



Shaping the Future of General Medical Services (GMS)

General Medical Services Review

Draft report from engagement periods 1 – 3
(January – November 2025)

Executive summary

The report outlines engagement activities for the General Medical Services (GMS) Review in Dumfries and Galloway, covering January–November 2025.

Process

Engagement was structured in three phases: **Phase 1** (scope definition), **Phase 2** (workshop-based planning), and **Phase 3** (testing and thinking).

Method

Methods included surveys, workshops, and targeted outreach, supported by Artificial Intelligence (AI) assisted thematic analysis and manual validation.

Participation

- **658** online surveys (Phases 1 & 3)
- **306** workshop attendees (Phase 2)
- **35** engagement sessions (29 in person)

Key Findings

Two dominant themes emerged:

- System fragmentation
- Balancing human connection with digital dependency

Stakeholders emphasised the importance of integrated services, clear access routes, sustainable workforce models, and maintaining face-to-face care alongside digital tools.

Outputs

A Draft Action Framework was developed with immediate actions and longer-term objectives across four horizons (up to 10 years).

Lessons learned

Learning includes

- recognising the value of partnership working
- how important Practice Learning Time sessions are,
- how AI can support analysis, but is not without challenges

Conclusion

The engagement process provided a robust evidence base for future GMS planning. It highlighted the need for integrated systems, relational care, and sustainable models. The findings will inform delivery planning for 2026 and beyond.

Introduction

This report summarises the engagement process undertaken during the review of General Medical Services (GMS). This review was mandated by the Integration Joint Board at their meeting in December 2024.

The report covers the steps included in the Service Review Framework, which forms the foundation on which the GMS review was built. Engagement with stakeholders is a critical and pivotal part of that review process.

The GMS review and associated engagement activities were undertaken in 3 phases.

- **Defining the scope** - between January and June 2025
- **Workshop-based planning** - June to September 2025
- **Testing and thinking** - October to December 2025

The final phase of the review - Analysis and Delivery planning, will take place between January and March 2026.

The aim of the engagement was to ensure that people who access or deliver General Medical Services had the opportunity to share their knowledge and experience. The information they initially shared, informed the direction of the review of GMS in Dumfries and Galloway.

The engagement

All feedback received during the engagement periods had been thematically analysed using secure Large Language Model : Artificial Intelligence. AI can make mistakes, therefore all outputs were reviewed and sense-checked by members of the GMS Review Team. This ensured factual accuracy, consistency, and alignment with the evidence base.

This also ensured the results, including emerging themes, were identified without bias and that there were no identifiable patient or staff details included.

Process

The [National Standards for Community Engagement](#) (2005, updated 2015) and [Planning with People](#) (updated 2024) have provided crucial guidance for the planning, monitoring and evaluation of the GMS review.

Engagement activities in relation to the review benefitted from the oversight of the Dumfries and Galloway Consultation and Engagement Working Group. This group's membership reflects local and national participation, engagement and consultation knowledge and expertise. It is led by the Dumfries and

Galloway Health and Social Care, Communication and Engagement Manager and includes support and oversight from Healthcare Improvement Scotland's Engagement Advisor – Service Change (West).

The group provided feedback, guidance and support including links to stakeholders in protected characteristic group that had previously been hard to reach. As a result of this support the engagement activities and stakeholder groups grew in both attendance and diversity as the review went on.

Opportunities to engage were available to people across Dumfries and Galloway, including the public, all sectors of the health and social care (particularly primary care), statutory partners, independent sector and third sector organisations.

Support to engage was received from third sector and statutory sector partners to ensure stakeholders from a wide range of communities and communities of interest were able to participate.

Accessible Easy Read resources were available at all sessions. Online and in-person options were available, to meet group's and individual people's needs.

Methodology

Engaging with people across the region was challenging as the whole population is potentially impacted by any changes to GMS and the engagement team was relatively small.

