices were never originally designed to accommodate. This case study raises an important question for the wider health system: how many other practices across Oxfordshire may currently be operating from buildings that were designed for healthcare models of the 1980s and 1990s rather than the needs of the 2030s? The Wallingford case study also illustrates a future model where health infrastructure needs are considered as early as possible in local strategic and growth planning; and where GP practices can play a leading role; and where the layer of developer profit is removed or reduced. Could local systems be freed up by national reform to the renting system to bring it in line with the requirements of modern and sustainable general practice?

5. Funding for housing growth is secured currently through local housing development through s106 and sometimes with CIL (Community Infrastructure Levy) development funding. There is significant funding that is ringfenced at district level for the NHS to use for health estate, but the Working Group found severe barriers that prevent that funding being spent in a timely way and in line with the promises held out to local communities at the time of housing developments. This has been a very long-standing concern of the Committee, with previous developments like Wantage and Grove taking 12 years to materialise. The three case studies examined by the Working Group clearly illustrated that estate provision is not timely, resulting in higher cost and severe pressures on local practices and populations for many years. It is vital that the new wider Thames Valley ICB invest, as a priority, in capacity to support the necessary working with local partners so that builds can be completed sooner. It is also vital that national government and all policy makers make changes with a view to the local NHS, planning authorities, and general practice being able to deliver timely access to General practice; and with it plans for neighbourhood health.

6. Taken together, these three case studies provided powerful evidence that access, workforce sustainability, infrastructure planning and housing growth are fundamentally interconnected and that where there is systemic failure in timely delivery the real-life impacts on the population are profound. They also reinforced the Working Group's conclusion that primary care estate planning must urgently improve and become more proactive if future growth is to be supported effectively.

7. There is currently no financially viable mechanism for delivering the GP estate in a timely way. The Working Group found that local planners do engage with the ICB right from the start, but even when the need for estate and land is available there is a funding gap under the current model. The current funding system using developer contributions does not align with the reality of modern primary care. Modern premises standards and complex staffing requirements contributes to GP estate costing considerably more to build, operate, maintain and staff than in the past. Section 106 developer contributions are not sufficient to meet the costs to a private developer to satisfy requirements and to generate profit for commercial viability. Even with local CIL funding, it is rarely enough and not timely for residents. At best there are very significant delays due to the valuation and rent methodology applied by the District Valuation Service and the availability of local NHS capital and revenue funding. The Wallingford site visit identified an alternative model which we would urge the ICB and all policy makers to consider and engage with.

Recommendations:

8. Following its review, the Working Group makes the following recommendations to the Thames Valley Integrated Care Board:

Recommendation 1

For the Integrated Care Board to adopt a single, integrated approach to improving access to general practice, ensuring that workforce, estates, digital access and neighbourhood models are planned and delivered as a coherent whole rather than as separate initiatives. It is also recommended that variation between localities and communities at a neighbourhood level is supported in this process. The ICB needs to prioritise enhancing its own capacity to work with local authorities and communities to expand capacity of primary care services in light of increases in demand.

Recommendation 2

For active steps to be taken to reduce avoidable, system-generated workload on general practice, including workload arising from the wider NHS system, in order to protect clinical capacity and improve patient access. It is recommended that there is collaboration with local General Practice leaders (as well as patient representative bodies) to explore ways to reduce excessive administrative non-clinical work for qualified GPs; that there is national escalation when this excessive work is owed to national constraints; and that there is a local workshop between local partners to explore opportunities to identify efficiencies from improving shared understanding of administrative pressures and how these might be reduced.

Recommendation 3

That the Integrated Care Board ensures that workforce models for general practice in Oxfordshire are sustainable over the long term, with explicit regard to workload intensity, continuity of care and the retention of experienced GPs, rather than focusing solely on staffing numbers.

Recommendation 4

That the Integrated Care Board prioritises action to reduce inequalities in access to GP services across Oxfordshire, ensuring that improvements in access are experienced consistently by rural communities, digitally excluded residents and populations affected by rapid growth. It is recommended that local patient voices and the scrutiny function have meaningful input into the design and commissioning of GP services.

Recommendation 5

That the Integrated Care Board treats primary care estates capacity as a critical determinant of access to GP services, and ensures that the planning, delivery and expansion of primary care infrastructure in Oxfordshire is proactively aligned with population growth and housing development. It is recommended that there is early/structured engagement with local planning authorities and developers; and a timely delivery of adequate, fit-for-purpose primary care facilities as communities expand, rather than responding retrospectively once access pressures have already emerged.

Overall Conclusion:

9. The Working Group concluded that Oxfordshire's primary care challenges are not primarily the result of insufficient effort or activity within general practice. Rather, they are the product of increasing demand, workforce pressures, system-generated workload, infrastructure constraints, and a lack of alignment between health service planning and population growth. Sustainable improvements in access will therefore require coordinated action across the NHS, local government, planning authorities and wider system partners. National reform is urgently needed to provide a financially viable mechanism for delivering GP estate in a timely way and to help communities in parts of rural Oxfordshire that have experienced large housing growth without timely GP estate. The Group's recommendations are intended to support that shift and provide a framework through which Oxfordshire can maintain resilient, accessible and sustainable primary care services in the face of continued growth and increasing demand.

10. At the time of writing this report, the Working Group had conducted site visits to two GP practices in Oxfordshire; Hedena Health Centre in Oxford City, and Wallingford Medical Practice. Special thanks goes to these two practices for hosting the Group and for their engagement with this inquiry. The visits provide significant opportunity for the Group to understand first hand how GP services operate in both urban and rural areas respectively, and what some of the challenges are in this context. The findings and recommendations found throughout this report have been partly

shaped by what the Working Group had learnt through their experience at these two site visits.

INTRODUCTION AND OVERVIEW

11. Long-standing issues of concern with GP services in Oxfordshire have received regular scrutiny by the JHOSC over the past few years. The Committee held a primary care Workshop on 17 October 2022 which examined demand, capacity, and activity in General Practice, alongside primary care estate development and availability. (Please see link to the agenda of the November 2022 JHOSC meeting which contains a report of the findings of this workshop as well as an annex detailing the number of patients registered per GP practice in Oxfordshire from 2014-2022: Agenda for Oxfordshire Joint Health Overview & Scrutiny Committee on Thursday, 24 November 2022, 10.00 am | Oxfordshire County Council).

12. This topic also received significant attention in a deep-dive of JHOSC scrutiny of GP services in 2023 which resulted in:

- The creation of a dedicated GP estates role within the Integrated Care Board (ICB).
- Didcot Great Western Park being prioritised for ICB capital funding for a new GP estate.
- Formal correspondence from the Committee to the Secretary of State for Health and Social Care, calling for primary care estate to be delivered ahead of major housing developments in Oxfordshire, alongside action on national workforce shortages.

13. The Primary Care Access and Estates Working Group was established by the Oxfordshire Joint Health Overview and Scrutiny Committee following its public meeting on 11 September 2025. At that meeting, the Committee considered the increasing pressures facing general practice in Oxfordshire and agreed that a more detailed examination of the systemic issues affecting primary care delivery was required. The GP Access and Estates scrutiny held in the JHOSC's September 2025 public meeting highlighted significant variation in access, challenges in recruiting and retaining staff, and delays to major estate projects such as Didcot Great Western Park and Bicester Health Centre.

14. In the context of this item in September, the Committee identified the following system-wide concerns:

- Access to GP appointments varies significantly across Oxfordshire.
- Workforce pressures, including difficulties recruiting GPs, nurses and administrative staff.
- Delays to key estate projects are limiting service expansion.
- Estate constraints are preventing practices from increasing capacity even when workforce funding is available.
- Areas experiencing large housing growth face the greatest pressure on GP buildings.
- The above dynamics are having significant impacts on residents and on professionals working in primary care.

15. During the September 2025 meeting, the Committee recommended for there to be:

- Stronger engagement between the ICB and local planning authorities.
- Clearer ownership of estate strategy at local, place level.
- Assurance that estate constraints will not undermine commitments on access, workforce resilience or neighbourhood-based models of care.

16. The ICB responded to and accepted the JHOSC's recommendations, noting constraints relating to national capital funding, policy and regulatory frameworks. The Committee therefore agreed that these issues require continued and intensive scrutiny. Case studies needed to be central to this (e.g. Didcot Great Western Park), where regular updates on progress such as the most recent appointment of a developer and the start of building works continue to be crucial to the Committee as well as the local MP.

17. As a result of this scrutiny in September 2025 and the concerns identified with GP services in Oxfordshire, the Committee therefore resolved to create a time-limited Working Group to undertake a more focused "deep dive" into matters relating to primary care access, workforce pressures and estate capacity across the county.

18. The establishment of the working group was formally confirmed by the Committee at its meeting on 20 November 2025, at which point the Committee also agreed the proposed membership of the working group and its scope and methodology. The working group was tasked with developing a clearer understanding of the underlying drivers of access challenges in general practice, identifying structural and system-level barriers, and exploring potential solutions that could be pursued by the Integrated Care Board and its partners.

19. The agreed membership of the Working Group comprised elected members drawn from the Joint Health Overview and Scrutiny Committee and district councils, reflecting the cross-system nature of the issues under consideration. Membership included Cllr Jane Hanna, City Cllr Louise Upton, Cllr Gareth Epps (until his appointment as a Cabinet Member at Oxfordshire County Council), Cllr Paul-Austin Sargent, Cllr Ron Batstone, and District Cllr Katharine Keats-Rohan. District Cllr David Rogers was appointed by the Committee on 11 June 2026 to join the Working Group after the departure of Cllr Gareth Epps. Officer support was provided by the Health Scrutiny Officer, with input and attendance at evidence sessions from representatives of the NHS Buckinghamshire, Oxfordshire and Berkshire West

Integrated Care Board, Healthwatch Oxfordshire and other relevant stakeholders as appropriate.

20. In agreeing the scope of the Working Group, the Committee made clear that its focus should extend beyond short-term performance metrics and consider the wider factors influencing access to GP services. The agreed remit therefore included examination of primary care capacity and access arrangements, workforce sustainability and workload, the adequacy and delivery of primary care estates, and the interaction between population growth, housing development and health infrastructure planning. Particular emphasis was placed on understanding how these issues interact at system level and the implications for patients, practices and local communities across Oxfordshire.

21. The working group was also asked to consider relevant national policy and guidance, alongside local data and patient experience evidence, in order to contextualise Oxfordshire's challenges within the broader NHS policy framework. The Committee requested that the Working Group report back on its activities (including any interim findings and proposed recommendations) by June 2026.

Stakeholder Engagement Undertaken:

22. The Working Group engaged with (and expresses thanks to) a range of stakeholders to produce a review that is inclusive and comprehensive. These include:

    - NHS Thames Valley ICB (including estates, workforce, and commissioning leads). This includes Dan Leveson (BOB ICB Director of Places & Communities) and Julie Dandridge (Strategic lead for primary care across Oxfordshire).

    - Healthwatch Oxfordshire; including Veronica Barry (Executive Director of Healthwatch Oxfordshire) and Barbara Shaw (Chair of Healthwatch Oxfordshire).

    - South and Vale District council planning and estates officers.

    - Individuals representing General practitioners (including Dr Michelle Brennan, Dr Richard Wood, Dr Peter Burker, and Dr James McNally).

    - Local County and District councillors.

23. Engagement was conducted through online Microsoft Teams meetings, written submissions, and site visits. The Working Group also received written submissions including:

    - GP Appointment data and registered patient list sizes per practice from January 2023-December 2025 (labelled Annex A).

    - GP Appointment trends data month by month from January 2025-December 2025 (labelled Annex B).

- GP Patient Survey data as of the most recent collection in January 2025 (labelled Annex C).

- GP workforce data (labelled Annex D).

- Report submission to the working group from the Buckinghamshire, Oxfordshire, and Berkshire West Local Medical Committee on *Demand, Capacity & Activity in General Practice.* (labelled Annex E).

- The Healthwatch Oxfordshire report on what Healthwatch has heard about GP services in Oxfordshire from April 2025-March 2026.

- A written submission from Cherwell District Cllr David Rodgers on his views and understanding of primary care services.

- NHSE publication on the *Red Tape Challenge; recommendations and next steps.*

- NHSE guidance on *Bridging the interface between primary and secondary care, mental health and community services.*

- The Royal College of General Practitioners Study on uncovering the drivers and costs of unnecessary GP workload.

- The GP services update report submitted to the JHOSC as part of the Committee's public meeting item on GP services in its September 2025.

24. Further academic and policy-based sources have been independently utilised as part of informing the findings and recommendations of the Working Group on the current state of GP services.

Summary of working group activity and sessions:

25. This section provides an overview of the sessions that the working group held, including a summary of who the sessions were with, and the themes that were discussed in each session.

26. Below is a table which provides a summary at a glance of the sessions, followed by a breakdown of what was discussed in each session.

Date	Who with	Main focus
13 Feb 2026	Thames Valley ICB	GP access and workforce pressures
23 Feb 2026	BOB Local Medical Committee	GP staffing, workload and access
10 Mar 2026	Thames Valley ICB	Workforce and demand data

18 Mar 2026	South & Vale District Council officers	Planning and GP estates (Didcot GWP)
21 Apr 2026	Healthwatch Oxfordshire	Patient experience and access
23 Apr 2026	Thames Valley ICB	Primary care estates and infrastructure
9 June 2026	Thames Valley ICB	Digital tools and models in GP services.

