Shaping the Future of General Medical Services (GMS)

Dumfries and Galloway Health and Social Care Partnership
General Medical Services (GMS) Review - Phase Two Consolidated Thematic Analysis

October 2025

This document includes passages generated with the support of a Large Language Model (LLM).

Artificial intelligence can make mistakes. All outputs have been reviewed and sense-checked by members of the General Medical Services (GMS) Review Team to ensure factual accuracy, consistency, and alignment with the evidence base.

Method Overview

A Data Protection Impact Assessment (DPIA) previously authorised the use of a Large Language Model (LLM) to assist with the analysis of anonymised engagement data within the Dumfries and Galloway GMS Review. The same governance arrangements continued for Phase Two.

Evidence in this phase was drawn from GP and Practice Team workshops held in each of the four localities (Annandale & Eskdale, Nithsdale, Stewartry, and Wigtownshire), alongside public sessions, stakeholder engagement (in-person and online), and leadership discussions.

Data from each stream was cleaned and anonymised before being analysed using the LLM to surface cross-cutting patterns, reduce duplication, and ensure consistency across the six key themes and three underpinning principles (Equity, Integration, and Sustainability). Prompts used in this phase were aligned to those in Phase One to ensure comparability of approach.

Validation and Governance

All outputs were reviewed by members of the GMS Review Team to ensure factual accuracy, consistency, and alignment with the evidence base. No

unverified text has been included. The approach complies with NHS Dumfries and Galloway's information-governance policy and the Partnership's ethical standards for the use of AI in research and service review

Executive Summary

This consolidated thematic analysis integrates the full body of evidence from Phase Two of the General Medical Services (GMS) Review across Dumfries and Galloway. It draws on four streams of engagement - GP and Practice Teams, Wider Stakeholders, the Public, and Leadership & Governance - to provide a single, comprehensive picture of the challenges and opportunities facing general medical services. Structured by the six key themes (Service Delivery, Workforce, Digital, Data, Premises, Quality), the analysis reads findings through the underpinning principles of Equity, Integration and Sustainability.

Two emergent themes validated throughout the work describe both the core problem and the pathway forward: (1) system fragmentation undermining sustainability and equity, and (2) balancing human connection with digital dependency.

The report synthesises consistent calls for clearer access routes, stronger team-based working, interoperable digital and data systems, fit-for-purpose premises, realistic quality frameworks, and sustainable workforce models. It concludes with a consolidated action framework grouped by four time horizons - from immediate actions already underway to a 5–10 year vision for a coherent, connected model of general practice. Together, these findings and actions form the foundation for Phase Three and Delivery Planning, establishing a clear bridge from engagement evidence to implementation.

Introduction

This consolidated analysis integrates evidence from Workstream 1 (GP and Practice Teams), Workstream 2 (Wider Stakeholders), the Public engagement stream, and the Leadership & Governance perspective. Across the four, the same patterns recur: fragmented systems, workforce fragility, variable data and digital foundations, estate constraints, and a shared ambition to protect relational continuity while modernising how services connect. The analysis is read explicitly through the three underpinning principles - Equity, Integration, and Sustainability - and sets out how they intersect with the Four Cs framework (Consistency, Continuity, Collaboration, Connection) which has emerged naturally from the data.

Locality Context

While this consolidated thematic analysis presents a regional picture, it is

grounded in the distinct perspectives contributed by each locality. Evidence from Annandale & Eskdale, Nithsdale, Stewartry and Wigtownshire informed every theme, highlighting how shared challenges—particularly around workforce sustainability, access, and system integration—manifest differently across rural and urban settings. These locality-specific insights underpin the regional findings and ensure that local context remains visible within the overall synthesis

Service Delivery

Across all sources, day-to-day general practice is described as high-demand and reactive, with repeated failures at system interfaces generating duplication, delay and risk. GP teams report time lost chasing results, tracking downgraded or stalled referrals, and re-explaining pathways when hand-offs are unclear - a daily operating condition rather than rare events. Rurality adds travel and thin local provision, compounding waits and redirecting work back to practices. Where strong local relationships exist, many of these problems are mitigated informally; where they do not, patients can “bounce” between services with no single owner of the journey, and general practice absorbs risk to keep them safe. Wider stakeholders and leaders point to the same root causes - fragmented systems, variable standards and unclear accountability - and call for simplified referral routes, consistent communication protocols and team-based, proactive care models around practices. Public sessions mirror the experience from the other side: booking and access routes feel inconsistent, prevention is valued, and people favour local, community-based options that keep them well and reduce escalation.