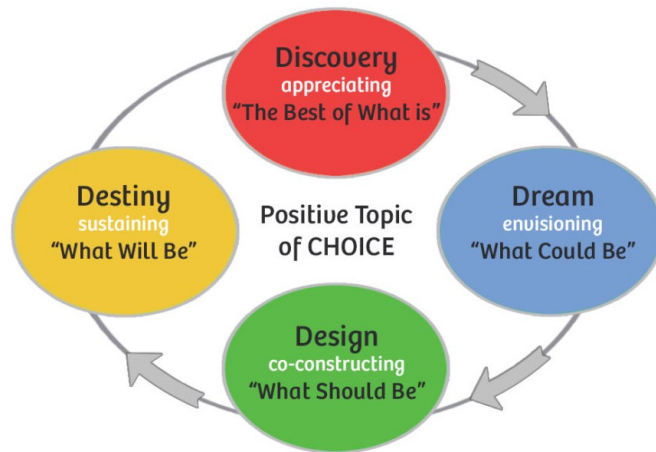
Early in the Review planning process stakeholder mapping took place, and a full stakeholder matrix was created. Subsequently, a series of Stakeholder Matrices were created, with one for each stakeholder group. These indicated where each group would be involved in each phase of the engagement process and ensured that no-one was excluded.

These were live documents and as each phase was completed and reviewed, where any gaps were identified, new contacts were added. This ensured groups whose voices are seldom heard, were included. The final full list of stakeholders and map of in person engagement events is included in

Appendix A

An **Appreciative Enquiry Approach** was used. This ensured that stakeholder groups could be involved in planning and co-designing how delivery against each aspect of the scope should be done.

Appreciative Enquiry follows the cycle of actions below. This approach embeds the principles of **Equity, Integration and Sustainability**.



To maximise population coverage, multiple methodologies were used to encourage as wide a demographic as possible to engage. These included

- Using electronic tools (such as MSTeams for online presentations and workshops, emails, social media posts, QR codes and weblinks to access online questionnaires)
- by phone
- in writing (hard copy documents were available at events and by post on request)
- in person workshops – delivered by the Project Team (a diverse group of experienced and knowledgeable staff that were able to record information from stakeholders and answer any questions).

Locality wide Practice Learning Time (PLT) sessions were planned and delivered with input from Primary Care leads and the wider project team. This enabled GP Practice Teams to fully engage without impacting on patient care.

This was the first time PLT had been done post-Covid. It was a massive undertaking and required a huge commitment from both the NHS board and individual GP Practices. Without the commitment of significant time and resources from multiple teams including the Primary Care Team and Out of Hours Team it could not have happened. This was very much appreciated by all those involved in the review.

Equality forms were available at all events and shared electronically with stakeholders that shared their contact details. The numbers of completed forms was low, but does show significant levels of diversity among those stakeholders that did complete them. The demographic information gathered from attendees has been included in **Appendix B**.

Phase 1

Initial questions focused on gathering information from 3 stakeholder groups

- **Those delivering GMS**

- **The public**
- **Wider stakeholders**

The questions were different for each group.

Those delivering GMS were asked

- what key challenges and opportunities they face
- how patient needs and expectations have changed
- how sustainable their practice is and what the main pressures are
- what the opportunities for improving workforce development and quality of service are
- how they work with other practices and how that could be improved
- how general practice could have a greater influence on wider healthcare planning
- how general practice could better support patients in managing their own health and well-being
- what changes or improvements would enable GMS to meet future healthcare needs and how GMS could contribute
- what role technology could play in improving service delivery within GMS

The public questions focused on stakeholder's experiences of **5** areas of service

- **Service Delivery**
- **Co-ordination**
- **Quality**
- **Workforce and Support**
- **Digital and Technology Integration**

People were asked questions about various topics under each of the above headings. *The survey is now closed but the questions can accessed on this [link](#)*

Questions for the **Wider stakeholders** focused on where improvements could be made in respect of

- Integration of services
- Technology
- Engagement and empowerment
- Promotion of health and well-being
- A vision for the future

Outcome – Phase 1

The responses enabled the project team (using the AI protocol and tool) to analyse the feedback responses.

Following the appropriate level of data interrogation and checks, **6 themes** were consistently identified. They were

- **Service Delivery**
- **Workforce**
- **Digital**
- **Data**
- **Premises**
- **Quality**

These themes have been invaluable in helping plan Phase 2 and have been the foundation for going into greater detail with stakeholders.

The survey is now closed but the questions can be accessed on this [link](#)

Phase 2

Feedback in this phase came from a series of **8** workshops held in each of the four localities (Annandale and Eskdale, Nithsdale, Stewartry, and Wigtownshire) plus a separate workshop for wider stakeholders.

