North Yorkshire Council

Thirsk and Malton Area Committee – 5 December 2025

Briefing note on GP surgeries

1.0	**PURPOSE**
1.1	Members requested a briefing note on GP surgeries.

2.0 Local surgeries – members of the South Hambleton and Ryedale Primary Care Network (SHaR PCN)

Surgery	**No of patients Jan 2025**	**GP** National Workforce Reporting Data Aug 25
Millfield Surgery (Easingwold)	7846	13 (9.8 WTE)*
Helmsley	3635	5 (1.8 FTE)
Kirkbymoorside	6116	5 (4.4 WTE)
Pickering	10960	12 (9.2 WTE)
Stilllington	3723	3 (2.2 WTE)
Tollerton	3556	4 (2.2 WTE)
Terrington	1750	3 (0.9 WTE)
Derwent (Malton and Norton) Not in SHaR PCN	21179	18 (14.5 WTE)

*WTE – Whole time equivalent

Other local surgeries

Surgery	**No of patients**	**GP** National Workforce Reporting Data Aug 25
Filey	8863	12 (7.8 WTE)
Thirsk Health Centre	8077	8 (5.8 WTE)
Lambert Medical Centre (Thirsk)	8562	10 (6.9 WTE)
Hunmanby	4261	3 (2.3 WTE)

3.0 Part time GP (AI results)

A GP classed as part-time typically works fewer than the NHS standard full-time definition of 37.5 hours per week. However, the actual number of hours can vary significantly depending on the GP's role, responsibilities and practice setting.

4.0 Patient ratios

4.1 There is no officially mandated "ideal" patient-to-GP ratio but 1,500 patients per GP is often cited as a desirable target for manageable workload and quality care.

In 2022, the average number of patients per GP (including trainees and locums) was 1,700. [ons.gov.uk]

4.2 As of May 2025, the average number of patients per full-time equivalent (FTE) fully qualified GP in England was 2,258, representing a 17% increase compared to 2015.

This figure reflects growing pressure on general practice, with rising patient numbers and relatively stagnant GP workforce growth.

4.3 The ideal patient-to-GP ratio can vary:

- Practices with older populations tend to have lower patient-to-GP ratios due to higher care needs.
- Practices in more deprived areas may require more GPs per patient to address complex health needs.
- The presence of nurses, pharmacists and other roles can offset GP workload.

4.4 The Royal College of General Practitioners (RCGP) and other bodies have warned that ratios above 2,000 patients per GP can lead to:

- Reduced appointment availability
- Increased GP burnout
- Lower patient satisfaction

5.0 Links with NYC

5.1 Local Plan

Local plans in the UK consider medical services, usually indirectly through broader planning frameworks and partnerships with health bodies.

5.2 Role of Local Plans

Local plans, developed by local planning authorities (usually councils), primarily focus on land use - housing, infrastructure, transport, and economic development. However, they are required to consider community infrastructure, which includes healthcare facilities such as GP surgeries, hospitals and community health centres.

Health infrastructure and planning
Local plans must be informed by Infrastructure Delivery Plans (IDPs), which assess the need for services in the context of growth such as:

- Primary care (GPs)
- Acute care (hospitals)
- Mental health services
- Community health services

These assessments are often done in collaboration with:

- Integrated Care Boards (ICBs) which plan local NHS services
- NHS England
- Public Health teams within councils

Integrated Care Systems (ICSs)
ICSs bring together NHS organisations, local authorities and other partners to plan and deliver health and care services. They influence local plans by:

- Identifying health needs of the population
- Advising on the location and scale of new health facilities
- Supporting health impact assessments for major developments

Neighbourhood and Community Health Services
Recent NHS initiatives like Neighbourhood Health Services aim to bring care closer to communities. These services are increasingly considered in local planning to ensure that new developments are supported by accessible healthcare infrastructure.

Planning obligations (Section 106 and CIL)
Developers may be required to contribute to healthcare infrastructure through:

- Section 106 agreements (site-specific)
- Community Infrastructure Levy (CIL) (broader area-based funding)

These funds can be used to expand or build new medical facilities where development increases demand.

5.3 Director of Public Health – NYC (from GOV.UK)

The Director of Public Health (DPH) has oversight and expertise across all determinants of health within local authorities, the NHS and other sectors and agencies.