Breakdown of Working Group Meetings and Evidence Gathered:

1. **ICB Session – Access to GP Services, Workforce Sustainability and Quality survey from Patients**

13 February 2026 – Julie Dandridge (Strategic Lead for Primary Care for Oxfordshire, ICB) and Dan Leveson (Director of Places & Communities, ICB)

This initial session with the Integrated Care Board focused on the overall accessibility of GP services in Oxfordshire and the sustainability of the primary care workforce, establishing a system-level context for the Working Group's work. ICB officers outlined the scale of demand pressures, noting sustained growth in registered patient numbers driven by housing development, population change, and increasing clinical complexity within the community.

A significant part of the discussion centred on workforce supply, including difficulties recruiting and retaining GPs and other clinical staff, and the reliance on short-term schemes to stabilise services. Members explored how workforce shortages translated into practical access issues for patients, including reduced appointment availability and pressures on continuity of care. The Working Group also questioned how far national workforce initiatives were delivering tangible local benefit and whether current planning assumptions adequately reflected Oxfordshire's rate of population growth.

There was also discussion about the importance of the national formula for funding of practices and the national contract, and that reform to improve the funding position of practices was critical.

While estates were not the principal focus, the discussion explicitly linked workforce capacity to physical estate limitations, with ICB officers acknowledging that constrained or outdated premises often prevented practices from expanding staffing or service offer even where demand and funding existed. This meeting helped frame access and workforce as interdependent system issues, rather than isolated challenges. The session was also helpful in exploring publicly available data links and the limits of usability of these for the working group; and securing agreement from the ICB to produce Oxfordshire focused tables for use in the next session.

2. BOB Local Medical Committee session – Practice-Level Perspective on Access, Workforce and Capacity

23 February 2026 – Dr Richard Wood (Chief Executive, BOB Local Medical Committee)

The session with the Local Medical Committee provided a front-line general practice perspective, complementing ICB data with lived organisational experience. Discussion concentrated on the operational reality of delivering access under sustained pressure, including the cumulative effect of workforce shortages, administrative burden, and increasing patient expectations.

The LMC described wide variation between practices in their ability to respond to demand, influenced by workforce stability, estate size, and local population characteristics. Particular emphasis was placed on how administrative workload and contractual requirements were consuming clinical time, limiting the extent to which practices could increase face-to-face capacity even where workforce numbers appeared stable on paper.

The Working Group explored how estate constraints exacerbated workforce pressures, with small or poorly-configured premises restricting recruitment of additional staff, limiting multidisciplinary working, and constraining modern models of care. The discussion reinforced the link between estates, workforce sustainability and access, and highlighted the risk that practices operating at the margins could become increasingly fragile without structural intervention.

3. ICB Session – Data on Demand, Workforce and Access Trends

10 March 2026 – Julie Dandridge (Strategic Lead for Primary Care for Oxfordshire, ICB) and Dan Leveson (Director of Places & Communities, ICB)

This meeting focused on quantitative data underpinning the working group's enquiry, allowing members to scrutinise trends in demand and capacity in detail. ICB officers presented data on registered patient list growth, GP workforce numbers, appointment volumes and utilisation patterns, including seasonal fluctuation and local variation.

The working group examined how increases in registered populations compared with workforce growth, and discussed the implications for future access if current trends continued. Members explored the limitations of headline workforce figures and probed how factors such as part-time working, portfolio roles and sickness absence affected real-world capacity. The discussion also addressed variation between localities, highlighting areas experiencing particularly acute pressure.

Attention was given to how data was used by the ICB to inform commissioning and prioritisation decisions, and whether existing mechanisms were sufficiently responsive to rapid population growth linked to new housing developments. This session strengthened the evidence base for the working group's findings by grounding narrative concerns about access in objective trend data.

Attention was also given to the capacity of the ICB (given its reorganisation into a Thames Valley ICB), and on what the associated impact would be on support by the ICB to practices that were struggling, and the capacity of the ICB to work in a timely way with district councils on primary care estate. This has been a critical theme from the BOB JHOSC as well as the Oxfordshire JHOSC for many years, constituting a priority concern.

4. Oxfordshire District Councils Session – Planning Systems and Primary Care Estates

18 March 2026 – South Oxfordshire and Vale of White Horse District Council planning and estates Officers

This meeting examined the local planning context influencing delivery of primary care infrastructure, with a particular focus on the interface between local authorities and the NHS. District council officers explained how planning obligations, including Section 106 agreements and Community Infrastructure Levy funding, were negotiated and the constraints affecting their deployment for health infrastructure.

A detailed case study of Didcot Great Western Park illustrated longstanding challenges in aligning housing growth with GP estate capacity. Discussion explored issues such as funding viability, land ownership, timing mismatches between development and NHS capital approval, and the complexity arising from multiple organisations holding different parts of the delivery responsibility. There was also a negative impact on continuity when NHS personnel changed.

Very detailed attention was given to the particular barriers existing at every stage along the timeline; from before the approval of local housing estate provision and the building of the estate, and the consequences including funding implications as well as GP estate implications for a local population. The increased housing developments resulted in delays in registering patients at local practices, with this having negative impacts on existing practices and the public.

The Working Group scrutinised whether existing planning and funding mechanisms were sufficiently robust to support timely primary care expansion, particularly in high-growth areas. Members also considered how earlier and more structured engagement between district councils and the NHS might mitigate delays and improve outcomes. This session was central in evidencing that primary care access is shaped by planning and infrastructure decisions well beyond the NHS.

4. Healthwatch Oxfordshire Session – Patient Experience and Inequality of Access

21 April 2026 – Healthwatch Oxfordshire

This session focused on patient experience of accessing GP services, ensuring that resident perspectives informed the working group's analysis. Healthwatch shared themes arising from its engagement work, including persistent difficulties securing appointments, challenges navigating digital systems, and concerns about continuity of care.

The discussion explored how digital access requirements were affecting different population groups, particularly older residents without carers or advocates, those with limited digital confidence, and people with learning difficulties or other additional needs. Healthwatch also highlighted how variations in practice responsiveness contributed to perceived inequality between communities.

The Working Group considered how patient experience should be used alongside quantitative access metrics, recognising that measures of availability alone did not always reflect the quality or equity of access. This meeting reinforced the importance of embedding patient voice within recommendations on GP service design and access improvement.

The discussion included the existing local model which included an independent patient voice and what would be lost without that. (Future digital models will be explored in a future dedicated session that the working group will have with the ICB on digital models for primary care).

5. ICB Session – Primary Care Estates, Infrastructure and Strategic Planning

23 April 2026 – Julie Dandridge (Strategic Lead for Primary Care for Oxfordshire, ICB) and Dan Leveson (Director of Places & Communities, ICB)

This session focused in-depth on primary care estates capacity, drawing together themes from earlier meetings. Officers outlined the current condition and distribution of GP premises across Oxfordshire, the constraints affecting expansion, and the impact of organisational restructuring on estates capability within the ICB.

The discussion examined in depth three specific estate case studies, Great Western Park, Bicester Health Centre, and Wallingford Medical Centre, considering progress to date, remaining barriers, and lessons for future developments. Members explored how estate limitations restricted workforce growth, constrained service transformation, and limited the ability to deliver more integrated models of care. There was also discussion of the particular barrier of the NHS valuation of rent and why this has taken so long, being a major contributor to delay.

The Working Group also discussed longer-term approaches, including neighbourhood health hubs, and questioned how future estate planning could better align with population growth and service redesign. This session clearly demonstrated how estates underpin the working group's core themes of access, workforce sustainability and service resilience.

6. ICB session- Digital tools and models in primary care services

9 June 2026 – Julie Dandridge (Strategic Lead for Primary Care for Oxfordshire, ICB) and Dan Leveson (Director of Places & Communities, ICB)

This session examined the ICB's role in providing and managing GP digital infrastructure, including IT equipment, remote access solutions, data storage arrangements and support services. The Working Group heard that significant work

had been undertaken to modernise GP technology, with particular emphasis on improving system resilience, supporting remote working and moving towards nationally provided digital platforms such as SharePoint, OneDrive and NHS Mail. Concerns were also discussed regarding the forthcoming replacement of Commissioning Support Unit services and the need to maintain continuity and resilience during that transition.

The Working Group also examined the evolving clinical systems landscape in primary care. Officers described the continued use of EMIS Web and System One across most practices and discussed emerging products such as Medicus. Members explored the challenges of introducing new clinical systems, including data migration, interoperability with existing applications, training requirements and the ability of suppliers to provide adequate support at scale. The importance of robust due diligence and engagement with practices before significant system changes was emphasised throughout the discussion.

A substantial part of the session focused on digital access and digital inclusion. The Working Group explored the extent to which digital tools can improve patient access to services while also recognising that some groups may face barriers. Discussion highlighted concerns that people living with frailty, older patients, those with complex needs (including people with learning disabilities), and individuals with limited digital skills, could be disadvantaged if services became overly reliant on technology. Officers described measures being taken to support digital inclusion, including digital cafés, support through Patient Participation Groups and maintaining alternative access routes such as telephone and face-to-face contact.

The Working Group also considered cybersecurity, information governance and business continuity arrangements. Officers explained the regulatory standards that NHS digital systems must meet and described contingency arrangements in place should systems fail. Members sought assurance that risks were being actively managed and that appropriate governance arrangements existed to maintain public confidence in digital services.

Finally, the session explored the use of the NHS App and other digital patient-facing tools. Members raised concerns about inaccurate or out-of-date information appearing within the app and discussed the processes available for escalation and correction. Officers acknowledged these issues and confirmed that concerns could be escalated to national teams where required.

27. Therefore, in line with its original scope, these meetings collectively allowed the Working Group to:

- Examine access to GP services from system, practice and patient perspectives.
- Assess workforce sustainability using both data and front-line insight.
- Understand how estate capacity and planning systems constrain service expansion.
- Start exploring digital access and patient experience, including inequality impacts.

- Identify structural issues requiring coordinated action across the NHS and local authorities.

Key snapshot extrapolations from Primary Care Data provided to the group:

28. The Working Group was provided with a comprehensive set of quantitative and qualitative datasets by the Integrated Care Board, covering GP appointment activity, patient list growth, workforce capacity and patient experience (Annexes A–D). When considered together, these datasets provide a clear picture of how demand, capacity and access interact across Oxfordshire's primary care system.

29. An overarching extrapolation is that high activity does not equate to sufficient or equitable access. The GP appointment and registered patient list data (Annex A), alongside monthly appointment trend data for 2025 (Annex B), demonstrate that practices across Oxfordshire are delivering consistently high volumes of appointments against a background of sustained list growth. The data does not suggest a system experiencing short-term pressure or seasonal fluctuation; rather, it points to a structural demand–capacity imbalance, particularly in areas of population growth. This indicates that access challenges are not driven by under-delivery of appointments but by demand that continues to rise faster than underlying capacity.

30. A second key extrapolation is that workload intensity within general practice is increasing even where appointment numbers are stable or rising. Workforce data (Annex D), considered alongside appointment trends (Annex B), suggests that growth in activity has not been matched by a proportional increase in full-time equivalent GP capacity. This implies that the marginal increase in demand is being absorbed through intensified workload rather than expanded capacity. The working group noted that this aligns with national evidence showing that appointment data alone significantly under-represents the total volume and complexity of work undertaken in general practice.

31. Patient experience evidence provides an important contextual layer to this picture. The GP Patient Survey results (Annex C) show that while many patients report positive experiences once they secure care, difficulties in contacting practices, obtaining timely appointments and seeing a preferred clinician persist. When viewed alongside Annexes A, B and D, this suggests that access problems are not primarily about willingness or effort within practices, but about constrained capacity and system design. High appointment delivery is therefore compatible with ongoing patient frustration, particularly where continuity of care and flexibility are reduced.

32. A further extrapolation is that access pressures are unevenly distributed, even when aggregate data appears stable. Combining list growth data (Annex A) with patient experience findings (Annex C) indicates that practices serving fast-growing areas, rural communities or populations with additional access barriers are more likely to experience acute pressure. The working group noted that this reinforces the need to treat access inequality as a structural issue rather than a side-effect of individual practice performance.

33. Finally, when workforce, activity and patient experience data are read together, they point to a system operating close to capacity with limited resilience. High baseline activity leaves little headroom to absorb additional demand, service change or workforce attrition. This helps explain why relatively small disruptions—such as staff absence, delayed estate development or interface failures elsewhere in the system—can have disproportionate effects on patient access.

Summary Table: What Each Dataset Tells the Working Group

Dataset	What the Data Shows	Key Extrapolation for the Working Group
Annex A – GP appointments and registered patient list sizes (2023–2025)	Sustained list growth and high appointment delivery across practices	Demand is structurally rising; access issues are not explained by low activity
Annex B – Monthly appointment trends (2025)	Consistently high activity throughout the year	Pressure is continuous rather than seasonal; limited slack in the system
Annex C – GP Patient Survey (Jan 2025)	Mixed patient experience, with persistent access barriers	High throughput does not automatically result in good access or continuity
Annex D – GP workforce data	Limited growth in GP capacity relative to demand	Increasing workload intensity and reduced resilience within practices

National Context: General Practice, Access, Workforce Sustainability and Primary Care Estates:

34. The work of the Oxfordshire Joint Health Overview and Scrutiny Committee (JHOSC) Primary Care Access and Estates Working Group has taken place during a period of unprecedented transition within the NHS. Few sectors of the health service have experienced more sustained policy attention over the last decade than general practice. Nationally, general practice has been expected to respond simultaneously to increasing demand, growing workforce shortages, an ageing population, greater levels of multimorbidity, rising patient expectations, digital transformation, financial constraint, and a fundamental reorientation of ambition that healthcare move away from acute hospitals and into prevention in communities. These pressures have been further compounded by the legacy impacts of the COVID-19 pandemic and the wider challenges facing the NHS estate, and a social care system also under strain.