Workshops involved GP and Practice Teams, the public and wider stakeholder engagement (in-person and online), as well as discussions with leadership and governance groups.

There were over **300** people at these sessions, the majority of those being people who work in Primary Care/GP Practice staff.

Levels of attendance/engagement was consistently excellent from GP Practices across the region (**265**). Public (**30**) and wider stakeholders (**11**) attendance was comparatively poor during this phase. That said, the public that did attend, appeared to be very health literate and provided great insight, knowledge and experience.

There was a significant amount of feedback gathered from these sessions. This was recorded by scribes at events rather than asking attendees to do it themselves, which was the initial plan. This was quickly amended following feedback from stakeholders and although having sufficient scribes at sessions was resource intensive, it proved a very valuable and necessary change.

Following the agreed AI protocol, all information was 'cleaned' 3 times by different members of the project team and Business Support colleagues. This ensured that no identifiable information such as names, locations or conditions were included in the data. After this process the information was entered into

the AI system and analysed using a complex series of prompts which were tested and approved by the GMS Project Team prior to use.

Finally rigorous checking for accuracy and relevance took place and a series of thematic analyses were produced for each geographical area, each stakeholder group and ultimately for all areas and stakeholders as one.

Outcomes – Phase 2

Two main themes that emerged from the consolidated thematic analysis of the feedback from this phase. They describe both the core problem and the potential solution - if the issues were resolved. The themes identified were

- **system fragmentation undermining sustainability and equity**
- **balancing human connection with digital dependency**

Suggested actions included

- clearer access routes
- stronger team-based working
- interoperable digital and data systems
- fit-for-purpose premises
- realistic quality frameworks
- sustainable workforce models

Subsequently the GMS Review Team worked together to develop a Draft Consolidated Action Framework grouped by four time horizons. This contained

- **Immediate Actions** (already underway or ready to proceed)
- **Horizon 1 - Priority Actions** (18 months to 3 years)
- **Horizon 2 - Strategic Objectives** (3 – 5 years)
- **Horizon 3 - Draft Vision** (5 –10 years)

These findings and draft actions formed the foundation for Phase 3 of the GMS Review Engagement and Delivery Planning. This evidences a clear bridge from engagement evidence to implementation. This analysis was shared with stakeholders following the engagement principle of '**you said, we did**'.

A full explanation of these themes and associated draft actions is contained in the 'Phase 2 GMS Consolidated Analysis' document - available on request.

Phase 3

Evidence in this phase came from a series of **25** engagement events comprising of targeted outreach, drop-in sessions at community venues, external group meetings, and virtual meetings in each of the four localities (Annandale and Eskdale, Nithsdale, Stewartry, and Wigtonshire).

Further sessions included Project Team attendance at various leadership and governance groups.

This was extremely resource intensive with between two and four staff at each session but resulted in a very good level of engagement across the region totalling **345** responses to the question ‘ What matters to you about the services at your GP Practice?’.

Inputs

- Information on how to engage was shared with people, groups and organisations (through emails, Facebook posts, partner web pages, posters, and through partner agencies email distribution lists)
- Online surveys were advertised and used for Phases 1 and 3
- Easy Read versions of the analysis of each phase were available along with the Plain English version – these were circulated electronically and available in hard copy at engagement sessions
- Protected characteristic groups were invited to engage
- Online engagement sessions were advertised
- Hard copy posters displayed (with QR codes on the poster)
- In person facilitated sessions/workshops were offered through partners across the region
- Cleaning of data – carried out by skilled and experienced staff. Time consuming and resource intensive but necessary
- Analysing of data – using AI was challenging, but much quicker and more effective than a manual analysis

Outputs

- **658** online surveys were completed during **Phase 1 and 3**
 - **306** people attended the in person workshops in **Phase 2**
 - **265 GP staff**
- **41 public and wider stakeholders**
- **34** engagement sessions (**28** in person, **6** hybrid) in **Phase 2 and 3**
- Multiple hybrid meetings with governance and other groups

The total number of people engaged with during the GMS review is not fully reflected in the number of responses. We are confident that numbers comfortably exceeded **1000**. This included

- Those who attendance governance groups where the review was presented
- Where organisations and GP practices were engaged with and chose to submit one response on behalf of the group

Outcomes – Phase 3

Key findings – what people said...