The DPH should:

- be an independent advocate for the health of the population and provide leadership for its improvement and protection, and, as a statutory chief officer of the local authority, lead on advancing their authority's public health objectives
- be the person to whom local authority elected members and senior officers look for expertise and advice on public health issues, from improving and protecting local people's health through to outbreaks of disease and emergency preparedness and access to health services
- provide the local public with expert, objective advice on health matters
- lead work to improve local population health by understanding the factors that determine health and ill health and how to change behaviour and promote health and wellbeing in ways that also reduce health inequalities
- play a key role on the Health and Wellbeing Board, advise on and contribute to the development of joint strategic needs assessments and joint local health and wellbeing strategies, and promote commissioning of appropriate services accordingly
- promote action across the life course, working together with local authority colleagues on matters such as planning, housing, transport and the environment as well as the director of children's services and the director of adult social services.
- contribute to and influence the work of NHS commissioners, providers and other ICS partners, helping to lead a whole systems approach to public health across the public and private sector to improve health and care outcomes and experiences across the whole population.
- work through local resilience forums and local health resilience partnerships to ensure effective and tested plans are in place for the wider health sector to protect the local population from risks to its health.
- work with UKHSA and the NHS through the ICP to include health protection in their integrated care strategy, to deliver improved outcomes and to reduce health inequalities.
- work with local sectors, such as education, employment, and criminal justice partners and police and crime commissioners (PCCs) to promote safer communities.
- take responsibility for the oversight of their authority's public health services, with professional responsibility and accountability for these services' effectiveness, availability and value for money.

6.0 Reports

6.1 NYC reports

Director of Public Health annual report 2023/24 - Live, Age and Engage: Healthy ageing in North Yorkshire. Pages 14 – 29: Health and reducing inequalities – see challenges on p17 and appointments info on p19 – 21.

6.2 National reports

Primary and community care - Care Quality Commission – see following summary - part of the “State of health care and adult social care in England 2024/25

NHS GP Patient Survey – search results by practice

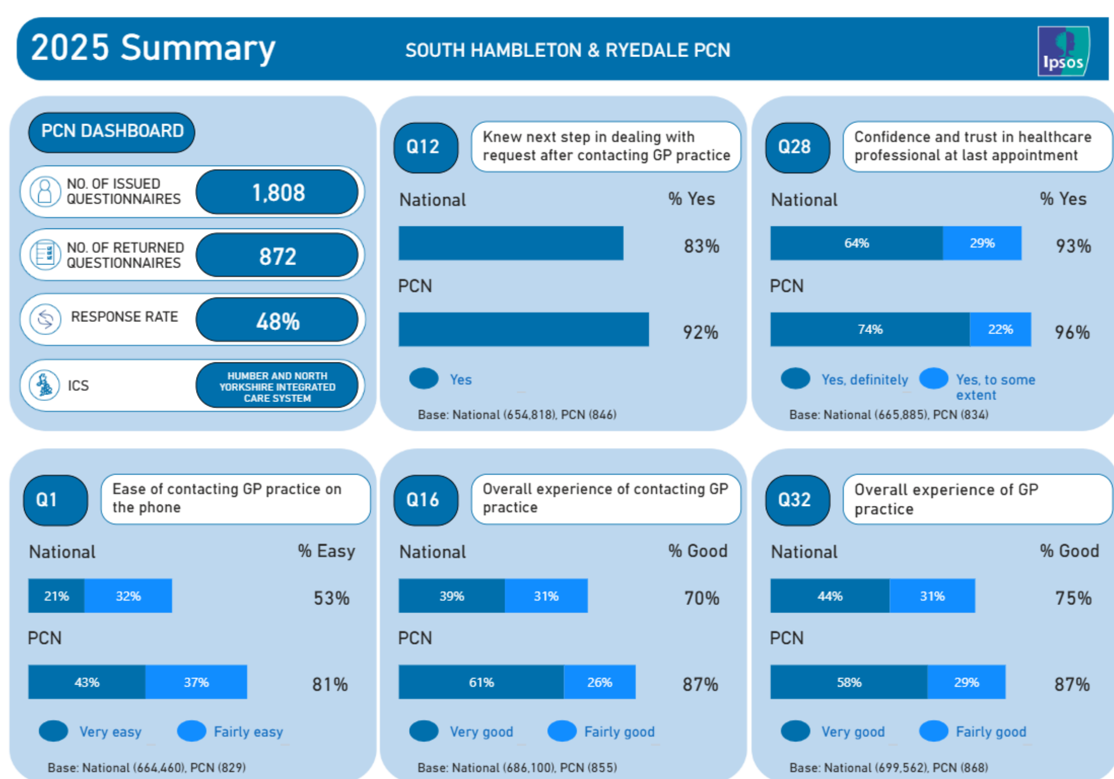
CQC - The state of health care and adult social care in England 2024/25

Primary and community care key findings
The demand for GP services is still growing, resulting in more pressure on services. Over 700,000 more patients were registered with a GP, on average, in 2024/25 compared with 2023/24, and the number of appointments has risen by nearly 10% over the last 2 years.