35. Consequently, national policy has increasingly moved away from viewing access to general practice as simply a question of appointment availability. Instead, there is growing recognition across government, NHS England, independent health policy organisations and professional bodies that access is the product of a

complex interaction between workforce, workload, infrastructure, technology, continuity of care, population growth, social need and system integration. NHS England's Fuller Stocktake argued that improving access requires fundamental reform of how primary care is organised and integrated with wider services rather than simply increasing appointments[1]. The 10 Year Health Plan for England subsequently identified primary care as central to the shift from hospital-based care to neighbourhood-based services and highlighted the need to align workforce, estates and digital transformation[2]. Analysis by The King's Fund has similarly emphasised that pressures in general practice are driven by a combination of workforce shortages, growing demand and increasing complexity of patient need[3]. The Health Foundation has highlighted the impact of demographic change and rising multimorbidity on primary care demand[4], while the Nuffield Trust has argued that workforce, workload and access challenges are interdependent and require system-wide responses[5]. Professional bodies have reached similar conclusions. The Royal College of General Practitioners has identified workload intensity and retention as key determinants of access through its study *Uncovering the Drivers and Costs of Unnecessary GP Workload*[6], whilst the British Medical Association has consistently highlighted the widening gap between patient demand and workforce capacity within general practice[7]. These findings collectively support the conclusion that access to general practice is influenced by a broad range of interconnected factors extending far beyond appointment availability alone.

36. Many of the issues examined by the Working Group mirror precisely those identified in national studies and policy reviews. Challenges relating to primary care estates, workforce sustainability, rising patient demand, continuity of care, administrative burden, neighbourhood working and housing growth are not unique to Oxfordshire. However, the scale of population growth across parts of rural Oxfordshire including in the Vale of White Horse area, coupled with longstanding estate challenges and variation in access, means that national developments have particular significance and impacts for local services in Oxfordshire.

The growing demand challenge:

37. One of the most significant issues affecting general practice, both nationally and within Oxfordshire, is the sustained growth in demand for primary care services. Whilst public debate often focuses on the availability of appointments, national evidence increasingly demonstrates that the challenge facing general practice is considerably more complex. Demand is being driven not simply by an increase in population, but by a combination of demographic change, increasing levels of chronic illness, rising multimorbidity, greater public expectations, increasing mental

[1] NHS England – *Next steps for integrating primary care: Fuller Stocktake Report*
[2] Department of Health and Social Care – *Fit for the Future: 10 Year Health Plan for England*
[3] https://www.kingsfund.org.uk/publications/understanding-gp-pressures
[4] https://www.health.org.uk/publications/reports/understanding-demand-for-general-practice
[5] https://www.nuffieldtrust.org.uk/topic/general-practice
[6] https://www.rcgp.org.uk/getmedia/26330bb5-eecc-4e25-84b3-bbc0f5614dd7/Uncovering-the-GP-workload-burden-A-study-of-the-drivers-and-costs-of-unnecessary-and-hidden-workload-%E2%80%93-December-2025.pdf
[7] https://www.bma.org.uk/advice-and-support/nhs-delivery-and-workforce/pressures/pressures-in-general-practice

health need, and a continuing shift of activity from hospitals into community-based settings. As a result, general practice is now expected to manage larger numbers of patients, with greater levels of complexity, across a broader range of services than at any previous point in the history of the NHS.

38. Nationally, general practice remains the front door to the NHS and accounts for the overwhelming majority of patient contacts with the health service. NHS England, the Health Foundation and the Nuffield Trust have all highlighted that demand for general practice has increased substantially over the last decade, driven in part by England's ageing population and increasing prevalence of long-term conditions. Research published by the Health Foundation demonstrates that people are increasingly living longer with multiple long-term conditions, creating a pattern of demand that is significantly more complex than simple episodic illness and requiring more frequent and intensive clinical intervention[8]. Similarly, the Nuffield Trust has noted that the growth in multimorbidity is placing unprecedented pressure on primary care services because patients increasingly require coordinated management across multiple conditions rather than isolated interventions[9].

39. The King's Fund has argued that increasing demand should not be understood solely through the lens of appointment volumes. Its analysis suggests that the nature of consultations has changed markedly over time, with GPs spending increasing amounts of time managing complex physical and mental health needs, coordinating care across different services, addressing social determinants of health and supporting populations with increasingly sophisticated expectations regarding access and responsiveness[10]. This is reinforced by research published in the *British Journal of General Practice*, which found that consultation complexity has risen significantly over time and that the average consultation increasingly involves multiple conditions, medications and care needs being addressed simultaneously[11].

40. The challenge has been compounded by activity flowing into primary care from other parts of the health system. Successive governments have sought to deliver more care outside hospital settings, a direction that has accelerated following publication of the Government's 10 Year Health Plan for England in July 2025. The Plan explicitly sets out a strategic shift “from hospital to community” and places general practice at the centre of a future neighbourhood health service, envisaging far more care being delivered locally through multidisciplinary teams and primary care networks rather than acute hospitals[12]. This reflects conclusions previously reached by NHS England's Fuller Stocktake, which argued that the future sustainability of the NHS depends upon significantly enhancing the role of primary

[8] https://www.health.org.uk/publications/reports/understanding-demand-for-general-practice
[9] https://www.nuffieldtrust.org.uk/topic/general-practice
[10] https://www.kingsfund.org.uk/publications/understanding-gp-pressures
[11] https://bjgp.org/content/69/680/e720
[12] 10 Year Health Plan for England

care and integrated neighbourhood teams in managing both urgent and long-term care needs[13].

41. Whilst these reforms offer significant opportunities, they also imply a substantial increase in the volume and complexity of activity expected from general practice. The Health Foundation has observed that healthcare demand is increasingly shaped not only by demographic trends but by changing patterns of disease, including rising rates of obesity, diabetes, cardiovascular disease and mental ill-health[14]. Academic studies have similarly demonstrated that mental health presentations to primary care have increased significantly over recent years, with many GPs now reporting that mental health care forms a substantial proportion of daily workload. Research published in the *Lancet Psychiatry* identified general practice as playing an increasingly central role in meeting unmet mental health demand, particularly in areas where specialist services face capacity constraints[15].

42. Against this national backdrop, the evidence reviewed by the JHOSC's primary care working group suggests that Oxfordshire is experiencing many of these challenges in an acute form. Data supplied by the Integrated Care Board (Annex A) demonstrates significant growth in registered patient populations across most Oxfordshire practices between January 2023 and December 2025. Importantly, this growth is not evenly distributed, creating particular inequalities of access in areas worst affected. Practices serving areas of substantial housing development and population expansion have experienced considerably greater growth pressures than others. In Oxfordshire, this has mainly been focused in rural parts of the County, which is also where there is a growing aging population compared with the city which has not experienced this housing and population growth (this being the case particularly in the Vale of White Horse and South Oxfordshire areas). This finding is consistent with concerns raised repeatedly during the Working Group's discussions regarding communities such as Didcot, Bicester and other growth locations across the county. The Working Group heard evidence suggesting that population growth has frequently outpaced corresponding investment in primary care infrastructure, creating significant challenges for practices attempting to absorb new demand within existing capacity constraints.

43. GP appointment trend data supplied to the Committee by the ICB (Annex B) provides further evidence of the sustained nature of demand pressures. Rather than displaying temporary spikes or purely seasonal pressures, the data in Annex A indicates consistently high levels of appointment activity across successive months. This suggests that the challenge facing Oxfordshire is not one of occasional demand surges but of sustained system pressure operating throughout the year. National analyses by NHS England have similarly shown that general practice is now delivering record numbers of appointments, but that increased activity has frequently failed to translate into corresponding improvements in

[13] NHS England – Fuller Stocktake
[14] https://www.health.org.uk/publications/long-reads/health-in-2040
[15] https://www.thelancet.com/journals/lanpsy/home

patient-perceived access, indicating that growing demand often absorbs gains in capacity[16].

44. The Working Group also noted that increasing demand is being experienced alongside changing patient expectations. The expansion of digital services, same-day access models, online consultation systems and improved communication technologies has brought considerable benefits for many patients. However, research commissioned by Healthwatch England and analysed by the King's Fund demonstrates that public expectations regarding convenience, speed of access and responsiveness have risen significantly as a consequence, creating additional challenges for practices already operating under pressure[17]. National GP Patient Survey data consistently shows that patient satisfaction is closely linked not merely to whether appointments are available, but whether patients feel they can access the right professional, at the right time, through the right route.

45. A further dimension of demand recognised nationally is the interaction between deprivation, rurality and healthcare utilisation. Research published by the Health Foundation shows that populations living in more deprived areas often experience higher levels of need whilst receiving proportionately less healthcare resource—a phenomenon often referred to as the "inverse care law"[18]. Oxfordshire presents an interesting challenge in this regard, combining affluent areas with pockets of significant deprivation, alongside extensive rural communities who are also experiencing inequalities of access if they happen to be in the areas with high housing and population growth. The working group's review of patient experience evidence suggests that the impact of rising demand is therefore unlikely to be felt uniformly across the county, with some communities facing greater barriers to access than others.

46. Taken together, the national and local evidence presents a compelling picture. Growth in demand for primary care is being driven by multiple interconnected factors: housing and population growth, ageing demographics, increasing multimorbidity, rising mental health needs, greater public expectations, service shifts from hospitals into communities, and broader societal change. The significance of the challenge lies not simply in the number of additional appointments required, but in the increasing complexity of the work that those appointments represent. The working group therefore concluded that rising demand should be understood as a systemic issue affecting workforce planning, estates capacity, neighbourhood service design, continuity of care, digital access arrangements and long-term sustainability. Crucially, the evidence suggests that no single intervention will be sufficient to address these pressures; rather, a coordinated and integrated response will be required if general practice is to continue meeting the needs of Oxfordshire's growing and changing population.

---

[16] NHS England – GP Appointments Data

[17] https://www.healthwatch.co.uk/news/2026-03-11/our-position-gp-access; https://www.kingsfund.org.uk/publications/public-satisfaction-nhs

[18] https://www.health.org.uk/publications/long-reads/reducing-health-inequalities

The National GP Contract: Policy Framework, Recent Reforms and Implications for General Practice:

47. Any assessment of the current challenges facing general practice must recognise the central role played by the national General Medical Services (GMS) contract and wider GP contractual framework. Whilst public debate often focuses on appointment availability, workforce numbers or patient satisfaction, the reality is that many aspects of how general practice operates are shaped by national contractual arrangements negotiated between NHS England, the Department of Health and Social Care and the British Medical Association's General Practitioners Committee. The GP contract determines not only how practices are funded, but also influences workforce models, service priorities, access arrangements, digital requirements, quality improvement activity and the wider role expected of general practice within the NHS[19].

48. Over the past two decades, GP contracts have evolved from relatively straightforward arrangements focused on core medical services towards increasingly complex frameworks that seek to use contractual incentives and funding mechanisms to drive wider healthcare transformation. The modern GP contract now encompasses core practice funding, the Quality and Outcomes Framework (QOF), enhanced services, Primary Care Network (PCN) requirements, workforce reimbursement arrangements, digital obligations and access expectations. As a result, changes in the national contract can have significant implications for how practices organise services and how patients experience access to care[20].

49. Recent years have seen substantial changes to the contractual framework for general practice. NHS England's 2025/26 and 2026/27 contract reforms represented some of the most significant contractual changes since the introduction of Primary Care Networks. The 2025/26 contract included approximately £969 million of additional investment, comprising increased core contract funding and support for advice and guidance activity between primary and secondary care. Contract reforms also expanded the Additional Roles Reimbursement Scheme (ARRS), enabling Primary Care Networks to employ a broader range of professionals, including GPs and practice nurses alongside pharmacists, physiotherapists, social prescribers and care coordinators. These reforms were intended to improve workforce capacity, support modern multidisciplinary models of care and improve patient access[21].

50. The contracts also strengthened expectations around digital access, online consultation systems and modern access models. These developments reflect the continued national emphasis on the "Modern General Practice" approach, whereby practices are expected to improve responsiveness through a combination of care navigation, structured patient contact routes, digital systems and more effective use of multidisciplinary teams.

---

19 [england.nhs.uk], [bma.org.uk]
20 [england.nhs.uk]
21 NHS England GP Contract Documentation 2025/26 / BMA Analysis of GP Contract Changes 2025/26

51. The significance of recent contractual reforms extends beyond access alone. They form part of a wider transformation agenda reflected in the Government's 10 Year Health Plan for England, which seeks to shift care from hospitals into communities and create a "Neighbourhood Health Service" delivered through integrated multidisciplinary teams. The GP contract is increasingly being used as a mechanism to support this transition by encouraging collaboration through Primary Care Networks, supporting integrated workforce models and incentivising closer working between primary care, community services and other local partners.

52. This direction of travel has its roots in NHS England's Fuller Stocktake, which argued that future primary care should be organised around neighbourhood populations and integrated multidisciplinary teams rather than stand-alone practices operating independently[22]. Increasingly, contractual arrangements are being designed to support these objectives through network-level delivery, collaborative workforce models and shared service provision[23].

53. The working group recognises that recent contractual reforms have delivered tangible benefits. Additional investment in Primary Care Networks has enabled many practices nationally to recruit members of the wider multidisciplinary team who would previously have been unaffordable. This has allowed pharmacists to undertake medication reviews, physiotherapists to manage musculoskeletal presentations, social prescribing teams to support wider wellbeing needs, and care coordinators to assist patients with complex conditions.