Equity concerns centre on variable access (including rural transport and administrative costs). Integration focuses on weak feedback loops across primary-secondary-community boundaries. Sustainability focuses on the fragile reliance on goodwill and workarounds to maintain continuity.

Within this picture, participants consistently seek consistency of access and communication standards, continuity for complex patients within first-contact and triage models, collaboration across sectors for escalation and hand-back, and connection with communities via hubs and third-sector links. Leaders reinforce the need for clear regional priorities and protected planning time to stabilise the operating model; stakeholders propose practical steps such as central referral functions and standardised protocols; the public emphasise transparent information on what general practice can and cannot provide and the importance of compassionate, relational encounters. These preferences align with a proactive, population-based approach that preserves relational care while simplifying journeys and avoiding unplanned work transfer to practices.

Workforce

Workforce is the defining constraint and the primary lever for resilience. GP teams highlight inconsistent back-fill for MDT roles, the drag of administrative load, and split employment arrangements (board-employed MDT alongside practice-employed staff) that blur accountability and complicate supervision. Localities with stable teams report stronger continuity, safer decision-making and better morale; rural areas describe recruitment challenges and locum dependency that destabilise relationships. Wider stakeholders echo the need for coordinated MDT roles, clear supervision and equitable distribution of skills; the public support expanded MDT roles alongside permanent GPs to stabilise continuity and experience. Leaders frame the response as a regional workforce strategy with parity of esteem, clear progression routes, extended skills (including prescribing/diagnostics), wellbeing and leadership development — all connected to GMS priorities. Equity concerns relate to postcode variation in MDT/admin support and rural exposure; Integration requires joint workforce planning and single-route escalation for cover; Sustainability depends on predictable rotas, explicit back-fill rules and targeted administrative capacity to unlock clinical time.

Participants also describe what strengthens teams: consistency in role standards and cover arrangements, continuity through stable staffing and protected supervision, collaboration through cluster-level sharing and peer learning, and connection via recognition, debriefs and visible wellbeing measures. Where these conditions are present, pressure is buffered and quality signals rise; where absent, risk and burnout increase and general practice becomes the default absorber of system gaps.

Digital

Digital foundations are described as both constraint and opportunity. Practices report unreliable platforms, multiple log-ins and systems that don’t talk to each other, creating clinical risk and duplicate work; rural bandwidth and ageing hardware add friction. Yet where tools are co-designed with clinicians (e.g., Near Me, Consultant Connect, BP telemonitoring, digital dictation), teams see fewer unnecessary appointments, faster coordination and better patient experience — provided the tools are stable and simple to use. Public sessions strongly favour hybrid access models: digital when it helps, while keeping telephone and face-to-face routes available to protect relational care and avoid exclusion. Stakeholders focus on joining up GP and hospital portals and standardising templates; leaders position digital enablement as a clinical priority requiring one regional direction, shared records, and clear accountability so innovations reduce burden and improve experience. Equity requires default non-digital options and support for those who need them; Integration requires

interoperable records and single-sign-on; Sustainability requires reliable, usable systems that reduce cognitive load and free time for patient contact.

Across the streams, the preferred digital posture is clear: consistency in standards and roadmap, continuity enabled by shared records that let any clinician “pick up the story,” collaboration through cross-sector tools for rapid advice and hand-offs, and connection by designing digital to support human encounters, not displace them.