- The number of full-time equivalent fully qualified GPs per 100,000 patients dropped by 0.7%, on average, in 2024/25 compared with 2022/23. In the same period, the number of full-time equivalent GPs in training grade per 100,000 patients rose by 10%.
- In the 2025 GP Patient Survey, 75% of respondents stated that their overall experience was ‘good’ or ‘fairly good’. However, the survey also found that only around half (53%) of people who had tried to contact their GP by phone said it was easy. It also found that access to GP services can be harder for some groups than others, including those living in the most deprived areas, autistic people and people with a learning disability, those with a mental health condition, a neurological condition and/or another long-term condition or illness.
- When a GP service is unable to meet people’s needs, it can lead to pressure on other parts of the health and care system. For example, the 2025 GP Patient Survey found that 6.6% of people went to A&E when they could not contact their GP practice or did not know what the next step would be. This proportion was higher for people living in the most deprived areas (8%), compared with people in the least deprived areas (4%).
- Although district nursing services are an important part of shifting care from hospital settings into the community, the number of qualified district nurses per 10,000 people aged 65 and over has dropped by 50% in the last 14 years. A shortage of qualified district nursing staff is contributing to a shift away from providing holistic care to delivering services in a task-based way.
- Although over four-fifths of GPs we surveyed thought that artificial intelligence (AI) will have a positive impact on general practice in the next 5 years, less than half (42%) were using it. Although the public thought it could improve access to a GP, just over a quarter (27%) thought the use of AI by GPs could make their care better

7.0 GP Patient Survey

ShaR outperform the national results for all categories. The ease of contacting the practice by phone in particular is a lot higher.



8.0 Funding

GP surgeries in the UK are funded through a combination of national contracts and local commissioning arrangements.

8.1 Core funding via NHS contracts

There are three main types of contracts used to fund GP practices:

- General medical services (GMS): This is the standard national contract used by around 70% of practices. It provides a fixed payment per patient, adjusted for factors like age, gender, and health needs. For 2025/26, the *Global Sum* payment is £121.79 per weighted patient.
- Personal medical services (PMS): These are locally negotiated contracts that allow more flexibility in service delivery, often used to tailor services to specific community needs.
- Alternative provider medical services (APMS): These contracts allow non-traditional providers (e.g., private companies or social enterprises) to deliver GP services, often in underserved areas.

8.2 Additional funding streams

- Quality and outcomes framework (QOF): Practices earn additional income based on performance against clinical and public health indicators.

- Enhanced services: These are optional services commissioned locally, such as vaccinations or extended hours access.
- Additional roles reimbursement scheme (ARRS): Provides funding for hiring non-GP staff like pharmacists, paramedics, and social prescribers.

8.3 Infrastructure and capital investment

In 2025, the government pledged over £102 million for GP surgery upgrades, aimed at creating more consultation rooms and improving facilities to handle increased patient demand.

Primary Care Utilisation and Modernisation Fund 2025 to 2026 lists 1027 GP practices that have received an allocation from the fund, including 42 in the Humber & North Yorkshire ICB region (230 practices). The list includes Pickering, Stillington, Thirsk, Malton, Hunmanby and Malton.

8.4 Local commissioning

Integrated Care Boards (ICBs) manage contracts and funding at the local level. They can commission additional services based on local population needs.

8.5 Funding formula

A weighted patient is a concept used in NHS funding formulas to reflect the varying levels of healthcare need among different patients. Not all patients require the same amount of care, so the funding a GP practice receives is adjusted based on the characteristics of its patient population.

Raw patient numbers are adjusted using a formula (currently the Carr-Hill formula) that accounts for factors like:

- Age and gender
- Health status and morbidity
- Socio-economic deprivation
- Rurality
- Mortality rates

These adjustments produce a weighted list size, which is often higher or lower than the actual number of registered patients, depending on the population's needs.

Example: If a practice has 10,000 registered patients, but many are elderly or have complex health needs, their weighted list might be 11,500. This means they receive funding as if they had 11,500 average-need patients, for those practices serving more vulnerable or high-need populations to meet demand.

9.0 RECOMMENDATION

10.1 That the information be noted.

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