54. National evaluations conducted by NHS England suggest that these roles have contributed to expanding clinical capacity and reducing pressure on GPs by ensuring that patients are directed to the most appropriate professional. NHS England has consistently linked such workforce diversification to improved productivity and better utilisation of clinical skills[24]. Oxfordshire has benefited from many of these developments. Workforce data reviewed by the Working Group demonstrates growth in the wider primary care workforce, reflecting the broader national trend towards multidisciplinary delivery models. Annex D shows that many practices now rely on a much broader range of staff than would have been typical a decade ago, enabling practices to meet rising demand despite ongoing recruitment pressures affecting GPs themselves.

55. However, despite these positive developments, significant concerns have emerged regarding the impact of the contractual framework on the sustainability of general practice. One of the most persistent criticisms raised nationally by organisations such as the British Medical Association and the Royal College of General Practitioners is that contractual reforms have often increased activity expectations faster than core capacity. Whilst workforce diversification has expanded the number of staff working within primary care, the underlying demand facing practices has continued to grow. The BMA has repeatedly argued that although recent

[22] Fuller Stocktake Report
[23] [england.nhs.uk], [navigator....lth.org.uk]
[24] NHS England Network Contract DES

contracts have increased funding, they have not fully compensated for rising workload, inflationary pressures and increasing complexity of care[25].

56. Evidence considered by the Working Group suggests that these concerns are reflected locally. The GP appointment data and monthly trend data within Annexes A and B (of this report) demonstrate sustained growth in patient activity and registered list sizes, whilst workforce data suggests continuing pressures on GP availability and workload. The Working Group repeatedly heard during its sessions with the BOB Local Medical Committee and the Integrated Care Board that activity growth has often outpaced increases in capacity, leading to concerns about clinician wellbeing, sustainability and continuity of care.

57. Furthermore, whilst the contract has successfully facilitated recruitment into wider multidisciplinary teams, concerns remain that continuity of care and experienced clinical leadership can be diluted if workforce planning focuses primarily on overall workforce numbers. Research cited by the King's Fund and published within the *British Journal of General Practice* suggests that continuity of care is strongly associated with improved outcomes, reduced hospital admissions and higher patient satisfaction[26]. These findings are particularly relevant given concerns raised through Oxfordshire's GP Patient Survey data and patient experience evidence regarding continuity and access to preferred clinicians (found in Annex C of this report).

58. Another increasingly important issue is the relationship between contract design and workload. Whilst the GP contract seeks to improve access, national studies suggest that general practice continues to experience substantial administrative burden arising from reporting requirements, quality frameworks, interface issues and system-generated activity. The Royal College of General Practitioners' report *Uncovering the Drivers and Costs of Unnecessary GP Workload* concluded that a substantial proportion of GP activity originates from avoidable administrative tasks and workload transferred from elsewhere in the NHS. The report estimated that such activity consumes significant clinical time that could otherwise be available for patient care[27]. This challenge prompted the introduction of NHS England's Red Tape Challenge, which seeks to reduce bureaucracy and unnecessary workload within primary care[28]. The existence of these initiatives demonstrates a growing national recognition that improving access cannot simply be achieved through contractual requirements for more appointments or new access routes. It also requires active efforts to reduce avoidable demands on clinician time. The Working Group heard similar concerns throughout its evidence-gathering sessions.

59. For Oxfordshire, the significance of the GP contract extends well beyond funding arrangements. The contractual framework increasingly shapes how practices

[25] https://www.bma.org.uk/advice-and-support/nhs-delivery-and-workforce/pressures/pressures-in-general-practice
[26] https://www.kingsfund.org.uk/publications and https://bjgp.org/content/72/715/84
[27] https://www.rcgp.org.uk/getmedia/26330bb5-eecc-4e25-84b3-bbc0f5614dd7/Uncovering-the-GP-workload-burden-A-study-of-the-drivers-and-costs-of-unnecessary-and-hidden-workload-%E2%80%93-December-2025.pdf.
[28] https://www.gov.uk/government/news/gp-reforms-to-cut-red-tape-and-bring-back-family-doctor

organise access, recruit staff, utilise digital technologies, work within Primary Care Networks and interact with wider neighbourhood-based services.

60. The Working Group's review suggests that many national contractual reforms are directionally positive and consistent with broader policy objectives around integration, prevention and multidisciplinary care. However, it also highlights that contractual reform alone cannot resolve underlying pressures relating to workforce sustainability, estates capacity, housing growth, continuity of care and workload intensity.

61. Consequently, whilst the national GP contract provides important opportunities and resources to support the transformation of primary care, its success in Oxfordshire will depend heavily on local implementation and the extent to which workforce planning, estates development, digital transformation and neighbourhood service reform are pursued in a coordinated and integrated manner. The evidence considered by the working group suggests that the future sustainability of general practice will depend not only on the contents of the national contract itself, but on how effectively local systems are able to translate those contractual reforms into meaningful improvements for both patients and clinicians.

Primary Care Estates, Housing Growth and Infrastructure Planning: A Critical Determinant of Access to General Practice:

62. Whilst discussions regarding access to general practice frequently focus on workforce numbers, appointment availability and digital access routes, there is increasing recognition nationally that the physical primary care estate is one of the most significant determinants of whether patients can access timely and sustainable GP services. Put simply, workforce expansion, neighbourhood models of care and increased appointment capacity cannot be delivered if practices lack sufficient space, infrastructure and facilities to accommodate them. Over recent years, healthcare policy has increasingly shifted towards recognising estates not as a peripheral issue but as a core strategic enabler of service delivery, workforce sustainability and healthcare transformation. This change in thinking is particularly relevant to Oxfordshire, where significant housing growth and population expansion have coincided with longstanding concerns regarding primary care infrastructure capacity.

63. The evidence considered by the Working Group demonstrates that many of the challenges facing Oxfordshire mirror wider national concerns. Across England, healthcare leaders are increasingly questioning whether existing primary care infrastructure is capable of supporting the future NHS envisioned through the Government's 10 Year Health Plan, the Neighbourhood Health Service model, and the continued transfer of care from hospitals into community settings. These questions are particularly pressing in areas experiencing substantial housing growth where population increases frequently outpace healthcare infrastructure delivery.

64. The NHS estate is increasingly recognised as one of the most significant barriers to healthcare transformation. Historically, policy discussions have focused primarily on workforce recruitment and funding, but a growing body of national evidence

demonstrates that infrastructure constraints can significantly limit the effectiveness of investment in services and staff. The Institute for Government's report *Delivering a General Practice Estate Fit for Purpose* argues that many GP premises across England are ageing, undersized and increasingly unable to support modern service delivery. The report highlights that significant proportions of the primary care estate were designed for a model of care that relied on small teams of GPs and nurses rather than the multidisciplinary teams now promoted by national policy. The report concludes that estate limitations increasingly constrain workforce growth, integrated working and service expansion[29].

65. Similarly, NHS Property Services has noted that more than twenty major national reviews published since 2017 have raised concerns regarding the suitability of NHS premises. Its report *Making Neighbourhood Health Centres a Reality* argues that many existing facilities are unable to accommodate emerging neighbourhood-based models of care and highlights the significant backlog of maintenance and infrastructure investment required nationally[30].

66. These concerns have become sufficiently significant that the House of Commons Health and Social Care Committee launched a dedicated inquiry in 2026 examining the role of estate infrastructure in delivering the Government's proposed Neighbourhood Health Service. The inquiry specifically identified ageing infrastructure, estate capacity, capital investment and the relationship between healthcare infrastructure and population growth as key challenges facing the NHS[31].

67. One of the most important developments in recent national policy is the growing recognition that estate capacity and workforce capacity are fundamentally interconnected. National GP contracts and workforce programmes have increasingly invested in multidisciplinary working through Primary Care Networks, supporting the recruitment of pharmacists, physiotherapists, social prescribing link workers, mental health practitioners, care coordinators and other healthcare professionals. However, multiple organisations have highlighted that workforce expansion is often constrained by a lack of physical space within practices.

68. The Fuller Stocktake specifically identified premises as one of the major barriers to implementing integrated neighbourhood teams and argued that workforce expansion would be difficult to achieve without parallel investment in infrastructure. The report emphasised that multidisciplinary teams require consulting rooms, meeting space, diagnostic facilities and integrated working environments that many existing GP premises struggle to provide[32]. This issue has been repeatedly raised within Oxfordshire. Evidence received by the Working Group suggests that in most locations practices are already operating at or near capacity, limiting opportunities to recruit additional staff even where workforce funding is available. Members heard that estate constraints may frequently be the factor preventing practices from

[29] https://www.instituteforgovernment.org.uk/sites/default/files/2024-06/Delivering-general-practice-estate-fit-for-purpose.pdf.
[30] NHS Property Services – Making Neighbourhood Health Centres a Reality.
[31] Health and Social Care Committee Inquiry on Neighbourhood Health Service Estates.
[32] NHS England – Fuller Stocktake

expanding services, rather than a lack of willingness or workforce funding opportunities.

Emergence of Neighbourhood Health and the Need for Modern Infrastructure:

69. The publication of the Government's 10 Year Health Plan for England in July 2025 marks a significant shift in expectations regarding the role of primary care infrastructure. The Plan proposes a fundamental shift "from hospital to community" and places primary care at the heart of a new Neighbourhood Health Service[33]. To support this ambition, NHS England has subsequently published both a *Neighbourhood Health Framework* and detailed *Neighbourhood Health Centre Guidance*. These documents recognise that delivering integrated neighbourhood-based healthcare requires a very different type of estate compared to traditional GP premises. Future facilities are expected to accommodate wider multidisciplinary teams, community services, mental health provision, social prescribing, prevention services and partnership working with local authorities and voluntary organisations[34].

70. The guidance explicitly describes primary care infrastructure as an essential enabler of neighbourhood working and highlights the need for estate planning to be integrated with population growth forecasts, workforce strategies and local development plans. This is highly relevant to Oxfordshire, where future implementation of neighbourhood models will inevitably depend upon the availability of suitable infrastructure across both urban and rural communities.

71. Alongside estate condition and capacity, housing growth has emerged as one of the most important challenges affecting primary care nationally. Across England, significant concerns have been raised regarding the ability of healthcare infrastructure to keep pace with large-scale residential development. Whilst planning policy mechanisms such as Section 106 Agreements and Community Infrastructure Levy (CIL) contributions are intended to support infrastructure provision, numerous national reviews have identified challenges regarding funding, viability, timing and coordination between local authorities, NHS organisations and developers.

72. The Town and Country Planning Association, the Local Government Association and the NHS Confederation have all argued that health infrastructure needs to be integrated much earlier within strategic planning processes if communities are to receive adequate healthcare provision from the outset[35]. The challenge is particularly significant in Oxfordshire. The county is expected to accommodate more housing growth over coming decades, with major development sites continuing to emerge across several districts. Evidence reviewed by the Working Group identified concerns that in some locations healthcare infrastructure has historically lagged behind population growth, creating situations where additional demand is absorbed by existing practices for extended periods before expansion projects can be delivered.

---

[33] 10 Year Health Plan for England

[34] Neighbourhood Health Framework and Neighbourhood Health Centres Guidance

[35] https://www.nhsconfed.org/publications and https://www.local.gov.uk/topics/planning-housing-and-infrastructure/planning

73. The Working Group's examination of major Oxfordshire schemes, including Great Western Park and Bicester Health Centre, reflects concerns seen in many parts of the country. Nationally, numerous examples demonstrate how delays in healthcare infrastructure delivery can have long-term consequences for access. Studies conducted by NHS Property Services and the King's Fund have shown that where health facilities are planned retrospectively—after population growth has already occurred—access pressures become more difficult and expensive to remedy[36]. Conversely, areas that have successfully integrated healthcare planning into strategic housing and place-making processes have generally been better placed to accommodate growth. Several Integrated Care Systems are increasingly using population health modelling and integrated infrastructure planning to identify healthcare requirements far earlier within the planning cycle. The Government's Neighbourhood Health agenda explicitly encourages this approach, recognising that effective healthcare infrastructure planning must be aligned with broader place-based development strategies[37].

74. The evidence reviewed by the Working Group suggests that primary care estates should no longer be viewed simply as a property issue. Rather, they should be understood as a fundamental determinant of access, workforce sustainability, service integration and neighbourhood healthcare delivery. National policy is increasingly clear that the future NHS will depend upon the ability to deliver more care closer to home, through integrated neighbourhood teams operating from modern, flexible and appropriately sized facilities. Oxfordshire's significant housing growth, combined with the ambition to improve access and expand neighbourhood-based models of care, means that proactive infrastructure planning will be essential.

75. The Working Group therefore concluded that effective primary care estate planning must be regarded as a core strategic function rather than a reactive response to emerging demand. Early engagement between the Integrated Care Board, district planning authorities, developers and local communities will be essential if healthcare infrastructure is to keep pace with future growth. Failure to do so risks undermining many of the wider ambitions contained within national policy and could constrain the ability of general practice in Oxfordshire to meet the needs of its growing population in the years ahead.

Case study 1- Great Western Park, Didcot: Relationship Between Housing Growth, Primary Care Capacity and Estate Delivery

The Scale of Growth and Why Great Western Park Matters:

76. The Working Group selected Great Western Park as a dedicated case study for this deep-dive because it encapsulates many of the challenges that have emerged repeatedly throughout the inquiry. It demonstrates the practical consequences of sustained population growth, highlights the importance of primary care estate as a determinant of access, and illustrates the difficulties that can arise when healthcare

[36] https://www.kingsfund.org.uk/publications/nhs-capital and NHS Property Services
[37] House of Commons Library – 10 Year Health Plan Analysis

infrastructure is not delivered within the same timeframe as major residential development.

