Shaping the Future of General Medical Services (GMS)

Dumfries and Galloway Health and Social Care Partnership

General Medical Services (GMS) Review - Phase Three

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WORKING TOGETHER FOR THE FUTURE OF HEALTH AND SOCIAL CARE
DUMFRIES AND GALLOWAY
Health and Social Care Partnership

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Introduction

This Phase Three consolidated thematic analysis integrates the full body of engagement evidence gathered through the dual-pronged approach used in the final engagement phase of the GMS Review. Although Phase Three involved fewer overall engagement questions than the earlier phases, the depth of narrative provided by communities, patients, carers, and local stakeholders strengthens and extends the insights generated through Phase One and Phase Two.

Participants described their real-world experiences of accessing general practice, navigating care pathways, managing long-term conditions, coordinating transport, interacting with MDT staff, and coping with variability between practices. These lived-experiences sharpen the detail around key pressures such as access, continuity, communication, transport, rural isolation, digital exclusion, and fragmented interfaces with hospital services.

As in Phases One and Two, the analysis is structured using the six key GMS themes - Service Delivery, Workforce, Digital, Data, Premises, Quality - and interpreted through the underpinning principles of Equity, Integration and Sustainability, with continued reinforcement of the Four Cs: Consistency, Continuity, Collaboration and Connection. As in Phase Two, these concepts emerge naturally from participants' accounts, validating the review's foundation.

Locality Context

Phase Three engagement included a high proportion of input from rural and remote communities. People described stark variation across practices: from highly responsive, relationship-based care with same-day triage, to severely stretched systems where people struggled to obtain an appointment at all.

Rurality intensified challenges around transport, communication, travel for blood tests and specialist appointments, and limited access to local clinics. Older adults, carers and people with complex conditions reported the greatest burden, especially when reliant on public transport or when appointments were scheduled at distant hospitals with multiple connecting buses.

Service Delivery

Across Phase Three, participants described a system that can deliver excellent, relational, person-centred care - but only in some practices and only some of the time. The most consistent message is extreme variability, with access, responsiveness, communication, and follow-up depending heavily on local staffing levels, triage systems, appointment models and continuity of GP presence.

People repeatedly expressed confusion and frustration about modern access routes, the 8am bottleneck, inconsistent triage experiences, and difficulty navigating between GP, hospital, and community services.

Conversely, where practices maintain clear communication, flexible triage and relational contact, confidence is extremely high.

People described:

- Long telephone queues at 8am, often with appointments gone by the time they reached the front.
- A perception that first-come, first-served access is inequitable, particularly for working people, carers, those with cognitive impairments, or those unable to navigate phone systems.
- Feeling bounced around between reception, triage, ANPs, GPs and occasionally Accident and Emergency, with little clarity about who is responsible for follow-up.
- Delays in being seen for acute deterioration, leading some people to attend Accident and Emergency due to persistent inability to secure a GP appointment.
- Inconsistency in how practices communicate service changes, test results, staff turnover and clinic availability.
- Significant distress caused by lack of privacy at reception and repeated disclosure of symptoms.
- Sharp contrast with practices offering relational access, rapid triage, compassionate staff, and timely appointments.

Interpretation:

Many participants highlighted the emotional toll of unpredictable access, describing the process as stressful, exhausting, or "hit-and-miss," particularly when caring responsibilities or work pressures limited their ability to wait in queues. Several noted that system unpredictability is now influencing health-seeking behaviour, with some delaying care until symptoms worsen or presenting to Accident and Emergency when GP access feels unattainable.

Service Delivery in Phase Three illustrates widening variation across general practice. The model functions exceptionally well where relational access, flexibility and clear communication exist; it deteriorates sharply where these conditions are absent. Variation directly tests Equity and Integration: those least able to navigate systems face the highest barriers, and fragmented interfaces force patients to compensate for system gaps, undermining Sustainability.

Workforce

Workforce pressures continue to be the defining constraint. People described an almost complete loss of GP continuity in some practices, with heavy reliance on locums and part-time GPs, resulting in repeated storytelling, missed history and reduced trust. In contrast, stable MDT teams produced high confidence and visible continuity.

People reported:

- Difficulty seeing the same GP twice, with rapid turnover and limited full-time GP presence.
- Concern that no one clinician knows their history, especially for chronic pain, multimorbidity and mental health.
- Appreciation for ANPs, pharmacists and nurses when experienced and consistent, but anxiety where scope, continuity or supervision were inconsistent.
- Reception teams under pressure, sometimes empathetic and effective, sometimes overwhelmed and stretched to triaging beyond their role.
- A sense that the workforce is too thinly stretched to deliver proactive care.
- Strong desire for retention strategies to reduce locum dependency and rebuild relational continuity.

