Shaping the Future of General Medical Services (GMS)

GMS Review Final Thematic Analysis: Phases 1 – 3

December 2025

Executive Summary

This paper presents the consolidated thematic analysis from Phases One, Two and Three of the Dumfries and Galloway General Medical Services (GMS) Review. Spanning several months of structured evidence review and extensive engagement across practices, communities, multidisciplinary teams and system partners, the analysis provides the clearest and most comprehensive picture to date of how General Medical Services are experienced across the region, what pressures and strengths define the current system, and what must be addressed to secure sustainable, equitable and integrated care for the future.

The thematic analysis was developed using a combined human and large language model (LLM) approach. Qualitative material from all three phases - including workshop transcripts, locality sessions, surveys, written submissions and lived-experience narratives - was organised, coded and clustered using the LLM. The review team then iteratively checked, refined and validated the outputs to ensure accuracy, preserve local nuance and maintain alignment with the underpinning principles of equity, integration and sustainability. This approach enabled a high-volume, high-detail dataset to be handled consistently and transparently across the three phases of the review.

Across all phases, six themes remained stable and consistently reflected the lived experience of patients, the insights of professionals, and the practical realities of delivering primary care: Service Delivery, Workforce, Digital, Data, Premises and Quality. Each theme deepened in specificity as the review progressed, with early signals from Phase One validated and expanded through the system-wide evidence of Phase Two and the lived-experience detail of Phase Three. This stability across multiple rounds of engagement - each using different methods and question sets - provides strong assurance that the thematic framework accurately reflects the core determinants of current system performance.

The thematic analysis shows striking consistency in what people value, what challenges they face, and what conditions enable safe, relational and effective general practice. Service delivery is characterised by significant variation in access, communication and follow-up, with continuity fragile and heavily dependent on workforce stability. Workforce emerges as the dominant structural constraint across the entire review, with fragility in GP, MDT and administrative capacity driving variation, reducing continuity, and shaping patient confidence.

Digital tools are experienced as helpful when optional and supported, but exclusionary or unsafe when they replace relational contact or operate inconsistently. Data systems and follow-up pathways are widely described as fragmented and unreliable, generating anxiety, duplication, risk and avoidable workload. Premises consistently influence dignity, privacy, accessibility and the practical ability to deliver modern multidisciplinary care. Quality - as defined by patients and professionals alike - is experienced relationally: through continuity, clarity, compassion and coordinated care.

Two powerful emergent themes appear across every phase of the review, regardless of geography, stakeholder group or engagement method. System fragmentation undermines safety, equity and sustainability, forcing patients to hold responsibility for coordination and increasing avoidable workload for professionals. Human connection - expressed through continuity, communication, compassion and being known - is the foundation of trust, perceived safety and high-quality care. These two themes provide the interpretive lens that explains why the six GMS themes behave as they do and why pressures persist across the system.

The cross-phase synthesis demonstrates a coherent trajectory of insight. Early concerns about variation, workforce fragility, digital exclusion, data gaps, privacy, travel burdens and interface failures were not only repeated but sharpened as the review progressed. Phase Two provided the system-level explanation for these patterns, while Phase Three added the personal, emotional and practical detail that brings clarity to where change is most urgently required. The combined evidence base is both extensive and unusually stable: nothing in later phases contradicts earlier findings; instead, each layer strengthens and deepens the conclusions.

This thematic analysis does not set out solutions or financial options. Its purpose is to present a rigorous, triangulated understanding of how general practice currently functions, what matters most to those who use and deliver it, and what conditions must change to secure equity, integration and sustainability. The findings provide the essential foundation for the next stage of the review: feasibility testing, development of the emerging vision and planning framework, and creation of the Year One Delivery Plan for consideration by the Integration Joint Board in March 2026.

Introduction

This paper presents the consolidated thematic analysis from Phases One, Two and Three of the Dumfries and Galloway General Medical Services (GMS) Review, undertaken between December 2024 and November 2025. The purpose of this analysis is to bring together the full breadth of evidence gathered across twelve months of engagement and insight to create a coherent, system-wide understanding of how General Medical Services are currently experienced and what changes are required to support a sustainable, equitable and integrated future model of care.