77. Great Western Park represents one of the largest housing developments in Oxfordshire. The development is expected to comprise approximately 3,300 homes and has formed a major component of Didcot's expansion over the last fifteen years. The development was originally conceived as a major urban extension that would include a range of supporting infrastructure, including education, transport, community facilities and healthcare provision. Evidence reviewed by the working group indicates that the principle of delivering primary healthcare infrastructure alongside housing growth has been accepted by planners, developers, the NHS and elected representatives for many years. Land for a GP facility was secured through planning obligations associated with the development and the need for healthcare infrastructure has never been disputed[38].

78. However, despite widespread agreement regarding need, the delivery of the health facility has significantly lagged behind occupation of the development itself. Residents have moved into thousands of new homes whilst the new health facility remains undelivered. As a result, existing GP services have been required to absorb increasing demand generated by the expanding population (see Annex A of this report which shows increases in patient list sizes). The Working Group concluded that Great Western Park therefore provides a valuable opportunity to examine the implications of allowing substantial population growth to proceed ahead of healthcare infrastructure delivery.

79. Importantly, Great Western Park does not exist in isolation. Members noted that Didcot continues to experience broader strategic growth pressures through developments such as Valley Park and other allocated sites. Consequently, the challenge faced by local primary care services is not simply accommodating one housing development but responding to cumulative population growth across the wider Didcot area.

Growing Demand and Pressure on Existing Services:

80. A recurring message throughout the Working Group's inquiry was that access pressures in primary care are often described as workforce issues when in reality they arise from a combination of population growth, infrastructure constraints and increasing demand. The evidence considered by the working group indicates that this dynamic is clearly visible within Didcot. Data provided by the Integrated Care Board demonstrates sustained levels of appointment activity across local practices and significant patient list sizes within the locality. The Didcot Health Centre Practice alone had a registered population approaching 20,000 patients by 2025 and was delivering thousands of appointments each month (see Annex A data pack on GP appointment data).

81. The Working Group was keen to emphasise that population growth does not simply translate into additional appointments. Growth generates demand across the entire

[38] [bucksoxonb...icb.nhs.uk], [whitehorsedc.gov.uk], [thisisoxfo...hire.co.uk]

primary care system. New residents require registration, preventative care, childhood immunisations, maternity services, long-term condition management, mental health support and wider health interventions. Over time, these demands become cumulative. Evidence previously presented to JHOSC by the Integrated Care Board acknowledged that existing primary care estate within Didcot had already absorbed significant growth through previous expansions and internal reconfiguration projects. This included the extension of Woodlands Medical Centre and conversion of existing space into additional consulting accommodation. However, the ICB also advised that these measures alone were insufficient to address longer-term population growth, hence the strategic importance attached to the Great Western Park project.

82. The Working Group considered this particularly significant because it challenges a common assumption that access problems can be resolved purely through improving appointment systems or increasing workforce numbers. The evidence suggests that there comes a point where physical estate capacity itself becomes the limiting factor. Once consultation rooms, treatment spaces and associated infrastructure are fully utilised, opportunities for further expansion become increasingly constrained.

Understanding the Delays: Why a Recognised Need Has Proven Difficult to Deliver:

83. One of the most important aspects of the Great Western Park case study concerned understanding why delivery has proven so difficult despite broad agreement that the facility is required. The working group heard evidence that the project has been affected by a combination of legal, financial, planning and organisational complexities rather than a single identifiable cause. The project requires coordination between multiple bodies including the Integrated Care Board, NHS England, Vale of White Horse District Council, healthcare property developers, GP providers, district valuers and legal advisers. This inherently creates a more complex delivery environment than many other forms of infrastructure[39]. Significant progress was made in 2023 when the ICB approved a business case for the project, citing the strategic need arising from population growth within Didcot. The project was subsequently advanced towards planning and delivery stages, and planning permission was secured during 2025. However, by late 2025 the ICB announced that the proposed funding model submitted by the original developer was no longer considered affordable under NHS reimbursement arrangements and did not comply with the requirements of the Premises Costs Directions. As a result, the ICB concluded it could not proceed with the proposal and began seeking alternative development partners[40].

84. The Working Group attached considerable importance to this issue because it highlights a structural challenge affecting primary care estate delivery nationally. Members noted that healthcare facilities are frequently dependent upon complex reimbursement arrangements and private development models. Consequently, even where land is available, planning consent is secured and strategic need is established, projects may still face significant barriers if the financial model underpinning delivery becomes unviable. This was reinforced by evidence

[39] [bucksoxonb...icb.nhs.uk]
[40] [bucksoxonb...icb.nhs.uk], [thisisoxfo...hire.co.uk], [whitehorsedc.gov.uk]

considered elsewhere in the inquiry indicating that many primary care estate projects struggle to satisfy traditional value-for-money assessments despite there being a clear service need.

What Great Western Park Reveals About the Wider Primary Care Estate System:

85. The Working Group concluded that Great Western Park is illustrative of broader issues affecting primary care estates nationally. A key lesson concerns the relationship between housing growth and infrastructure delivery. Whilst healthcare provision is increasingly recognised as essential infrastructure, current funding and delivery arrangements can often mean that primary care facilities are delivered later than schools, roads or residential units. In practical terms, this means that population growth frequently occurs before corresponding healthcare capacity is available. The consequences are significant. Existing practices absorb demand over extended periods, access pressures increase, appointment availability becomes constrained and workforce pressures intensify. By the time new facilities are delivered, services may already have been operating under strain for many years.

86. The Great Western Park experience raises important questions regarding whether current systems are sufficiently proactive. A consistent theme emerging from evidence sessions with the ICB and district planning officers was that many interventions remain reactive. Infrastructure is often expanded once growth has occurred rather than being delivered in anticipation of it. The Working Group believes that this case study therefore supports a broader argument that primary care infrastructure should be treated more explicitly as a prerequisite for sustainable growth rather than a consequence of growth.

Key Conclusions Drawn by the Working Group:

87. The Working Group's analysis of Great Western Park ultimately informed several of its wider findings and recommendations. Firstly, the project demonstrates that primary care estates are not simply property matters; they are a fundamental determinant of access. Estate constraints directly influence workforce capacity, appointment availability and service resilience. Secondly, the project illustrates that housing growth and healthcare infrastructure remain insufficiently aligned under current arrangements. Whilst planning obligations can secure land and contributions, delivery remains vulnerable to wider financial and system challenges. Thirdly, the Working Group concluded that population growth should be regarded as one of the most significant future drivers of demand within Oxfordshire primary care services. Finally, the case study reinforces the need for earlier and more structured engagement between healthcare commissioners, planning authorities, developers and central government. Many of the challenges encountered at Great Western Park could have been mitigated through stronger strategic alignment between housing delivery, infrastructure planning and healthcare funding arrangements.

88. For these reasons, Great Western Park has become one of the central examples underpinning some of the working group's recommendations found below in this report. It illustrates not only the challenges currently facing Oxfordshire but also the

policy changes that may be required if future growth is to be supported by healthcare infrastructure delivered at the right scale and at the right time.

Case Study 2- Bicester Health Centre: Primary Care Capacity, Population Growth and Estate Modernisation

89. The experience of Bicester Health Centre provides a particularly important case study for understanding the challenges facing primary care infrastructure across Oxfordshire and nationally. Whilst debates about GP access often focus on workforce shortages, appointment availability, or digital transformation, the Bicester example demonstrates that the physical estate within which healthcare is delivered remains a critical determinant of access, capacity, workforce sustainability and service quality.

90. The case illustrates a wider national issue identified repeatedly by NHS England, Integrated Care Boards and parliamentary committees: many GP practices are operating from buildings that were designed for smaller populations and older models of care. Modern primary care requires space for multidisciplinary teams, digital infrastructure, community services, preventative programmes and integrated neighbourhood working. However, across Buckinghamshire, Oxfordshire and Berkshire West, the NHS has acknowledged that many practices have outgrown their premises and have limited ability to expand. The proposed expansion of Bicester Health Centre therefore represents more than a local estates project; it is an example of how health systems are attempting to respond to rapidly increasing population demand whilst simultaneously delivering the ambitions of modern neighbourhood healthcare.

91. For the Working Group, the Bicester case provides a useful lens through which to explore several interconnected themes:

- Population growth and healthcare demand.
- The relationship between housing development and health infrastructure.
- The importance of primary care estate capacity.
- Barriers to delivering estate expansion.
- The role of planning and infrastructure funding.
- Future opportunities for neighbourhood health and integrated care.

92. The case also demonstrates why scrutiny of primary care estates is increasingly important if local authorities are to fulfil their responsibilities for promoting health and wellbeing and ensuring that healthcare infrastructure keeps pace with community growth.

<u>Population Growth, Demand Growth and the Strategic Importance of Bicester:</u>

93. Bicester represents one of the clearest examples in Oxfordshire of the challenge facing NHS primary care infrastructure in areas of sustained housing growth. Over the past decade, the town has experienced substantial expansion through a series of major housing developments, including Kingsmere, Graven Hill and other strategic allocations identified within local planning frameworks. Whilst these developments have contributed significantly to housing supply and economic

growth, they have also generated corresponding increases in demand for healthcare services. Evidence reviewed by the Working Group demonstrated that Bicester Health Centre's registered patient list increased from approximately 16,216 patients to 20,173 patients between January 2023 and December 2025. This represents growth of approximately 24.4% over a relatively short period, making it one of the most rapidly expanding practices considered during the working group's inquiry. At the same time, the practice was delivering in excess of 8,000 appointments per month, demonstrating the scale of demand being managed by primary care teams.

94. The significance of these figures extends beyond simple population growth. An increase of nearly a quarter in the registered patient population has implications for every aspect of practice operations. Additional patients require more GP appointments, more nursing capacity, more prescription processing, expanded chronic disease management programmes, greater administration support and increased demand for preventative services. Such growth also creates pressures on continuity of care, with larger patient populations placing additional pressures upon clinicians seeking to maintain long-term relationships with patients and families.

95. The Working Group considered that Bicester therefore provides a practical demonstration of a challenge that is occurring nationally: healthcare demand can increase significantly within a relatively short timeframe, whilst the infrastructure needed to accommodate that growth often develops at a much slower pace. The result is that primary care providers can become victims of their communities' success, serving rapidly expanding populations from premises originally designed for much smaller catchment areas.

The Bicester Health Centre Expansion Project:

96. A key reason why the working group selected Bicester as a case study was because it demonstrates both the challenges and opportunities associated with estate expansion. Unlike Great Western Park, which involves the development of new primary care infrastructure, the Bicester project centres upon the expansion and repurposing of existing NHS estate. Evidence provided to the working group identified plans to expand Bicester Health Centre into accommodation vacated by Oxford Health NHS Foundation Trust, thereby increasing the number of consulting and clinical rooms available within the facility. At first glance, utilising vacated NHS accommodation may appear to be a relatively straightforward solution. However, the Working Group concluded that the project illustrates the complexity of delivering what might otherwise seem to be modest estate improvements.

97. The fundamental objective of the project is not simply to increase floor space. Rather, it is to create additional clinical capacity within one of Oxfordshire's fastest-growing communities. Additional consulting rooms create the opportunity to accommodate more clinicians, expand appointment availability and support wider multidisciplinary teams. They also help create the infrastructure necessary for future service transformation and neighbourhood-based delivery models.

98. The modern primary care increasingly relies upon multidisciplinary approaches involving GPs, practice nurses, pharmacists, social prescribers, mental health practitioners, care coordinators and other professionals. Expanding workforce capacity therefore requires physical accommodation for those staff. Without additional rooms, practices may find themselves unable to maximise the benefits of national workforce initiatives because there is nowhere for additional professionals to work. The Bicester project therefore demonstrates that estate capacity is often a precondition for workforce expansion rather than a consequence of it.

What the Bicester Case Reveals About the Relationship Between Estates and Access:

99. Throughout the inquiry, the working group repeatedly heard that physical estate constraints can directly affect patient access to services. The public debate surrounding GP access often focuses upon appointment availability, waiting times and workforce shortages. However, evidence gathered throughout the inquiry suggested that estate limitations frequently sit behind many of these access challenges. If a practice lacks consulting space, it becomes more difficult to recruit additional clinicians. If additional clinicians cannot be accommodated, the ability to increase appointment numbers is restricted. If appointment supply cannot increase at the same rate as demand, patients experience greater difficulty securing appointments. The Working Group considered that Bicester illustrates this relationship particularly clearly. With a patient population growth of over 24% during the period examined, maintaining existing service levels would itself require significant increases in capacity. Improving access, continuity of care and workforce resilience requires additional capacity beyond merely keeping pace with demand growth.

100. The case therefore highlights that estate investment should not be viewed as a separate infrastructure issue. It is fundamentally an access issue. The quality, size and functionality of primary care premises directly influence how many patients can be seen, how quickly they can be seen and which services can be provided locally.

Planning, Infrastructure Funding and System Coordination:

101. A further lesson emerging from the Bicester case concerns the relationship between healthcare planning and housing growth. During evidence sessions, the working group explored concerns regarding the extent to which healthcare infrastructure planning is sufficiently integrated with local planning and development processes. Discussions highlighted wider system concerns regarding the alignment of housing growth, infrastructure provision and primary care capacity planning. Evidence submitted to the Working Group suggested that stronger engagement between health organisations and planning authorities is required if healthcare infrastructure is to keep pace with population growth.