Interpretation:

People repeatedly linked workforce instability to rising levels of stress, uncertainty, and emotional fatigue when trying to secure care, particularly where turnover meant having to “start again” at every contact. Several people noted that inconsistent staffing directly alters clinical decisions and safety, with delayed reviews, incomplete follow-up, or differing advice depending on who is available on the day.

Workforce fragility undermines all other themes. Without stable GP presence, responsibility blurs, continuity collapses and patients absorb risk. Equity suffers when only some localities maintain stable teams; Integration weakens when MDT roles aren’t consistently supported; Sustainability is threatened by burnout and inadequate capacity.

Digital

Digital tools are experienced as both helpful and exclusionary. Digital exclusion disproportionately impacts older adults, people with disabilities, those in poverty and those with unreliable connectivity.

People described:

- Frustration with Patient Hub, including unexpected logouts and limited support.
- Difficulty uploading photographs or completing online forms due to poor rural connectivity.
- Anxiety when digital replaces rather than supplements relational care.
- Appreciation for digital repeat-prescription systems and online messaging when optional and reliable.
- Confusion about email/text authenticity and lack of clarity on notifications.
- Barriers created by 8am online release systems requiring fast responses.

Interpretation:

People repeatedly highlighted the emotional impact of feeling “shut out” when digital gateways are the only route to care. Several individuals reported abandoning digital tools entirely due to stress, repeated authentication failures, or fear of doing something wrong.

Rural communities emphasised that poor connectivity is not a choice issue but an infrastructure barrier, meaning digital pathways can actively widen inequity. Older adults described relying on neighbours or family members to upload photos or complete forms, which many felt compromised their privacy and autonomy.

Participants also raised concerns about transparency: who reads online submissions, how triage decisions are made, and what happens after sending information. Many expressed anxiety after submitting digital queries when no confirmation, timeframe, or clear next step followed.

Conversely, when digital options are optional, predictable, and supported by clear communication, they were praised for reducing travel, enabling quick tasks, and avoiding long phone waits. People want systems that work with them, not systems that make them feel judged by their digital ability.

Digital is valued when it increases convenience, consistency, and connection, but becomes a barrier when it replaces human contact or introduces inequity. Phase Three strengthens the case for hybrid, choice-based digital models that do not force dependency. Phase Three participants described digital systems as helpful only when they complement- not replace human contact.

Data

Data handling remains one of the most problematic interfaces. People described uncertainty about responsibility for follow-up, missing results, conflicting medication advice and repeated retelling of history.

People reported:

- Being told to phone hospitals directly despite results already visible to primary care.
- Receiving vague messages like satisfactory without context.
- Delays in receiving critical results.
- Conflicting medication instructions between specialists and GPs.
- Repetition of history due to unfamiliarity of locums with notes.
- Concerns about cross-border transfer of results for those receiving treatment in England.

Interpretation:

Phase Three feedback shows that problems with data are no longer experienced as isolated errors but as a routine, predictable weakness in the system. People described a sense of being personally responsible for ensuring information moves between services, often having to phone repeatedly, chase results, or act as the “connector” between secondary care and their GP. These patterns undermine trust and place disproportionate strain on those least able to self-advocate, including people with long-term conditions, carers, and those navigating multiple services.

Data fragmentation compromises safety, confidence, and workflow. Equity depends on reliable follow-up; Integration on interoperability; Sustainability on eliminating duplication and unnecessary chasing.

Premises

Premises issues were especially prominent, particularly regarding privacy, dignity, and travel.

People described:

- Waiting rooms too small for privacy, with conversations overheard easily.
- Consulting rooms opening directly into waiting areas.
- Underuse of cottage hospitals increasing travel burdens.
- Limited availability of local clinics for routine procedures.
- Accessibility barriers, including poor parking and ramps.
- Significant travel burdens for short appointments.

Interpretation:

Phase Three participants consistently highlighted that the physical environment is inseparable from their experience of care. Many people described feeling exposed or embarrassed when reception areas lacked privacy, especially when sensitive personal information had to be repeated. People reported that cramped layouts, overheard conversations, and consulting rooms opening directly into busy waiting areas created anxiety and discouraged disclosure.

Rural and remote communities emphasised the cumulative impact of distance, transport barriers, and the closure or underuse of local facilities. Several people described travelling long distances for routine checks or bloods that used to be available closer to home. For those without cars, unreliable or non-existent public transport meant entire days lost to short appointments. Carers and people with mobility issues reported that poor parking, steep ramps, heavy doors, and inadequate disabled access made already difficult journeys even harder.