The thematic analysis in this paper has been supported by a large language model (LLM), which was used to organise, code and synthesise qualitative data from across all engagement phases. The LLM was applied as an analytical tool to identify patterns, clusters and recurring concepts within the dataset, with all outputs reviewed, challenged and refined by the review team to safeguard meaning, context and accuracy. This method ensured consistency across the three phases and allowed the analysis to reflect the full depth and breadth of what participants contributed

The review has been delivered through the local Service Review Framework (SRF), which has provided the process and structure for gathering evidence, exploring lived experience, understanding system pressures, and identifying the conditions that support or undermine safe and effective general practice. The SRF enabled the review to combine public insight, professional experience, system partner perspectives and baseline evidence into a single, triangulated assessment rather than siloed thematic snapshots.

Phase One (Discovery) surfaced the early signals of system pressure and identified the six core themes that have structured the entire review: Service Delivery, Workforce, Digital, Data, Premises and Quality. These themes reflected what patients, communities, clinicians and staff consistently described as the domains where variation, risk, inequity and opportunity were most evident. Early engagement highlighted concerns about access, continuity, privacy, travel, digital exclusion, workforce fragility, data reliability and communication across interfaces. These initial insights established the foundation for subsequent phases and provided the shared language through which the system made sense of its challenges and strengths.

Phase Two (Engagement and Synthesis) expanded and deepened this evidence base significantly. Through structured workshops, multidisciplinary and multi-agency engagement, locality sessions and partner discussions, Phase Two transformed the early signals of Phase One into a detailed, system-level understanding. It clarified how variation arises between practices, how workforce instability affects every other theme, how digital and data challenges interact, how premises constrain or enable care, and how communication and relational continuity shape perceptions of quality and safety. Crucially, Phase Two also revealed the Four Cs - Consistency, Continuity, Collaboration and Connection - as a clear, authentic and repeated pattern in what people believe good general practice should deliver.

Phase Three (Furthering the Conversation) completed the experiential picture by adding lived-experience richness and fine-grained locality detail. Through modular engagement focused on patient narratives and real-world examples, Phase Three sharpened understanding of how people experience access variation, digital exclusion, data gaps, privacy concerns, workforce turnover, travel demands and interface breakdowns. It reinforced the stability of the six themes and the universality

of the Four Cs across geographies and demographics, and clarified the emotional and practical impacts of fragmentation and inconsistency.

The sections that follow set out the approach used to synthesise evidence across all three phases, present thematic findings under each of the six key themes, describe the two emergent themes that cut across the entire review, and consolidate the cross-phase insight into a coherent system-wide interpretation of what must change. Together, these findings form the evidential basis for the next stage of the GMS Review, where feasibility testing and Delivery Planning will translate this thematic analysis into a structured implementation plan for the Integration Joint Board's consideration.

Thematic Analysis By Key Review Theme

Service Delivery

Across all three phases of the review, service delivery has emerged as the most consistently discussed and consistently pressured domain. The overarching pattern is one of extreme variation - between practices, within practices over time, and between different population groups - with consequences for access, continuity, confidence and equity. While strong relational models exist and are deeply valued, they are not experienced uniformly across the region.

Phase 1 Foundations

Early engagement in spring/summer 2024 surfaced the core determinants of service experience:

- the central importance of relational access
- the need for clarity on "what to expect" when contacting a practice
- frustration with repeated retelling of concerns
- early signals that triage systems were inconsistently understood
- strong dependency on the practice's staffing stability and communication style

Service delivery was already described as "brilliant when it works, bewildering when it doesn't," with rural communities particularly emphasising travel, transport and the difficulty judging when to contact a GP versus another service.

Phase 2 deepening of insight

The large multidisciplinary engagement (GPs, practice teams, public, wider partners, governance and leadership) provided a much more detailed system map of how service delivery operates in reality. Participants highlighted:

- structural variation between practices in appointment models, triage pathways, callback arrangements and follow-up responsibility

- access pressures created by workforce fragility, increasing complexity, and demand misalignment
- different interpretations of “on-the-day”, “urgent”, “routine” and “appropriate to see the GP”
- inconsistency in communication about capacity, delays, service adjustments and timeframes
- the heavy burden placed on patients to bridge gaps between primary care, community teams and secondary care

Phase 2 also revealed that where clear systems, stable MDTs and good communication exist, people reported confident, relational, proactive care. The contrast with practices experiencing disruption or staff turnover was stark and repeatedly emphasised.