Data

Participants across streams characterise data as labour-intensive to handle yet crucial when made timely and meaningful. GP teams describe duplication, inconsistent coding, and delayed or incomplete transfers (often scanned documents that require manual summarising), increasing risk of omission and consuming clinical time. Wider stakeholders highlight uncertainty around which indicators matter and the gap between national guidance and realistic capacity; they call for pragmatic quality indicators, disease-register use, and local sharing agreements that reflect real workflows. The public strongly support better data sharing between GP, hospital and wider services — with robust consent models and availability in emergencies — because lack of interoperability drives duplication and safety risks they can see. Leaders call for a shared regional data platform with real-time visibility of demand/capacity, recognition of NMAHP activity/outcomes, and dashboards that translate data into actionable insight for local teams.

Equity is advanced when reliable, timely data ensure nobody is ‘invisible’ to recall; Integration improves when templates and transfers are standardised; Sustainability improves when light-touch automation and protected review time convert data effort into clinical value. Narratively, participants are asking for consistency in definitions and measures, continuity via longitudinal data that support proactive follow-up and reconciliation, collaboration through a single version of the truth for joint decisions, and connection through transparent information that builds trust with professionals and the public alike.

Premises

Premises are a physical brake on MDT growth, training capacity and co-location. Many buildings are at or near capacity; some staff are working from unsuitable spaces. Maintenance responsiveness, accessibility and energy efficiency vary and are often opaque to practices. The public are clear that they want local surgeries modernised where necessary — not large centralised ‘super-surgeries’ — with space for MDT staff and facilities for digital consultations. Wider stakeholders emphasise creative use of council and third-sector venues,

community hubs, and standardised room-booking to make the most of available space. Leaders describe estates as both symbol and enabler of system change and call for a regional strategy aligned with workforce and service planning, delivering flexible rooms, hot-desking for visiting professionals, digitally enabled workspaces and shared community hubs that co-locate partners.

Equity demands safe, accessible environments regardless of locality; Integration requires estates planning to move in step with digital and workforce; Sustainability points to proactive maintenance and energy upgrades to reduce disruption and cost. Put simply, participants seek consistency through a published premises audit and transparent priorities, continuity by protecting supervision and training spaces, collaboration via co-location and shared hubs, and connection by keeping care local and welcoming for patients and staff.

Quality

Quality is upheld by professional commitment and teamwork under pressure. Practices describe relational continuity, local knowledge and rapid informal communication as the strongest predictors of good outcomes. Counter-pressures include short appointments, documentation load and digital downtime that narrows safety margins. Public sessions equate quality with being listened to, compassion and continuity, alongside proactive prevention (health MOTs, screening) and consistent standards across practices. Wider stakeholders question the relevance of some existing indicators and advocate co-produced, realistic measures that motivate improvement; leaders call for a single regional quality framework with practical improvement methods (e.g., PDSA, small tests of change) and rapid learning loops, underpinned by protected time for supervision and reflection.

Equity requires respectful, timely care regardless of practice size or location; Integration depends on reliable two-way communication with hospitals for results, discharge and medication reconciliation; Sustainability rests on protecting wellbeing and learning time so quality can be maintained under pressure. The direction of travel is to embed consistency via common standards and safety-critical admin processes, protect continuity for complex patients, normalise collaboration through peer-review and PLT, and make connection — compassionate, person-centred care — a visible and measured quality domain.

Emergent Theme Validation

Two major emergent themes were confirmed and strengthened across all four Phase Two streams:

1. System fragmentation undermining sustainability and equity: Evidence from every stream shows that disconnected systems, split accountability and weak feedback loops create duplication, delay and risk. GP teams report absorbing unplanned workload to maintain safety; stakeholders describe patients defaulting to GPs when other pathways fail; public participants experience these weaknesses as confusion, inconsistency and loss of trust. Leaders translate the same problem into structural terms — multiple digital platforms, separate workforce governance lines, and fragmented estate planning — all of which undermine Integration and Sustainability and drive inequity of access and experience. Integration across digital, data, workforce and estates emerges as the single most powerful lever for improvement, echoed throughout the analysis.