102. The Bicester experience demonstrates that healthcare infrastructure cannot be considered after development has occurred. By the time thousands of new residents have moved into newly completed homes, the demand has already materialised. Estate projects, however, may require years of planning, business

case development, funding approvals and implementation. The Working Group concluded that this creates a structural risk whereby primary care services are continually attempting to catch up with growth rather than planning proactively for it. Therefore, Bicester demonstrates the importance of:

- Earlier engagement between Integrated Care Boards and planning authorities.
- Stronger alignment between Local Plans and healthcare infrastructure planning.
- Greater use of infrastructure planning mechanisms to identify future healthcare requirements.
- More strategic forecasting of future primary care demand arising from large housing developments.

103. The lessons are applicable not only to Bicester but to emerging growth locations across Oxfordshire and the wider Thames Valley region.

Implications for Neighbourhood Health and Future Service Models:

104. The Bicester project also has significance beyond traditional GP services. National policy increasingly focuses on neighbourhood health models that bring together primary care, community services, mental health support, preventative services and wider partners around local populations. The Working Group considered how estate projects such as Bicester Health Centre could contribute to these ambitions. Modern healthcare delivery requires facilities capable of accommodating a range of professionals and services working collaboratively. Older buildings designed solely around a traditional GP-partner model may struggle to support emerging models of care.

105. The proposed expansion at Bicester therefore offers an opportunity not merely to deliver additional appointments, but to create infrastructure capable of supporting future integrated neighbourhood working. The case highlights the importance of ensuring that estate projects are designed with future service transformation in mind rather than simply addressing immediate capacity pressures.

Working Group Conclusions and Lessons Learned:

106. The Bicester Health Centre case study generated two important conclusions for the Working Group's broader inquiry into primary care access and estates. Firstly, it demonstrated that rapid population growth can significantly increase healthcare demand within a relatively short period, creating pressures that are difficult to manage without corresponding expansion of estate capacity. The observed 24.4% increase in registered patients provides a clear example of this phenomenon. Secondly, the case reinforced the Working Group's conclusion that estate and workforce issues cannot be considered independently. Additional workforce capacity can only be fully utilised where sufficient clinical accommodation exists.

Case Study 3 - Wallingford Medical Practice: Future-Proofing Primary Care Infrastructure

107. The Wallingford Medical Practice case study provides one of the most significant examples examined by the working group. Unlike the case of Bicester Health Centre, where the focus has largely been on expanding existing NHS accommodation, Wallingford represents a much more fundamental challenge concerning the long-term suitability of primary care infrastructure and the need for entirely new premises. The Working Group conducted a site visit to Wallingford Medical Practice on 16 July 2026, and witnessed first hand some of the challenges with the existing estate. The insights outlined below in this section were partly informed by the briefing and tour of the building that the group received during the site visit.

108. The working group considered Wallingford because it illustrates a number of strategic issues facing primary care nationally and locally, including ageing infrastructure, population growth, rising healthcare demand, workforce expansion, planning processes, capital investment challenges and the development of neighbourhood-based models of care. Importantly, the Wallingford project demonstrates that some estate challenges cannot be solved through incremental modifications to existing premises and instead require comprehensive redevelopment solutions. The case therefore provides valuable lessons for the wider Oxfordshire health and care system about how primary care infrastructure must evolve to meet future demand.

From Incremental Expansion to Complete Redevelopment: The Evolution of the Wallingford Project:

109. One of the most significant findings emerging from the Wallingford case study is that the current estate challenge did not emerge suddenly. Rather, it has developed gradually over many years as population growth, service expectations and models of healthcare delivery have evolved. The existing Wallingford Medical Practice building dates from the 1980s and has already undergone three separate extensions over approximately thirty years. The fact that the building has been extended repeatedly demonstrates that attempts have been made over a prolonged period to respond to rising demand through incremental expansion. However, despite those efforts, the existing premises are no longer suitable for providing modern primary care services and further piecemeal adaptations are unlikely to provide a sustainable solution.

110. This is a particularly important lesson for the Working Group. Throughout the inquiry, members encountered examples of primary care premises where temporary or incremental solutions had been adopted over many years. Whilst such approaches can provide short-term benefits, the Wallingford experience demonstrates that there eventually comes a point at which an estate can no longer be adapted efficiently and a more fundamental solution becomes necessary. The proposed redevelopment at Winterbrook Meadows therefore represents more than a relocation exercise. It represents a strategic decision that the future healthcare needs of Wallingford cannot be accommodated within the limitations of the existing

estate and that entirely new infrastructure is required if services are to grow in line with anticipated demand.

Quantifying the Scale of the Estate Deficit:

111. The Working Group considered that one of the most compelling aspects of the Wallingford evidence is the availability of robust estate planning data which quantifies the scale of the current problem. The current surgery provides approximately 797 square metres of accommodation. NHS capacity modelling undertaken for the project suggests that the building is already approximately 46 per cent undersized for current requirements and could become approximately 59 per cent undersized by 2033 if anticipated population growth and service requirements materialise.

112. These figures are striking because they illustrate that the estate challenge facing Wallingford is not simply a question of needing one or two additional consulting rooms. Instead, the evidence suggests a significant mismatch between the size of the premises and the needs of the population being served. The proposed new facility is planned to provide approximately 1,898–1,922 square metres of accommodation, representing an increase of more than 1,100 square metres compared with the existing building and more than doubling the available clinical space.

113. The scale of the proposed increase reflects the fact that modern primary care requires significantly more space than was envisaged when many practices were originally developed. Contemporary healthcare delivery involves multidisciplinary teams, teaching facilities, digital infrastructure, collaborative working environments and integrated services that would not have been anticipated when the current Wallingford building was first designed.

114. For the Working Group, this raises an important question for the wider health system: how many other practices across Oxfordshire may currently be operating from buildings that were designed for healthcare models of the 1980s and 1990s rather than the needs of the 2030s?

Population Growth, Demographic Change and Rising Complexity of Demand:

115. Whilst the Wallingford estate challenge is substantial, the Working Group recognised that the issue cannot be understood solely through the prism of buildings. The underlying driver remains growing and increasingly complex healthcare demand.

116. Data reviewed by the working group indicated that Wallingford Medical Practice's patient list increased from approximately 18,116 patients to 19,108 patients between January 2023 and December 2025. During this period the practice was providing around 8,700 appointments per month, demonstrating both the scale of service delivery and the intensity of activity already taking place within the existing premises. However, the strategic significance of Wallingford lies less in historic growth and more in expected future growth. The wider Wallingford and Surrounds Primary Care Network serves approximately 34,128 residents and

forecasts population growth of approximately 14.9 per cent over the following five years. The area has a higher proportion of older residents than Oxfordshire overall, including significant numbers of people aged over eighty-five.

117. The implications of this are profound. Healthcare demand does not increase in a linear fashion. An additional thousand residents may generate very different levels of healthcare activity depending upon age profile, health inequalities, housing type and prevalence of long-term conditions. Older populations typically require:

- More frequent GP consultations.
- Greater medicines optimisation activity.
- Increased management of long-term conditions.
- More community nursing input.
- Stronger integration with social care.
- Greater coordination between primary and secondary care services.

Consequently, the challenge facing Wallingford is not merely accommodating population growth. It is accommodating increasingly complex healthcare demand that may grow faster than raw population figures alone would suggest.

<u>Winterbrook Meadows: Integrating Healthcare Infrastructure into Growth Planning:</u>

118. Perhaps one of the most important strategic lessons arising from the Wallingford case study concerns the relationship between healthcare planning and wider development planning. The proposed new medical centre forms part of the wider Winterbrook Meadows development and has been brought forward jointly by Wallingford Medical Practice and Berkeley Homes. The proposal includes a purpose-built healthcare facility of approximately 1,898 square metres with associated parking, landscaping and supporting infrastructure. The new facility would be located within the wider growth area and would replace the existing surgery on Reading Road.

119. The Working Group considered this particularly significant because it demonstrates the benefits of integrating healthcare infrastructure into the planning of major developments at an early stage. A recurring theme throughout the inquiry was concern that healthcare infrastructure frequently lags behind housing development. New homes may be occupied years before new healthcare capacity becomes available, leaving existing services struggling to absorb growing demand.

120. The Wallingford project potentially offers a different model. By embedding primary care infrastructure within a wider strategic development, there is greater opportunity to ensure that health facilities develop alongside population growth rather than attempting to catch up after growth has already occurred. This approach is consistent with planning policies referenced within the scheme that identify health infrastructure as a key requirement for future development within Wallingford. The Working Group considered that this provides a valuable lesson for planning authorities, developers and NHS organisations across Oxfordshire.

Enabling Workforce Expansion and Neighbourhood Health:

121. A key theme emerging throughout the working group's inquiry has been that workforce challenges and estate challenges are inseparable. The NHS has invested heavily in multidisciplinary teams through initiatives such as the Additional Roles Reimbursement Scheme. General practice now increasingly relies upon pharmacists, physician associates, care coordinators, social prescribers, mental health practitioners and advanced nurse practitioners. However, evidence gathered throughout the inquiry consistently suggested that workforce funding alone cannot increase patient access if there is insufficient physical space to accommodate additional professionals. The Wallingford project provides a particularly clear example of this issue.

122. The new facility will support wider Primary Care Network functions, workforce training and future service development in addition to core GP services. The working group concluded that the project should therefore be viewed not simply as a building project but as an access improvement project, a workforce sustainability project and an enabler of neighbourhood health. Without the new premises, future workforce growth may be constrained by the physical limitations of the existing building. With the new premises, opportunities exist to expand services, increase appointment capacity, improve resilience and support wider integrated care delivery.

Lessons for Primary Care Access and Estates Across Oxfordshire:

123. The Wallingford case study generated several broader lessons which the Working Group considered applicable across Oxfordshire and the wider Thames Valley system. Firstly, estate challenges frequently develop gradually over many years before becoming critical. Organisations should therefore monitor estate adequacy proactively rather than waiting until buildings reach capacity limits. Secondly, population growth forecasts must be integrated into long-term estate planning. Once healthcare demand has materialised, estate projects often require many years to progress through planning, approval and delivery processes. Thirdly, estate investment should not be viewed as an isolated infrastructure issue. The evidence from Wallingford demonstrates that workforce expansion, patient access, service transformation and neighbourhood health ambitions are all dependent upon having sufficient physical capacity. Fourthly, the case demonstrates the value of integrated planning between NHS organisations, local planning authorities and developers. The Winterbrook Meadows proposal provides an example of how healthcare infrastructure can be incorporated within wider strategic growth planning rather than addressed retrospectively.

124. Finally, the Working Group concluded that Wallingford demonstrates the growing importance of future-proofing primary care infrastructure. The purpose of the new facility is not merely to solve today's estate problems but to create capacity capable of supporting healthcare delivery, workforce growth and population needs over the coming decades. In that sense, Wallingford represents one of the clearest examples examined during the inquiry of how long-term investment in primary care estates can underpin improved access, workforce sustainability, integrated care and system resilience.

KEY POINTS OF OBSERVATION & RECOMMENDATIONS:

125. This section highlights five key observations and points that the Working Group has in relation to GP services in Oxfordshire. These five key points of observation have been informed by the evidence received by the group from its sessions, its site visits, as well as from written submissions/data supplied. These points of observation have been used to determine the recommendations being made by the Working Group which are outlined below:

Importance of an integrated approach to improving access to general practice (ensuring that workforce, estates, digital access and neighbourhood models are planned and delivered as a coherent whole): The evidence considered by the Working Group demonstrates that access to general practice in Oxfordshire is shaped by the combined effects of population growth, workforce capacity, estate constraints and the design of access routes, rather than by any single factor in isolation. The Working Group therefore concluded that meaningful and sustainable improvements in access can only be delivered through a single, integrated approach, in which workforce, estates, digital access and neighbourhood models are planned and delivered as a coherent whole.

Analysis of GP appointment activity and registered patient list sizes between January 2023 and December 2025 (Annex A) shows that most practices across Oxfordshire are serving a growing registered population, with significant variation in list size growth between areas. While the data demonstrates that practices are collectively delivering very high volumes of appointments, it also highlights substantial differences in demand pressure at practice level. In particular, practices serving areas of rapid housing growth have experienced disproportionate increases in registered patients without corresponding increases in clinical capacity or physical space. The working group noted that, under such conditions, additional appointments alone cannot resolve access issues where workforce availability and estate capacity are already fully stretched.

This is reinforced by the month-by-month GP appointment trend data for January to December 2025 (Annex B). The data indicates that appointment volumes fluctuate seasonally but remain consistently high throughout the year, reflecting sustained demand rather than short-term pressure. However, the working group observed that delivery of high appointment numbers has not translated into a uniform improvement in patient experience. This supports national evidence that appointment counts do not capture the full range of work undertaken in general practice, nor the intensity and complexity of consultations now required. The working group therefore concluded that reliance on appointment data as a proxy for access risks obscuring underlying capacity constraints.

Patient experience evidence, as captured in the most recent GP Patient Survey (January 2025, Annex C), provides further context. While many patients reported positive experiences once they were able to secure an appointment, results relating to ease of contact, waiting times and choice of appointment type showed considerable variation. The working group noted that these findings align with feedback gathered by Healthwatch Oxfordshire, which highlights that improvements implemented through digital and triage-based access models have not been experienced equally across all population groups. This reinforces the conclusion that changes to access routes, when implemented separately from workforce and estates planning, can unintentionally widen inequalities rather than reduce them.