Phase 3 lived-experience confirmation

Phase 3 brought intensely detailed, highly personal accounts mainly from public participants. These narratives confirmed - in depth - the systemic patterns already identified:

People described:

- long telephone queues at 8 am, often with appointments gone by the time they reach the front
- confusion and frustration with modern access routes, online forms, and inconsistent triage experiences
- uncertainty about who is responsible for follow-up, particularly after hospital contact
- feeling “bounced around” between reception, triage, ANPs, GPs and occasionally A&E
- being asked to repeatedly disclose private information at crowded receptions
- distress linked to lack of privacy in some premises, especially small rural buildings
- deeply positive experiences where staff knew them, triage was compassionate, and appointments were timely
- relief when communication was clear, proactive and honest about pressures

Phase 3 sharpened the relational contrast: service delivery feels safe and humane where connection, clarity and continuity are preserved - and feels fragmented where these are absent.

Integrated Interpretation

When triangulated, the three phases show a single, coherent picture:

- Service delivery is the frontline expression of the system.

Where continuity, clear communication and flexible relational access exist, the whole system functions well. Where they deteriorate, patients must compensate for system gaps.

- Variation is now the defining feature.
  People in one practice may describe excellent care, while others - sometimes only a few miles away - experience severe access barriers and confusion.

- Equity is directly tested by current models.
  Those least able to navigate digital or telephone systems, those with complex needs, and those relying on public transport face the highest hurdles.

- Integration breaks down at points of transition.
  Interfaces between GP services, hospital teams, diagnostic services and community teams remain a persistent source of risk, repetition and frustration.

- Sustainability depends on stabilising service delivery foundations.
  Without more consistent access models, clearer communication standards, and better-supported MDTs, pressure will continue to cycle back into the system in avoidable ways.

Across Phases 1, 2 and 3, the message is unambiguous: the region delivers excellent general practice - but not consistently, and not predictably. Stabilising, standardising and strengthening core elements of service delivery is essential to equity, integration and sustainability across Dumfries and Galloway.

Workforce

Workforce has consistently emerged as the dominant system constraint across all phases of the review. Capacity, continuity, role clarity, and stability are the foundations of general practice, and all three phases show the same pattern: where the workforce is stable and communication is strong, care feels safe, relational and proactive. Where it is fragile or fragmented, experiences deteriorate sharply.

Phase 1 foundations

Early engagement highlighted that workforce pressures were already undermining key aspects of service delivery. Participants described:

- frequent turnover of GPs and locums
- difficulty accessing the same clinician twice
- uncertainty about who was responsible for follow-up
- variation in MDT roles across practices
- concerns about burnout and the emotional load placed on staff
- a growing sense from the public that “staff are doing their best in a system under strain”

Phase 1 established that continuity and stability were the most important determinants of confidence in care.

Phase 2 system-wide detail

The larger, multi-group engagement in Phase 2 exposed the deeper structural workforce issues shaping the region:

GPs and practice teams described:

- high clinical complexity and rising demand
- fragmented rotas and limited full-time GP availability
- heavy reliance on locums and short-term cover
- pressure to triage, redirect or manage presentations that historically sat in other parts of the system
- lack of consistent supervision or support for MDT roles in some practices
- the emotional labour of managing distressed, frustrated or anxious patients
- the difficulty maintaining relational continuity under these conditions

Partners (AHPs, mental health, community teams, pharmacy, leadership) reported:

- limited visibility of each other's pressures
- inconsistent integration of MDT roles
- variation in who does what across practices
- frustration when patients were redirected without clarity or adequate information

Phase 2 participants repeatedly emphasised that workforce fragility was not only a capacity issue but a system alignment issue - unclear boundaries, inconsistent expectations and escalating demands across the interface.

Phase 3 lived experience confirmation

Public narratives brought sharp human detail to pressures already identified:

People described:

- inability to see the same GP twice, even for deteriorating or complex issues
- repeated retelling of history because different clinicians were involved each time
- anxiety about locum turnover and inconsistent decision-making
- strong appreciation for ANPs, pharmacists and nurses when supported and integrated
- concern when MDT roles felt interchangeable, rushed or poorly coordinated
- emotional impact when reception staff appeared overwhelmed, leading to abrupt or transactional interactions

- reassurance and trust when practices maintained stable teams and communicated openly about staffing

Phase 3 confirmed that continuity is not a luxury - it is the mechanism by which safety, confidence and relational care are maintained.