The feedback in Phase 3 reinforced and strengthened the two dominant emergent themes identified earlier in the review. This provided greater clarity on what really mattered to people and a sense of urgency to deal with them

that was shared across communities, GP and practice teams, and system partners.

Participants repeatedly described

- Lack of joined up services
- inconsistent processes
- poor data flow
- significant variation across a range of issues

Fragmentation is experienced most acutely by those who are the most vulnerable.

In every stakeholder group across every locality, people emphasised the importance of face to face interactions and having consistent follow-up. This appears to be the core determinant of quality for most people.

Although digital and MDT models are welcomed, people did not want them to replace human connection/relationships with GP's or add additional layers of uncertainty. The engagement in this phase demonstrated that confidence rises sharply where staff communicate clearly, offer relational access, and provide continuity.

These themes continue to act as cross-cutting tests for **equity, integration, and sustainability** across the whole system.

What we have done

The feedback from the engagement activities in Phase 3 has influenced and supported the emerging vision and planning framework now being prepared for the Integration Joint Board.

Why some things that people raised were not included

We were unable to action some comments as they were not within the scope of the review.

These included comments about

- secondary care such as hospital waiting times, blood and other test results
- lack of health and social care services (not GP services) in specific areas of the region.

People were signposted to services/departments that could support them in exploring these issues.

Conclusions

The aim of the engagement was to ensure that people who access or deliver General Medical Services had the opportunity to share their knowledge and experience. The information they initially shared, informed the direction of the subsequent phases of the GMS Review in Dumfries and Galloway.

The assistance of AI to thematically analyse the feedback at all stages of the review made sure the methodology was consistent and unbiased.

Working with partners ensured engagement information was shared widely and consistently across a broad demographic.

The review accurately reflects people's knowledge and experiences of GP Services. It provides a solid evidence base for the planning of the future GMS across Dumfries and Galloway.

It has helped to identify

- areas for improvement
- what is already working well in different localities
- opportunities for learning, sharing skills and experience
- that there is a shared desire to have more face to face contact with patients.

Lessons learned

Involving people who have lived experience of delivering or accessing GP Services has been fundamental to carrying out a review that effectively meets all stakeholder's needs. This required a significant commitment to working in partnership with colleagues from different disciplines, as well as stakeholders and partners from all sectors. This has not been without its challenges as each discipline had conflicting priorities, pressures and resource issues to deal with. However, a great deal of flexibility, compromise and sharing of knowledge took place. This has built skills and relationships between teams.

The **Practice Learning Time** sessions were very resource intensive and logistically very difficult to co-ordinate. This was well worth the effort as they were invaluable in respect of;

- enabling GP practice staff to have their voices heard
- the project team getting access to the wealth of knowledge and experience that staff have

Good communication with people impacted (directly or indirectly) is crucial – builds relationships and trust. Providing regular updates from each phase of the engagement process let people know their time, knowledge and

experience was appreciated and that what they have told us has been used effectively.

Using AI is very useful but is only as good as the information and directions it is given. It cannot, and should not be trusted/expected to produce information without close supervision and checking.