Workforce data (Annex D) was central to the Working Group's analysis. Although Oxfordshire has benefited from the introduction of additional roles through multidisciplinary teams, the data shows that growth in full-time equivalent GP capacity has not kept pace with increasing demand and list sizes. Moreover, the distribution of workload within practices has changed significantly, with GPs increasingly managing higher-complexity cases alongside supervision, triage and administrative responsibilities. National research demonstrates that GPs dedicate immense time to work that sits outside direct face-to-face consultations, including tasks generated at the interface between primary and secondary care[41]. The Working Group therefore concluded that workforce planning, if considered independently of system design and workload drivers, cannot deliver sustainable access improvements.

The interaction between workforce limitations and estate constraints is particularly significant. Evidence reviewed by the working group shows that practices operating from constrained or outdated premises face limits on the number and type of clinical staff they can accommodate, restricting both appointment capacity and the development of neighbourhood-based, multidisciplinary working. National analyses show that many primary care estates were not designed to support modern service models, with limited flexibility to expand or reconfigure space[42]. In Oxfordshire, this challenge is intensified in areas of population growth where estate delivery has lagged behind housing development, resulting in persistent access pressure despite high clinical effort.

The Working Group also considered how digital access and neighbourhood models interact with these pressures. Evidence from the GP Patient Survey (Annex C) demonstrates that while digital routes may improve convenience for some patients, they are not a substitute for sufficient clinical capacity or appropriate physical infrastructure. National Healthwatch evidence consistently highlights that digital-first approaches, when introduced without adequate support and alternative routes, risk disadvantaging digitally excluded populations[43]. The working

[41] RCGP, Uncovering the GP workload burden
[42] Institute for Government
[43] Healthwatch England

group concluded that digital access must therefore be planned alongside workforce availability and estate suitability, rather than deployed as a stand-alone solution.

Experience from other parts of the country reinforces this conclusion. Integrated care systems that have aligned workforce strategy, estates investment and service redesign—such as North Central London and Hertfordshire and West Essex—demonstrate that access improvements are more sustainable when these elements are considered together[44]. Conversely, where initiatives have progressed in isolation, systems have struggled to convert activity growth into improved patient experience.

The Committee's examination of GP services in its September 2025 public meeting focused appropriately on understanding activity, performance and programmes underway. The working group's subsequent analysis, drawing on detailed appointment, population, workforce and patient experience data (Annexes A–D), shows that the primary challenge now facing Oxfordshire is not the absence of initiatives, but the absence of a coherent framework linking them. Without such integration, gains in one area—such as increased appointment delivery or expanded digital access—are repeatedly constrained by workforce, estates or system-generated workload pressures elsewhere.

For these reasons, the working group concluded that the Integrated Care Board should adopt a single, integrated approach to improving access to general practice, ensuring that workforce, estates, digital access and neighbourhood models are planned and delivered as a coherent whole rather than as separate initiatives. This approach provides the clearest route to sustainable improvements in access, more equitable patient experience, and a transparent basis for future scrutiny by the Oxfordshire Joint Health Overview and Scrutiny Committee.

Recommendation 1: *For the Integrated Care Board to adopt a single, integrated approach to improving access to general practice, ensuring that workforce, estates, digital access and neighbourhood models are planned and delivered as a coherent whole rather than as separate initiatives. It is also recommended that variation between localities and communities is supported in this process. The ICB needs to enhance its own capacity to work with local authorities and communities to expand capacity of primary care services in light of increases in demand.*

Taking active steps to reduce avoidable GP Workload: The working group concluded that active steps to reduce avoidable, system-generated workload on general practice are essential to protecting clinical capacity and improving patient access in Oxfordshire. This conclusion arises from a consistent theme across the evidence considered by the working group: that pressures on access are not primarily explained by a lack of effort or productivity within general

[44] North Central London Infrastructure Strategy

practice, but by the cumulative burden of work generated by the wider health system that falls to GPs by default.

Local appointment activity and registered patient list data (Annex A) show that general practices across Oxfordshire are delivering very high volumes of appointments against a backdrop of sustained population growth. Registered list sizes of GP practices across Oxfordshire as a whole increased by an average of 8.4% between January 2023 and December 2025. This is placing additional demand on practices without a commensurate increase in clinical or administrative capacity. Month-by-month appointment trends for 2025 (Annex B) demonstrate that activity remains consistently high throughout the year rather than being driven by short-term seasonal spikes. Despite this, patient experience data (Annex C) indicates that many patients continue to report difficulties in accessing care, particularly in contacting practices and securing timely appointments. The working group concluded that this apparent contradiction—high activity alongside persistent access problems—cannot be adequately explained by appointment supply alone.

A central explanation lies in how GP time is consumed. Workforce data (Annex D) confirms that while Oxfordshire has benefited from growth in wider primary care roles, growth in full-time equivalent GP capacity has not kept pace with demand and complexity. This mirrors national trends, where GPs are increasingly required to manage complex, multi-morbid patients, provide supervision within multidisciplinary teams, and absorb additional tasks generated elsewhere in the system. National analysis by the *British Medical Association* highlights that workload growth in general practice has significantly outstripped workforce growth over the past decade, undermining sustainability and access despite record appointment delivery[45].

Evidence submitted by the BOB Local Medical Committee (Annex E) was particularly influential in shaping this recommendation. The LMC highlighted that a substantial proportion of GP workload arises not from patient-initiated demand, but from tasks transferred—formally or informally—from secondary care, community services and wider public systems. This includes follow-up investigations, onward referrals, medication queries, care coordination and administrative work that does not require GP-level expertise but nonetheless consumes clinical time. This finding aligns closely with national research by the Royal College of General Practitioners, which estimates that “unnecessary” and hidden workload costs practices over £400 per GP per day and contributes directly to burnout, reduced retention and loss of clinical capacity[46].

The working group’s evidence sessions reinforced these findings. In sessions with NHS representatives, members repeatedly heard that poorly designed interfaces between primary and secondary care

[45] BMA – Pressures in General Practice
[46] RCGP, Uncovering the GP workload burden).

continue to generate avoidable workload for general practice. Tasks such as incomplete discharge information, inappropriate test result follow-up and unclear referral pathways were identified as routine sources of additional work. National guidance published through the NHS England Red Tape Challenge explicitly recognises these interface failures as a major driver of GP workload and calls for integrated care boards to take active steps to reduce bureaucracy rather than allowing work to default to general practice[47]. Complementary guidance from the Getting It Right First Time programme sets out clear standards for improving processes between primary, secondary, mental health and community services, with the explicit aim of relieving pressure on GPs and improving patient flow[48].

Patient experience evidence further supports the working group's conclusion. The GP Patient Survey (Annex C) and Healthwatch Oxfordshire's engagement between April 2025 and March 2026 consistently show that patients' frustration with access often reflects delays created by system processes rather than unwillingness or inefficiency within practices. Healthwatch evidence points to confusion about care pathways, repeated contacts generated by unresolved administrative issues, and increased demand for GP intervention when other services are difficult to access. National Healthwatch reporting echoes these themes, warning that failure to address access barriers across the system risks entrenching inequality and driving patients back to general practice as the "service of last resort"[49].

The Working Group also drew on learning from other parts of the country. Integrated care systems that have actively addressed system-generated workload—by standardising referral processes, clarifying responsibilities at discharge and investing in interface roles—have demonstrated improvements in GP capacity and patient flow. For example, Cheshire and Merseyside's work on implementing standardised interface principles has been cited nationally as good practice in reducing avoidable GP workload and improving system efficiency[50].

Academic literature published in the *British Journal of General Practice* also highlights that measuring access purely through appointment numbers obscures the "hidden labour" of general practice, much of which is driven by system design rather than patient need[51].

The GP services update item considered by the Committee in its September 2025 meeting rightly focused on understanding activity levels and programmes underway. However, the Working Group's subsequent scrutiny, informed by detailed data (Annexes A–D), professional evidence (Annex E) and national research, demonstrates that further improvements in access cannot be achieved simply by increasing

[47] NHS England – GP Red Tape Challenge
[48] GIRFT – Bridging the interface
[49] Healthwatch England
[50] RCGP – Red Tape Challenge response
[51] BJGP editorial

appointment counts or introducing new access routes. Without addressing avoidable, system-generated workload, any additional clinical capacity released will continue to be absorbed by inefficiencies elsewhere in the system.

Therefore, the Working Group concluded that active steps must be taken to reduce avoidable, system-generated workload on general practice, including workload arising from the wider NHS system. This is not a request for further information, but a call for systemic action by the Integrated Care Board to protect scarce clinical capacity, improve sustainability within general practice and deliver meaningful improvements in patient access across Oxfordshire.

Recommendation 2: *For active steps to be taken to reduce avoidable, system-generated workload on general practice, including workload arising from the wider NHS system, in order to protect clinical capacity and improve patient access. It is recommended that there is collaboration with local General Practice leaders (as well as patient representative bodies) to explore ways to reduce excessive administrative non-clinical work for qualified GPs; and that there is national escalation when this excessive work is owed to national constraints.*

Ensuring Sustainable Workforce Models in General Practice: The Working Group concluded that improving access to general practice in Oxfordshire cannot be achieved through a narrow focus on workforce headcount alone. Instead, the evidence considered by the working group demonstrates that long-term sustainability depends on how workload is distributed, how continuity of care is supported, and whether experienced GPs are able and willing to remain in practice. For this reason, the working group recommends that the Integrated Care Board ensures workforce models explicitly address workload intensity and retention, rather than relying primarily on increases in staffing numbers.

Local data on registered patient lists and appointment activity between January 2023 and December 2025 (Annex A) shows sustained and, in many areas, accelerating growth in demand for general practice. Registered list sizes have increased unevenly across Oxfordshire, reflecting housing growth and demographic change, with some practices absorbing significantly higher patient-to-GP ratios than others. While overall appointment volumes have risen, the working group noted that list growth increases not only the number of consultations but also the complexity of work, as larger lists inevitably contain greater numbers of older patients and people with multiple long-term conditions.

Month-by-month appointment trends for 2025 (Annex B) reinforce this picture. Appointment delivery remains consistently high throughout the year, suggesting that general practice is already operating near the limits of its available capacity. However, the working group observed that sustained appointment volume does not equate to sustainable workload. National research demonstrates that appointment counts capture only a portion of the work undertaken in general practice and do not reflect the

cognitive, administrative and coordination burden that increasingly characterises GP roles[52]. As a result, workforce models based primarily on appointment throughput risk masking intensifying pressures on individual clinicians.

Workforce data (Annex D) was central to the working group's analysis. While Oxfordshire has seen growth in wider primary care roles, including those funded through multidisciplinary team arrangements, growth in fully qualified, experienced GPs—particularly on a full-time equivalent basis—has been limited. Evidence consistently shows that GP workload intensity has risen faster than the GP workforce, contributing to reduced job satisfaction, increased part-time working, and early retirement[53]. The working group therefore concluded that workforce sustainability cannot be assured through recruitment alone, without parallel action to manage workload and support retention.

The submission from the BOB Local Medical Committee (Annex E) strongly reinforced this conclusion. The LMC highlighted that workload intensity—rather than absolute staffing numbers—is a key determinant of GP retention. Experienced GPs are increasingly choosing to reduce sessions or leave practice altogether due to cumulative workload pressures, including administrative burden and system-generated tasks that detract from direct patient care.

Evidence from the Working Group's sessions with NHS partners further demonstrated that workload intensity is closely linked to system design. Poorly defined interfaces between primary and secondary care routinely shift work to GPs, increasing complexity and time pressure without corresponding resource transfer. The NHS Red Tape Challenge similarly identifies excessive administrative burden as a driver of poor workforce sustainability and reduced continuity of care[54].

Continuity of care emerged as a critical theme linking workforce sustainability and patient experience. GP Patient Survey results from January 2025 (Annex C) show that patients place high value on seeing a preferred or familiar clinician, particularly those managing long-term or complex conditions. Healthwatch Oxfordshire's engagement work between April 2025 and March 2026 on GP services in Oxfordshire reinforces this, highlighting patient frustration when continuity is disrupted by high staff turnover, reliance on locums, or fragmented workforce models (the outcome report will be published on the Healthwatch Oxfordshire website by June 2026). Academic research, including from the King's Fund, also consistently demonstrates that continuity of care is associated with improved patient outcomes, reduced hospital admissions, and higher professional satisfaction among GPs, all of which contribute to workforce retention[55].

[52] British Journal of General Practice
[53] BMA – Pressures in General Practice).
[54] NHS England – Red Tape Challenge
[55] https://www.kingsfund.org.uk/insight-and-analysis/long-reads/continuity-care-general-practice

The Working Group noted that models which prioritise workforce flexibility without protecting continuity risk undermining both patient experience and staff retention. Evidence from other parts of the country indicates that systems investing in smaller, stable clinical teams and protecting experienced GPs' roles within them see better retention outcomes than those relying heavily on short-term staffing solutions. For example, integrated care systems that have explicitly linked retention strategies to workload reduction and continuity—such as parts of Greater Manchester and Cheshire and Merseyside—have been cited by national bodies as demonstrating more sustainable general practice models[56].

The GP services update item discussed by the Committee in September 2025 appropriately focused on understanding activity levels and workforce initiatives underway. However, the Working Group's subsequent, deeper scrutiny demonstrates that a focus on staffing numbers alone risks obscuring the factors that determine whether clinicians remain in practice. Without addressing workload intensity, continuity of care and the working conditions experienced by senior GPs, increases in workforce supply may result only in churn rather than sustainable capacity.