Integrated Interpretation

When triangulated, the three phases generate one clear conclusion:

- Workforce stability is the core determinant of system performance.
  Every other theme - access, digital, data, quality, premises - is shaped by whether the workforce is stable, supported and aligned.

- The region relies heavily on locums, short-term solutions and stretched MDTs.
  This undermines continuity and creates a cycle of reactive rather than proactive care.

- MDT roles are valued but inconsistently embedded.
  Where ANPs, pharmacists and nurses are well supported, people experience high-quality relational care. Where support or clarity is lacking, confidence deteriorates.

- Workforce fragility amplifies inequity.
  Those with long-term conditions, multimorbidity or complex social circumstances are most affected by inconsistent clinician contact.

- Sustainability depends on stabilising teams and strengthening role clarity.
  Burnout, vacancy pressures and unclear expectations across the interface risk overwhelming already fragile services.

Across the full engagement period, Workforce is the strongest structural driver of variation - and the single greatest determinant of whether people experience safe, relational, integrated and sustainable general practice.

Digital

Across all phases of the review, digital systems were consistently described as both an enabler and a barrier. Digital tools provide convenience, speed and clarity when they function well and when patients retain meaningful choice. They become exclusionary and unsafe when they replace relational contact, rely on unreliable connectivity, or introduce new inequalities.

Phase 1 foundations

The earliest engagement highlighted three core concerns:

- variable digital literacy across age groups

- unreliable broadband and mobile signal in many rural areas
- confusion about expectations (phone-first, apps, text replies, online forms)

Participants stressed that digital change must expand access, not replace traditional routes, and must not assume universal connectivity or confidence.

Phase 1 established the first principle: digital must be optional, not compulsory.

Phase 2 system-wide detail

With a broader and deeper engagement base, Phase 2 exposed the operational challenges more clearly:

People described:

- inconsistent use of online forms, text messaging, and Patient Hub across practices
- frustration with automated systems that timed out or logged them off unexpectedly
- inability to upload photos due to poor signal
- lack of clarity about which messages were legitimate, particularly for older adults
- the stress of “fast-response” systems where appointments are released online at fixed times
- anxiety when digital processes replaced the option to speak to someone
- appreciation for reliable online repeat prescribing systems
- value in asynchronous communication when it supplemented - not replaced - human contact

Clinicians and staff reported:

- increased workload generated by digital systems “shifting the queue” but not reducing it
- mismatch between digital triage capacity and in-house workforce
- digital tools generating demand that the practice could not always absorb
- frustration when data from digital systems did not integrate with patient records

Phase 2 strongly reinforced that digital is not a standalone theme - it interacts with workforce, access, continuity and data.

Phase 3 lived experience confirmation

Phase 3 brought sharper personal narratives from public participants:

People described:

- being unable to complete online forms due to poor connections and losing entire submissions
- confusion about mixed, inconsistent communication routes between practices
- receiving messages without context (“your prescription is ready” / “your appointment is cancelled”)
- anxiety when digital notification systems (e.g. callback queues) failed or cut off unexpectedly
- uncertainty about email/text authenticity and fear of scams
- relief when they could bypass digital systems to speak to someone directly
- appreciation for hybrid models where digital is offered as a choice and is backed up by clear, relational communication

Digital exclusion now appears not only as a connectivity issue, but as a confidence, clarity and trust issue.

Integrated Interpretation

Triangulating all three phases shows a unified, consistent picture:

- Digital is highly valued when it enhances convenience, reliability and transparency.
  It reinforces continuity and connection when people can choose how they make contact.

- Digital becomes a barrier when it replaces human contact or assumes universal capability.
  Older adults, disabled people, carers, people in poverty and those with rural connectivity issues experience the greatest disadvantage.

- Digital uptake is strongly shaped by workforce capacity.
  When staff lack time to respond, digital systems create false expectations and amplify frustration.

- Digital and data cannot be separated.
  Failures in follow-up, missing results, inconsistent messaging and conflicting instructions often stem from weak digital–data interoperability.

- Sustainability requires a hybrid, choice-based digital model.
  The strongest message across all phases is that digital should support relational general practice, not displace it.