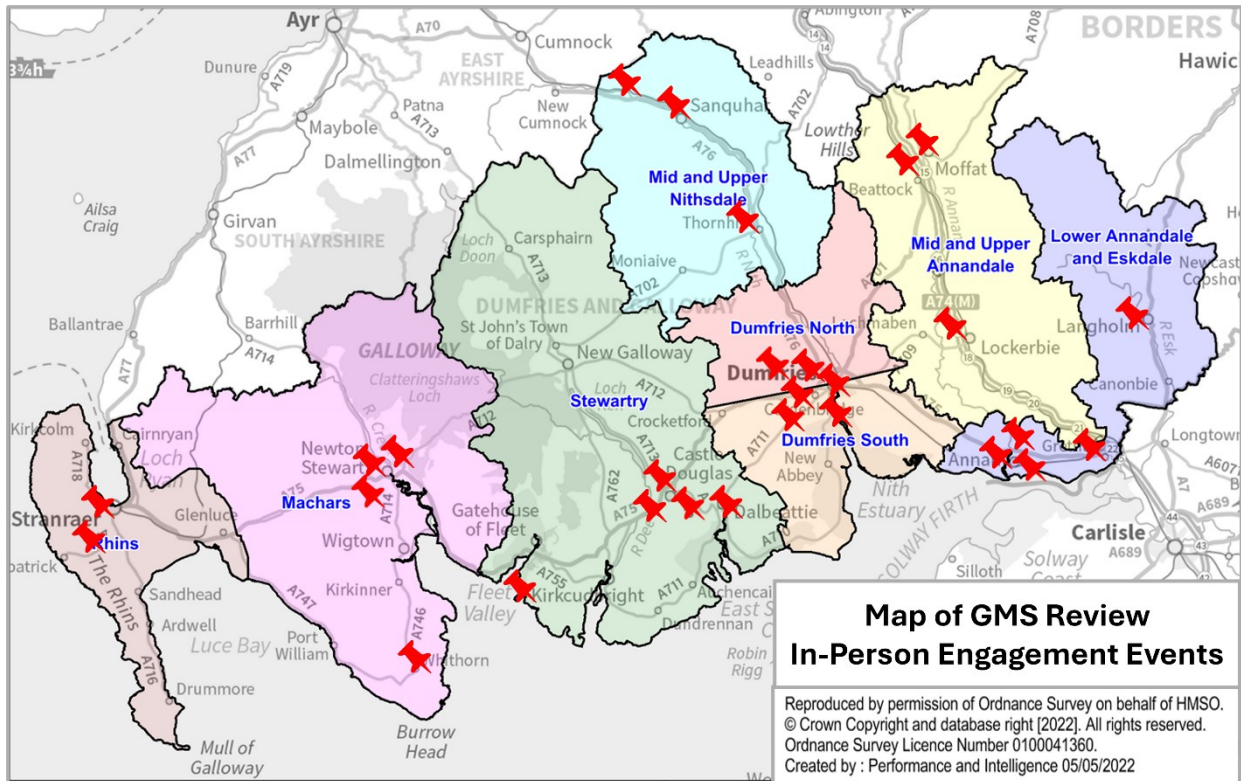
There were several challenges involved in the AI process, not least the large volume of data being processed and lack of 'memory' the AI has. This meant a lot of inconsistent results which meant significant repetition for the person inputting and requesting the analysis. This was challenging and very frustrating. However, it still saved a significant amount of time, enabling us to analyse a massive amount of data much more efficiently and effectively than doing so manually.

Appendix A – Full Stakeholder Matrix and Map of sessions

Stakeholder Group	Role in Engagement
Acute and Diagnostics	Interface with primary care, referral pathways
Administrative/Reception Teams	Access management, patient flow, triage
Advanced Nurse Practitioners (ANPs)	Extended clinical roles, urgent care
Allied Health Professionals (e.g. MSK physios, dietitians, podiatrists)	Multi-disciplinary care, early intervention
Care at Home providers	Impact of general practice access on in-home care and continuity
Care Homes	Interface with GPs for urgent and routine care; impact on resident access and MDT working
Carers' Organisations	Impact on unpaid carers, support needs
Child and Adolescent Mental Health Service	Impact on Young People
Community Councils	Local knowledge, geographic access
Community Health and Social Care	Locality-based integrated care
Community Link Workers	Social prescribing, community connections
Dental Services	Interface with general practice
Disabled People Support Organisations and Groups	Impact on disabled people including people who access services and those who provide services
Elected Members	Represent local democratic voice and community priorities; support public understanding of changes
GP Partners	Clinical leadership, contractor perspective
GP Sub-group Committee	Provide professional leadership input; shape clinical priorities and review direction
Health and Social Care Senior Leadership Group	Senior leadership oversight and strategic alignment of service planning
Healthcare Support Workers (HCSWs)	Direct patient support, workload insight
IJB	Governance body providing approval and direction for the review
IJB Strategic Planning, Delivery and Commissioning Committees	Oversight of strategic alignment and delivery assurance for commissioned services
LGBT+ support organisations and staff Network	Impact on the LGBT+ community
Mental Health Directorate	Integration, workload impact
Mental health Practitioners	Embedded roles within general practice, providing in-house mental health support