Participants also reflected on the emotional and community role of local premises. Where buildings felt welcoming, familiar, and embedded in a locality, people described a stronger sense of continuity and belonging. Conversely, where environments felt clinical, temporary, or disconnected from communities, participants reported feeling “processed” rather than cared for.

Premises shape whether care feels local, accessible, and dignified. Equity requires safe, private environments; Integration benefits from co-location; Sustainability improves when unnecessary travel is reduced.

Quality

Quality is defined by relational care.

People reported:

- Feeling dismissed or rushed, especially when seeing unfamiliar locums.
- Lack of trauma-informed practice.
- Positive experiences where clinicians took time, explained results, and joined up care.
- Negative experiences where follow-up failed, or communication was unclear.
- Dissatisfaction with complaint processes.

Interpretation:

Phase Three participants described quality as something experienced through how care is delivered, not just what is delivered. People highlighted that even straightforward clinical interactions could feel unsettling or unsafe when contact was rushed, unfamiliar, or poorly explained. Several individuals spoke about feeling “processed” rather than cared for when consultations were brief or repeated the same questions due to lack of continuity.

Quality was strongly associated with being known. Participants described significant reassurance when staff remembered their history, conditions, or prior conversations. Conversely, frequent changes in locum or rotating clinicians resulted in repetition, inconsistent advice, and feelings of instability, particularly for those with long-term or complex needs.

Communication also emerged as a central determinant of perceived quality. People valued clear, timely explanations of results, medication changes, and next steps. Prolonged silence, vague messages, or conflicting information from different parts of the system were experienced as eroding trust. Several participants noted that uncertainty after an appointment often had as much emotional impact as the appointment itself.

Quality hinges on Continuity and Connection. Trust rises where people feel heard; collapses where continuity and communication breakdown.

Emergent Theme Validation

Phase Three reinforces and strengthens the two dominant emergent themes identified earlier in the review. These themes now present with even greater clarity and urgency across communities, GP and practice teams, and system partners.

1. System fragmentation undermines equity, safety, and sustainability.
   Participants repeatedly described disjointed interfaces between GP, hospital, and community teams; inconsistent triage and follow-up processes; gaps in data flow; and variation in how practices manage results, communication, and continuity. Fragmentation is experienced most acutely by those least able to navigate complexity, amplifying inequity and creating avoidable risk. Phase Three confirms that people are carrying the burden of stitching the system together themselves when coordination fails.

2. Human connection is the foundation of safe, trusted care.
   Across every locality, people emphasised relational continuity — being known, being listened to, and having consistent follow-up — as the core determinant of quality. Digital and MDT models are welcomed when they enhance contact and reduce barriers, but trust erodes when they replace human connection or add additional layers of uncertainty. Phase Three demonstrates that confidence rises sharply where staff communicate clearly, offer relational access, and provide continuity across repeated contacts.

   Together, these themes continue to act as cross-cutting tests for equity, integration, and sustainability across the whole system and directly underpin the emerging vision and planning framework now being prepared for the Integration Joint Board.

Overall Summary and Critical Analysis

Across all three phases, the evidence base is now fully triangulated and highly consistent. Phase Three strengthens and sharpens the insights generated earlier in the review, offering clarity on where pressures converge and where variation presents the greatest risk.

The same core challenges persist: variable access and responsiveness, widening gaps in continuity, workforce fragility, digital exclusion when systems are inflexible, data fragmentation that compromises safety and confidence, premises constraints that undermine dignity and local access, and inconsistent quality of communication across the system. These pressures are universal but not evenly distributed, reinforcing unequal experiences across communities and practices.

Equity, Integration, and Sustainability remain under pressure, with the Four Cs — Consistency, Continuity, Collaboration, and Connection — emerging naturally across all phases as the organising tests of what works. The relational aspects of care remain the strongest predictor of trust, safety, and satisfaction, irrespective of geography, practice size, or model of service.

Phase Three provides the final experiential foundation before feasibility testing and delivery planning. It confirms the direction already established in Phase One and Phase Two, validates the need for system-level coordination rather than isolated practice-level fixes, and highlights the importance of focusing on influenceable levers - workforce stability, communication, interface alignment, digital usability, and managing variation - as the review moves into the next stage.

While the majority of Phase Three feedback focused on pressures, barriers, and the consequences of variation, it is important to note that positive experiences were also described - fewer in volume, but strong in depth. Where people encountered relational access, continuity, clear communication, and compassionate teams, confidence in general practice remained extremely high.

These examples reinforce that the system is capable of delivering excellent care when the right conditions are in place, and they offer a clear indication of what sustainable, equitable general practice should look and feel like across the region.