Across the full review, Digital emerges as a cross-cutting determinant of equity, access, trust and system coherence - powerful when optional and supported, harmful when compulsory or poorly integrated.

Data

Across all phases, data was described as one of the most fragile and frustrating parts of the system. People consistently reported uncertainty about test results, responsibility for follow-up, conflicting instructions between services, and repeated retelling of clinical history. These concerns intensified across the phases as participants expressed increasing confusion about where information sits, who owns it, and how safely it moves across the system.

Phase 1 foundations

Early engagement revealed a basic but widespread anxiety about lost results, lack of clarity on who follows up, and poor visibility of next steps. People described receiving messages without context ("satisfactory"), uncertainty about whether a GP or specialist was responsible, and a sense that they needed to "chase the system" to avoid being missed. Clinicians reported duplication, delays in receiving external results, and reliance on manual workarounds.

This established the first cross-phase pattern: data unreliability directly undermines trust.

Phase 2 system-wide detail

Phase 2 deepened this picture considerably.

People described:

- being told to contact hospital departments directly for results, even when results were visible to the practice
- conflicting advice on medication changes between specialists and GPs
- being asked to repeat blood tests because results had not transferred correctly
- receiving incomplete or unclear messages about abnormal findings
- repeated retelling of personal history due to unfamiliarity of locums with the clinical record
- anxiety that records felt "scattered" across systems, with no single accountable point
- concerns that external referrals and results (including those from out-of-region services) were delayed or not acted upon
- uncertainty about the status of investigations when communication between primary and secondary care was weak

Clinicians described:

- lack of interoperability between GP systems and hospital systems
- inefficient work patterns created by multiple inboxes and non-integrated portals

- dependence on administrative staff to chase other services on behalf of clinicians
- responsibility drift when multiple teams were involved but no one was clearly accountable

By Phase 2, data was consistently linked to safety risk, workflow disruption, and avoidable anxiety.

Phase 3 lived experience confirmation

Phase 3 brought sharper real-life examples, particularly around timeliness, responsibility and cross-service communication.

People described:

- delays in receiving urgent test results, leading to deterioration or emergency attendance
- being advised by one service to contact another, only to be redirected repeatedly
- confusion when digital messages regarding results arrived without explanation
- errors or omissions caused by inconsistent documentation by temporary or rotating staff
- distress when hospital-generated results did not reach the practice or were not acted upon
- fear that something serious could be missed due to fragmented systems
- frustration when cross-border results (particularly England–Scotland flows) failed to transfer reliably

These concerns were expressed with more emotion and urgency than in earlier phases, strengthening the conclusion that data gaps are experienced as care gaps.

Integrated Interpretation

Triangulating all phases produces a clear, coherent picture:

- Data fragmentation is one of the most significant system risks identified across the entire review.
  It undermines safety, continuity and confidence regardless of practice size or geography.

- Follow-up pathways are insufficiently clear to both patients and professionals.
  People do not know who is responsible, and clinicians often rely on workarounds.

- Interoperability failures directly erode equity.

Those least able to chase results - older adults, people with cognitive impairment, carers, and those with limited digital access - face disproportionate risk.

- Workflow inefficiencies are profound.
  Both clinical and administrative staff spend significant time compensating for gaps between systems.

- Sustainability requires system-level improvement, not practice-by-practice fixes.
  Across all phases, participants called for aligned systems, clearer accountability, and reliable information flows between primary care, secondary care, third sector partners, and external providers.

Data, more than any other theme, exposes how fragmentation across interfaces shapes patient experience, safety, equity and professional workload. The evidence across all three phases is unequivocal: reliable, accountable information flow is foundational to sustainable general medical services.

Premises

Across the review, premises have been described as far more than “buildings”. They shape whether care feels local, dignified, safe and accessible, and whether services can flex to new models of MDT working. The evidence across all three phases shows that premises constraints and opportunities are central to how people experience general practice, particularly in rural and remote communities.

Phase 1 foundations

In Phase 1, participants began to surface core concerns and expectations about premises:

- the importance of having a local place to go, especially in rural areas
- anxiety about the future of small practices and local facilities
- concerns about privacy in small, open waiting rooms where conversations can be overheard
- physical access challenges, including parking, ramps, doorways and internal layout
- the perceived underuse of some community and cottage hospital spaces
- the impact of travel distance and cost when care is centralised or relocated

Phase 1 established that premises are not neutral infrastructure. They are closely linked to identity, trust and a sense of being served locally.