Hence, the Working Group concluded that the Integrated Care Board must ensure workforce models for general practice in Oxfordshire are sustainable over the long term, with explicit regard to workload intensity, continuity of care and the retention of experienced GPs. This approach recognises that experienced clinicians are a finite and valuable resource, and that protecting their capacity and wellbeing is essential to improving access, maintaining quality, and ensuring the long-term resilience of general practice across Oxfordshire.

Recommendation 3: *That the Integrated Care Board ensures that workforce models for general practice in Oxfordshire are sustainable over the long term, with explicit regard to workload intensity, continuity of care and the retention of experienced GPs, rather than focusing solely on staffing numbers.*

Prioritising the reduction of inequalities in access to GP Services: The Working Group concluded that improving access to GP services in Oxfordshire must be accompanied by a deliberate and sustained focus on reducing inequalities in access. Evidence considered by the Working Group demonstrates that improvements in headline access metrics do not translate evenly across population groups or geographies, and that without targeted action, existing disparities risk being entrenched or widened. For this reason, the working group recommends that the Integrated Care Board prioritises action to ensure that improvements in access are experienced consistently by rural communities, digitally excluded residents and populations affected by rapid growth.

[56] RCGP – Continuity and Retention

Analysis of GP appointment data and registered patient list sizes between January 2023 and December 2025 (Annex A) shows significant variation across Oxfordshire in both list size growth and demand pressure. Practices serving areas of rapid housing development have seen disproportionate increases in registered patients over a short period, often without a corresponding expansion in workforce or estate capacity. The working group noted that such areas face particular challenges in maintaining timely access, as increased list size translates directly into higher baseline demand. Month-by-month appointment trends during 2025 (Annex B) show that while practices collectively deliver high volumes of appointments throughout the year, this activity does not resolve uneven access where underlying capacity constraints and population change are not evenly distributed.

Patient experience data highlights how these pressures translate into inequality. Results from the January 2025 GP Patient Survey (Annex C) show marked variation in patients' ability to contact their practice, secure appointments and see a preferred clinician. While many respondents report good experiences once an appointment is obtained, the working group noted that ease of access remains a persistent challenge for particular groups. Healthwatch Oxfordshire's engagement work on GP services between April 2025 and March 2026 reinforces this finding, with access to GP services remaining one of the most common issues raised by residents (the outcome of this study will be published on the Healthwatch Oxfordshire website by June 2026). Healthwatch evidence points to consistent barriers faced by rural residents, people with limited digital skills, and those living in areas undergoing rapid population growth, particularly where existing services have not expanded at the same pace.

Rural inequality emerged strongly in both the data and the Working Group's sessions. Rural practices often serve geographically dispersed populations, with fewer alternative providers nearby and greater reliance on a small number of clinicians. Workforce data (Annex D) shows that such practices can be more vulnerable to staffing gaps and fluctuations, with limited ability to absorb sudden increases in demand. National research confirms that rurality is associated with lower GP-to-patient ratios and longer travel times, compounding access issues even where appointment availability appears comparable on paper[57]. The Working Group concluded that policies aimed at improving access must explicitly recognise rural context, rather than assuming uniform delivery models are appropriate across the county.

Digital exclusion was another recurring theme. While digital access routes can improve efficiency and convenience for some patients, evidence reviewed by the working group shows that these benefits are not universal. GP Patient Survey data (Annex C) indicates that a proportion of patients struggle with online access or prefer telephone or

[57] RCGP – Health inequalities).

face-to-face contact. Healthwatch Oxfordshire also reported that older residents, people with disabilities, those on low incomes and individuals with limited English proficiency are disproportionately disadvantaged by digital-first models when alternative routes are constrained. This mirrors national findings from Healthwatch England, which has repeatedly warned that digital transformation in general practice risks widening inequalities unless supported by inclusive design and sufficient analogue access[58].

Moreover, workload pressures amplify these inequalities. Evidence from the BOB Local Medical Committee (Annex E) highlights that system-generated workload reduces the capacity of practices to offer flexible, responsive access, particularly in high-pressure areas. Nationally, the Royal College of General Practitioners has demonstrated that unnecessary and hidden workload consumes significant clinical time that could otherwise be directed towards patient access, with a disproportionate impact on practices serving more complex or deprived populations[59]. The Working Group concluded that unless workload pressures are addressed, practices in high-need areas will be least able to improve access, thereby exacerbating inequality.

Evidence from the Working Group's sessions with NHS organisations reinforced the importance of system coordination. Members heard that interfaces between primary, secondary and community services often generate additional demand for GP intervention, particularly where access to other services is limited. National NHS England guidance on bridging the interface between services recognises the role of poor system design in diverting patients back to general practice, disproportionately affecting areas with fewer alternative access routes[60]. Similarly, the NHS Red Tape Challenge acknowledges that bureaucratic burdens and unclear responsibilities reduce system efficiency and have uneven impacts across communities[61].

In addition, the written submission to the Working Group from Cherwell District Councillor David Rodgers illustrated how these issues intersect in areas of rapid growth. The submission highlighted the gap between housing delivery and primary care capacity, with new residents placing additional demand on already-stretched practices before new infrastructure is delivered.

National policy literature, including from the *Institute for Government's* work on GP estates, consistently identifies this mismatch as a driver of access inequality, particularly where local planning systems and healthcare commissioning are insufficiently aligned[62]. The Working Group concluded that populations affected by rapid growth are at

[58] Healthwatch England – GP access
[59] RCGP – Unnecessary workload study
[60] GIRFT – Bridging the Interface
[61] NHS England – Red Tape Challenge
[62] Institute for Government – GP estates

particular risk of deteriorating access if inequality is not explicitly addressed.

Learning from other parts of the country reinforces the need for a targeted approach. Integrated care systems that explicitly prioritise equity—such as Greater Manchester and parts of London—have used population health data to tailor access initiatives to specific communities, combining workforce support, outreach and flexible access routes. Evaluations from these systems demonstrate that access improvements are more likely to be sustained, and inequalities reduced, when services are designed around local need rather than uniform targets[63].

Therefore, the Working Group's analysis demonstrates that aggregate improvement does not guarantee equitable improvement. Drawing on detailed data (Annexes A–D), professional evidence (Annex E) and patient experience, the Working Group concluded that reducing inequalities in access requires explicit prioritisation and sustained action by the Integrated Care Board.

For the above reasons, the Working Group recommends that the Integrated Care Board prioritises action to reduce inequalities in access to GP services across Oxfordshire, ensuring that improvements in access are experienced consistently by rural communities, digitally excluded residents and populations affected by rapid growth. This approach recognises that equitable access is not a by-product of general improvement but a core objective that must be actively pursued if the benefits of investment and reform are to be shared fairly across the county.

Recommendation 4: *That the Integrated Care Board prioritises action to reduce inequalities in access to GP services across Oxfordshire, ensuring that improvements in access are experienced consistently by rural communities, digitally excluded residents and populations affected by rapid growth. It is recommended that local patient voices and the scrutiny function have meaningful input into the design and commissioning of GP services.*

Treating primary care estates capacity as a critical determinant of access: The Working Group concluded that capacity within primary care estate is a fundamental determinant of access to GP services in Oxfordshire. Evidence reviewed by the working group demonstrates that workforce growth, appointment delivery and service transformation are all constrained by the availability, suitability and timing of primary care infrastructure. Where estate provision fails to keep pace with population growth and changing models of care, access pressures emerge that cannot be resolved through short-term operational measures. For these reasons, the working group recommends that the Integrated Care Board treats primary care estates capacity as a critical system issue and

[63] https://www.kingsfund.org.uk/insight-and-analysis/long-reads/tackling-health-inequalities

ensures that planning, delivery and expansion of infrastructure are proactively aligned with housing development and population change.

Local GP appointment and registered patient list data between January 2023 and December 2025 (Annex A) illustrates the scale of demand growth across Oxfordshire and its uneven geographical distribution. Practices serving areas of significant housing development, including in the Vale of White Horse area, have experienced rapid increases in registered list sizes over a relatively short period, often without corresponding increases in consulting space, clinical rooms or supporting facilities. While practices have continued to deliver high volumes of appointments, the Working Group noted that physical estate limitations place a limit on the number of clinicians who can be accommodated and the range of services that can be delivered. Appointment trends for 2025 (Annex B) show sustained activity across the year, reinforcing the conclusion that access challenges in growth areas are structural rather than seasonal.

The relationship between estates and workforce capacity was explored in depth through workforce data (Annex D) and evidence sessions held by the Working Group. The data shows that even where funding is available to recruit additional staff, practices operating from constrained premises are often unable to expand their workforce. National analysis confirms that inadequacies in GP premises are a significant barrier to recruitment and retention, particularly where buildings are outdated, inflexible or too small to support multidisciplinary teams[64]. The Working Group therefore concluded that estate capacity directly limits the effectiveness of workforce initiatives intended to improve access.

Evidence submitted by the BOB Local Medical Committee (Annex E) reinforced this assessment. The LMC highlighted that estate constraints contribute to workload intensity by restricting opportunities to redesign services, share workload across roles, or co-locate community services. Nationally, the Royal College of General Practitioners has also emphasised that unsuitable premises increase administrative inefficiency and contribute to unnecessary workload, reducing the time available for direct patient care[65]. The Working Group concluded that estate limitations therefore exacerbate both access problems and workforce sustainability challenges.

Patient experience evidence further underlines the importance of estates provision. GP Patient Survey results from January 2025 (Annex C) show variation in access and satisfaction that correlates with capacity pressures at practice level. Healthwatch Oxfordshire's engagement between April 2025 and March 2026 consistently highlights difficulty in securing timely appointments in fast-growing communities, alongside frustration where practices are perceived to be "over capacity". Healthwatch evidence mirrors national findings that access problems are

[64] Institute for Government – Delivering a general practice estate fit for purpose
[65] RCGP – Uncovering the drivers and costs of unnecessary GP workload

particularly acute where population growth outstrips infrastructure delivery[66]. The Working Group concluded that patients' experience of access is shaped not only by appointment systems, but by whether physical infrastructure has expanded in line with need.

The issue of delayed or misaligned estate delivery was a recurring theme in the working group's sessions with NHS partners and local authority representatives. Members heard evidence of cases where GP premises were delivered years after housing completion, leaving practices to absorb new residents without additional space or facilities. The written submission from Cherwell District Councillor David Rodgers provided a local illustration of this challenge, highlighting how gaps between housing delivery and health infrastructure place sustained pressure on existing practices and undermine public confidence in access to services. National policy analysis from the Institute for Government and elsewhere identifies this misalignment as a systemic issue arising from fragmented responsibilities between planning authorities, developers and healthcare commissioners[67].

National NHS policy increasingly recognises the need for proactive and integrated estate planning. NHS England guidance on neighbourhood health centres emphasises that primary care infrastructure must be planned as a long-term enabler of service delivery, integrated with workforce and service models, and aligned with local growth strategies[68]. Similarly, guidance produced through the Getting It Right First Time programme highlights the inefficiencies that arise where primary care infrastructure is delivered retrospectively, forcing general practice to compensate for wider system shortcomings[69].

Learning from other parts of the country reinforces the Working Group's conclusions. Integrated care systems such as North Central London and parts of Greater Manchester have demonstrated that early, structured engagement with planning authorities and developers enables primary care estates to be delivered alongside housing growth, rather than lagging behind it. These systems have shown that proactive estate planning supports workforce recruitment, service integration and more equitable access[70]. By contrast, areas where estate planning is reactive continue to report persistent access challenges despite high clinical effort.

The GP services update item considered by the Committee in September 2025 focused appropriately on service activity and improvement initiatives. However, the working group's subsequent scrutiny demonstrates that without treating estate capacity as a core determinant of access, such initiatives are constrained in their impact. Evidence from

[66] Healthwatch England – GP access
[67] Institute for Government
[68] NHS England – Neighbourhood health centre guidance
[69] GIRFT – Bridging the interface
[70] https://www.kingsfund.org.uk/insight-and-analysis/long-reads/continuity-care-general-practice

Annexes A–E, combined with patient experience and national research, indicates that once access pressures have emerged due to inadequate infrastructure, they are difficult and costly to reverse.

Therefore, the Primary Care Access and Estates Working Group recommends that the Integrated Care Board treats primary care estates capacity as a critical determinant of access to GP services, ensures early and structured engagement with local planning authorities and developers, and secures the timely delivery of adequate, fit-for-purpose primary care facilities as communities expand. This proactive approach is essential to protecting access, supporting workforce sustainability and ensuring that the benefits of growth and development in Oxfordshire are matched by timely and equitable provision of primary care services.

Recommendation 5: *That the Integrated Care Board treats primary care estates capacity as a critical determinant of access to GP services, and ensures that the planning, delivery and expansion of primary care infrastructure in Oxfordshire is proactively aligned with population growth and housing development. It is recommended that there is early/structured engagement with local planning authorities and developers; and a timely delivery of adequate, fit-for-purpose primary care facilities as communities expand, rather than responding retrospectively once access pressures have already emerged.*

Legal Implications

126. 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.

127. 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’.

128. 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.

LIST OF ANNEXES:

- Annex A – GP Appointment data and registered patient list sizes per practice from January 2023-December 2025.

- Annex B - GP Appointment trends data month by month from January 2025-December 2025 (labelled Annex B).

- Annex C- GP Patient Survey data as of the most recent collection in January 2025.

- Annex D- GP workforce data.

- Annex E- Report submission to the working group from the Buckinghamshire, Oxfordshire, and Berkshire West Local Medical Committee on *Demand, Capacity & Activity in General Practice*.

Contact Officer: Dr Omid Nouri
Health Scrutiny Officer
omid.nouri@oxfordshire.gov.uk
Tel: 07729081160

September 2026