

Interim 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 May 2026), Cllr Paul-Austin Sargent, Cllr Ron Batstone, District Cllr Katherine Keats-Rohan.

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.

INTRODUCTION AND OVERVIEW

1. 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](#)).
2. 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.
3. 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.

4. 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 continue, 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.
5. 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.
6. 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.
7. As a result of this scrutiny in September 2025 and the concerns identified with GP services in Oxfordshire, and 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.
8. 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.
9. 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, Cllr Paul-Austin

Sargent, Cllr Ron Batstone, and District Cllr Katharine Keats-Rohan. 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.

10. 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.
11. 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:

12. The working group had 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 Burkner, and Dr James McNally).
 - Local councillors (including District Cllr David Rodgers).
13. 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 (this will be published on the Healthwatch Oxfordshire website at the end of May).
- 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.

14. 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:

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

16. 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

17. 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 and Dan Leveson (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.

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 and Dan Leveson (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 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.

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.

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 Inequalities 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 and Dan Leveson (ICB)

The most recent ICB 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.

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.

18. 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.

19. In terms of its next steps, the working group will:

- Hold an additional session with the representatives of the Thames Valley ICB on the use of digital tools and models in primary care services.
- Conduct site visits to GP practices in both rural and urban areas.
- Consider its findings against the backdrop of knowledge of evolving national NHS and local government reforms.

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

20. 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.

21. A key 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.

22. 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.

23. 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.

24. 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.

25. 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

KEY POINTS OF OBSERVATION:

26. 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 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 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 a substantial proportion of GP time is absorbed by work that sits outside direct face-to-face consultations, including tasks generated at the interface between primary and secondary care¹. 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 space². 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

¹ [RCGP, Uncovering the GP workload burden](#)

² [Institute for Government](#)

routes, risk disadvantaging digitally excluded populations³. The working 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 together⁴. 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

³ [Healthwatch England](#)

⁴ [North Central London Infrastructure Strategy](#)

primarily explained by a lack of effort or productivity within general 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 increased markedly between January 2023 and December 2025, particularly in growth areas, 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 delivery⁵.

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 capacity⁶.

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

⁵ [BMA – Pressures in General Practice](#)

⁶ [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 practice⁷. 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 flow⁸.

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"⁹.

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 efficiency¹⁰.

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 need¹¹.

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 appointment counts or introducing new access routes. Without

⁷ [NHS England – GP Red Tape Challenge](#)

⁸ [GIRFT – Bridging the interface](#)

⁹ [Healthwatch England](#)

¹⁰ [RCGP – Red Tape Challenge response](#)

¹¹ [BJGP editorial](#)

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 roles¹². 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 retirement¹³. 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 care¹⁴.

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 retention¹⁵.

¹² [British Journal of General Practice](#)

¹³ [BMA – Pressures in General Practice](#)).

¹⁴ [NHS England – Red Tape Challenge](#)

¹⁵ <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 models¹⁶.

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.

¹⁶ [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 paper¹⁷. 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 (this will be covered in more depth in a future dedicated session with the Thames Valley ICB). 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

¹⁷ [RCGP – Health inequalities](#)).

that a proportion of patients struggle with online access or prefer telephone or 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 access¹⁸.

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 populations¹⁹. 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 routes²⁰. Similarly, the NHS Red Tape Challenge acknowledges that bureaucratic burdens and unclear responsibilities reduce system efficiency and have uneven impacts across communities²¹.

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 aligned²². The working group

¹⁸ [Healthwatch England – GP access](#)

¹⁹ [RCGP – Unnecessary workload study](#)

²⁰ [GIRFT – Bridging the Interface](#)

²¹ [NHS England – Red Tape Challenge](#)

²² [Institute for Government – GP estates](#)

concluded that populations affected by rapid growth are at 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 targets²³.

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

²³ <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 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 teams²⁴. 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 care²⁵. 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 particularly acute where population growth outstrips infrastructure

²⁴ [Institute for Government – Delivering a general practice estate fit for purpose](#)

²⁵ [RCGP – Uncovering the drivers and costs of unnecessary GP workload](#)

delivery²⁶. 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 commissioners²⁷.

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 strategies²⁸. 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 shortcomings²⁹.

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 access³⁰. 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 Annexes A–E, combined with patient experience and national research,

²⁶ [Healthwatch England – GP access](#)

²⁷ [Institute for Government](#)

²⁸ [NHS England – Neighbourhood health centre guidance](#)

²⁹ [GIRFT – Bridging the interface](#)

³⁰ <https://www.kingsfund.org.uk/insight-and-analysis/long-reads/continuity-care-general-practice>

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

27. 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.
28. 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'.
29. 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*.

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