Phase 2 system-wide detail

Phase 2 added sharper system-level insight from GP teams, staff, partners and communities.

People and professionals described:

- cramped, outdated premises that limit the ability to host MDT clinics or new roles
- consulting rooms opening directly into waiting areas, compromising confidentiality and dignity
- waiting rooms that are too small or poorly designed to protect privacy or manage distressed patients
- premises that are difficult to navigate for people with mobility, sensory or cognitive impairments
- pressures created when growing populations and complexity outstrip the physical capacity of existing buildings
- underutilised clinical space in some local facilities and cottage hospitals that could potentially support more localised care
- challenges delivering modern digital or hybrid models where buildings lack reliable space, wiring, or infrastructure

Rural stakeholders emphasised:

- long travel distances for relatively short appointments when services are centralised
- the cumulative burden of repeated trips for tests, reviews and follow-up
- the importance of visible, local health presence as a marker of system commitment to their communities

By the end of Phase 2, premises were clearly framed as a key enabler or constraint for every other theme - service delivery, workforce, digital, data and quality.

Phase 3 lived experience confirmation

Phase 3 brought more detailed personal accounts, especially from rural and remote communities.

People described:

- waiting rooms where conversations at reception can be heard by everyone, making it difficult to discuss sensitive issues
- embarrassment and distress at having to repeat symptoms in earshot of others
- consulting rooms that open directly onto public spaces, with no buffer for privacy or decompression
- difficulty finding parking close enough to the building, particularly for people with mobility problems or caring responsibilities

- long journeys by car or public transport for brief appointments, sometimes across poor roads and in bad weather
- the emotional and financial impact of travel, especially for those on low incomes or without access to a car
- positive experiences where premises felt calm, accessible, welcoming and well laid out, with clear signage and enough space

Some participants also reflected on the symbolic importance of premises: the presence or loss of local facilities was experienced as a signal of how much their community “matters” to the wider system.

Integrated Interpretation

Triangulating evidence from all three phases produces a clear, consistent picture:

- Premises are core to equity.
  The location, design and capacity of buildings determine who can realistically access care, how often and at what cost. Those with mobility issues, caring responsibilities, low income or poor transport options are most affected when services move or space is constrained.

- Premises shape dignity, privacy and emotional safety.
  Layout, soundproofing, waiting areas and reception design all influence whether people feel able to disclose sensitive information, particularly in small communities.

- Premises are a practical constraint on modern MDT working.
  Even when workforce funding is available, space limitations can prevent practices from hosting the wider team or running new types of clinics.

- Premises decisions send a powerful message about commitment to local communities.
  The retention, repurposing or loss of local facilities is experienced not just as a logistical change but as a statement about priorities and value.

- Sustainability planning must bring premises into the centre of the conversation.
  Energy efficiency, co-location with other services, use of cottage hospitals, and flexible clinic models all sit at the intersection of premises, workforce and service delivery.

Across the review, premises emerge as a key structural determinant of whether general medical services feel local, accessible and dignified - and whether the system can safely deliver the hybrid, team-based models required for future sustainability.

Quality

Across the review, quality has consistently been defined not as a set of technical outputs, but as the lived experience of safe, relational, coordinated care. Every phase - from early exploratory insight in Phase 1, to structured system evidence in Phase 2, to deep lived-experience accounts in Phase 3 - confirms that quality in general practice is inseparable from continuity, clarity, communication, and the ability of staff to work as one coherent team.

Phase 1 foundations

Phase 1 established the core dimensions of quality from the perspective of residents, patients, carers, community organisations and practice teams:

- the importance of being known by a clinician
- confidence that the person you speak to "understands your story" and can carry it forward
- a desire for clear, compassionate communication that does not feel rushed or transactional
- early concerns about variation in safety - missed follow-ups, unclear responsibility, and fragmented referrals
- repeated emphasis on the difference made by relational continuity for people living with long-term conditions, multimorbidity or complex social needs
- worry that stretched workforce capacity was already beginning to dilute quality

Phase 1 consistently framed quality as relational, not procedural.