2. Balancing human connection with digital dependency: Equally consistent is the message that technology should amplify, not replace, the human relationship at the heart of general practice. Participants across all streams value the convenience of digital tools but emphasise that relational continuity, empathy and personal contact define quality. Digital must therefore be reliable, interoperable and supportive — a mechanism for connection, not a barrier to it. Together, these themes describe both the problem and the pathway forward. Fragmentation erodes consistency, continuity, collaboration and connection — the very conditions required for equitable, sustainable care. The Four Cs framework therefore provides the organising principle for Phase Three and Delivery Planning: building a coherent, connected system that protects relational care while achieving integration and efficiency at scale.

Actions - Consolidated (Grouped by Action Horizons)

Immediate Actions (already underway or ready to proceed)

Service Delivery: Publish clear, plain-English patient messages on GP remit and typical timeframes; agree a single named escalation route (with SLAs) for delayed results/referrals.
Workforce: Clarify governance/supervision for board-employed MDT staff in practices; make back-fill rules explicit; reinstate and protect PLT/peer-review time.
Digital: Stabilise EMIS/DOCMAN performance; introduce single-sign-on across core systems; guarantee non-digital access routes for the public.
Data: Simplify reporting; stop duplicate requests; standardise templates; provide coding and data-quality 'how-to' guides and protected review time.
Premises: Publish a region-wide premises audit with risk-based priorities; clarify estates roles/response times; progress accessibility fixes and essential maintenance.

Quality: Standardise safety-critical admin processes (results handling, repeat prescribing) and share 'what works' packs.

Horizon 1: 18 months to 3 years (Priority Actions):

Service Delivery: Implement standard referral/communication protocols; extend community-based prevention offers.
Workforce: Region-wide workforce plan with cover rules and rural incentives; targeted admin capacity; cluster-level sharing for specialist roles.
Digital: Fast-track electronic prescribing; deploy super-user support; improve rural hardware/connectivity.
Data: Pilot single-dashboard 'version of truth'; agree pragmatic local indicators; strengthen disease-register use.
Premises: Introduce maintenance tracking; pilot shared community hub models and standardised GP room-booking.
Quality: Reinforce PLT for spreading effective triage/continuity models; embed debriefs and reflective practice.

Horizon 2: 3 to 5 years (Strategic Objectives):

Service Delivery: Scale integrated locality teams around practices.
Workforce: Establish structured progression and cross-sector secondments; embed wellbeing and leadership development.
Digital: Deliver regional digital roadmap; enable shared electronic records across professions.
Data: Stand up regional data platform for demand/capacity and MDT impact.
Premises: Align estates investments to workforce/digital plans; co-locate partners in hubs.
Quality: Adopt regional quality framework with shared definitions, learning cycles and rapid spread mechanisms.

Horizon 3: 5 to 10 years (Draft Vision):

A coherent, connected GMS model that delivers consistency in standards and access, continuity in relationships and information, collaboration across professions and sectors, and connection with communities. Digital, data, workforce and estates are aligned to support relational, local, team-based care at scale — improving equity and making sustainability achievable in daily practice.

Overall Summary and Critical Analysis

Viewed together, the four streams describe the same system from different vantage points. GP teams provide operational reality; the public bring lived experience and expectations; wider stakeholders surface cross-boundary friction

and practical opportunities; leaders set enabling conditions and direction of travel. The evidence repeatedly ties back to Equity, Integration and Sustainability as practical tests: do pathways reduce duplication; do data follow the person; do digital and estates include those at risk of exclusion; do workforce models enable MDTs to function every day? The analysis validates the Phase One insight that success depends on relational, person-centred care, supported — not displaced — by digital. It also consolidates a set of organising principles now clearly present in the evidence: consistency, continuity, collaboration and connection. These principles give the bridge to Delivery Planning, logic models and horizon-based action, without losing sight of the immediate fixes that will restore confidence and capacity on the ground.