Multicultural and multi-faith groups and communities	Impact on people from different cultural, spiritual and ethnic backgrounds
Mid-life Adults (working age)	Access, prevention, and continuity
NHS Board	Governance oversight of NHS service priorities and alignment with national direction
Older Adults	Complex care needs, continuity of care
Optometry	Eye health, shared care opportunities
Participant Engagement Network (PEN)	Inclusion of seldom-heard voices
Patient and Public Representatives	Lived experience, access and equity
People with Lived Experience (e.g. long-term conditions, disability, mental health)	Service user insight, co-design
Performance and Resources Committee	Oversight of service delivery performance and alignment with financial and strategic objectives
Pharmacy (Community)	Public access to medicines, health promotion
Pharmacy (GP Practice-based)	Prescribing support, medication reviews, polypharmacy
Pharmacy Technicians	Medicines reconciliation, operational support
Planned Care Modernisation	Elective care redesign, GP interface
Poverty Action Group	Impact on people on low income
Practice Managers	Operational leadership, sustainability planning
Practice Nurses	Chronic disease management, patient care delivery
Primary Care Transformation Leads	Innovation, model testing and scaling
Project Group	Oversight, coordination, review
Public	Service users and community members providing lived experience and views on accessibility, continuity, and future priorities for general practice
Public Health	Population health, inequalities, data insight
Salaried GPs / Locums	Frontline delivery, flexible workforce insights
Strategic Planning Team	Programme design, facilitation, governance
Third Sector Dumfries and Galloway	Community-based support, co-production
University of the West of Scotland	Impact on students including those training to work in Health and Social Care
Unscheduled Care / Out-of-Hours	Urgent care interface, service design
Wider HSCP Management Teams	Strategic alignment, resource planning
Women and Children's Services	Family health, early years interface

Young Carers via DG Carers Centre	Impact on Young Carers
Youth (Young People's Forums, Schools)	Future service users, youth voice



Appendix B - Demographic breakdown

The demographic information collected throughout the engagement process relates only to the people who shared that information through the equality questionnaire. This is not necessarily representative of all the people who engaged, as the majority of people chose not to share this information.

Protected Characteristics

Age (83 people completed this section of the survey)

- 1 person (1%) was aged under 16
- 9 people (11%) were aged between 16 - 24
- 5 people (6%) were aged between 25 - 34
- 6 people (7%) were aged between 35 - 44
- 6 people (7%) were aged between 45 - 54
- 21 people (25%) were aged between 55 - 64
- 21 people (25%) were aged between 65 – 74
- 13 people (16%) were aged between 75 - 84
- 1 person (1%) was aged between 85+

Disability (83 people completed this section of the survey)

- 63 people (76%) identified as not being disabled
- 15 people (18%) identified as being disabled
- 5 people (6%) preferred not to say

Neurodivergence (80 people completed this section of the survey)

- 66 people (83 %) identified as not being neurodivergent
- 12 people (15%) identified as being neurodivergent
- 2 people (3%) preferred not to say

Unpaid Carer (80 people completed this section of the survey)

- 59 people (74%) identified as not being a Carer
- 20 people (25%) identified as being a Carer
- 1 person (1%) preferred not to say

Gender (81 people completed this section of the survey)

- 53 people (65%) identified as female
- 23 people (28%) identified as male
- 4 people (5%) preferred not to say
- 1 person (1%) identified as transgender

Sexual orientation (77 people completed this section of the survey)

- 60 people (78%) identified as being heterosexual/straight
- 2 people (3%) identified as bi-sexual
- 2 people (3%) identified as pansexual
- 4 people (5%) identified as being gay/lesbian
- 9 people (12%) preferred not to say

Religion (79 people completed this section of the survey)

- 24 people (30%) identified as not belonging to any religion
- 23 people (29%) identified as belonging to the Church of Scotland
- 18 people (23%) preferred not to say
- 9 people (11%) identified as belonging to the Roman Catholic faith
- 4 person (5%) identified as belonging to another Christian faith
- 1 person (1%) identified as belonging to the Humanist faith

Ethnicity (80 people completed this section of the survey)

- 54 people (68%) identified as white Scottish
- 11 people (14%) identified as white British
- 9 people (11%) identified as white English
- 2 people (3%) identified as white Northern Irish
- 2 people (3%) identified as white other
- 1 person (1%) identified as of mixed ethnic backgrounds
- 1 person (1%) objected to the question