Phase 2 system-wide detail

Phase 2 expanded this into a more precise picture across the system.

People and partners described:

- significant variation in clinical continuity between practices, with some offering stable teams and others relying heavily on short-term or rotating clinicians
- risk created by inconsistent communication - including unclear medication advice, mixed messages between primary and secondary care, and delays in relaying results
- instances where lack of familiarity with a patient's history led to repeated retelling, missed nuance, or missed clinical cues
- examples of excellent MDT-delivered care where GPs, ANPs, pharmacists and nurses worked seamlessly, contrasted with situations where MDT roles were poorly integrated or insufficiently supervised
- the cumulative impact of limited time and capacity, with clinicians reporting they were often unable to provide proactive, holistic reviews
- the emotional toll on patients when interactions felt rushed, impersonal or inconsistent

Phase 2 also highlighted examples of very high-quality care - stable teams, relational access, good communication, continuity across roles, proactive support - demonstrating that quality is achievable and visible where workforce, premises and data systems are aligned.

Phase 3 lived-experience confirmation

Phase 3 deepened the narrative detail and sharpened the contrasts.

People described:

- strong appreciation for clinicians who listened, remembered their history, and created a sense of safety, especially for mental health, chronic pain and complex multimorbidity
- distress when encounters felt transactional, unfamiliar or hurried, leaving people uncertain about next steps
- loss of trust when follow-up was unclear or inconsistent, particularly after acute deterioration or medication changes
- relief when practices provided clear explanations, proactive contact, and human connection despite pressure
- inconsistency in communication between GPs, ANPs, hospital teams and out-of-hours services, leading to mixed messages and confusion about responsibility
- the impact of clinician turnover on quality - not only clinically, but emotionally and psychologically
- the difference made by a single clinician or receptionist who went “above and beyond”, which was often described as restoring dignity and confidence

Phase 3 reaffirms that quality is experienced moment-to-moment, in relationship, clarity and reliability - not in organisational diagrams.

Integrated Interpretation

Triangulating Phases 1, 2 and 3 produces a strong, consistent set of messages:

- Quality is fundamentally relational.
  People define quality through being known, listened to, remembered and supported. Technical competence matters, but relational competence determines whether care feels safe.

- Continuity underpins perceived safety.
  When patients repeatedly see different clinicians, quality slips - histories are repeated, nuance is lost and people feel responsible for holding their own clinical narrative.

- Communication is the most visible signal of quality.
  Clear explanations, shared understanding of roles, consistent medication advice and proactive follow-up all strongly correlate with trust.

- Quality varies with workforce stability and MDT cohesion.
  Where teams are stable and well-integrated, quality is high. Where workforce is fragile or MDT roles lack support and supervision, quality is inconsistent.

- Fragmented interfaces erode quality.
  Patients face confusion and risk when communication breaks down between GP, hospital, community and OOH services.

- Quality is not an abstract ideal - it is lived.
  People judge quality based on whether they feel safe, understood and supported, and whether the system works as a connected whole around them.

Across the review, quality emerges as a relational, continuity-driven, communication-centred experience. High-quality care is visible and achievable - but fragile - and depends on the interaction of workforce stability, coherent systems, and the ability of clinicians to form ongoing relationships with the people they care for.

Emergent Themes

Across all three phases of the GMS review, two powerful cross-cutting themes have emerged with remarkable consistency. These themes were not predefined by the review - they were generated repeatedly by participants themselves in every phase, locality, group and engagement format. When triangulated, they form the connective tissue that explains why the six GMS themes behave as they do, and why equity, integration and sustainability remain under pressure.

1. System Fragmentation Undermines Equity, Safety and Sustainability

What Phase 1 surfaced

In Phase 1, people across Dumfries and Galloway described a system that felt disjointed and difficult to navigate.

Early patterns included:

- unclear responsibility between GP, community teams and hospital services
- patients holding their own stories because records and communication were inconsistent
- gaps between triage, appointments, follow-up and secondary care
- rural residents experiencing repeated travel and duplication
- early worries that fragmentation was “building in” inequity

This established fragmentation as a foundational pressure - one affecting access, confidence and fairness.

What Phase 2 added

Phase 2 broadened the picture with system-level detail from GP teams, hospital clinicians, third sector partners and community organisations.

Participants described:

- contradictory medication advice between specialists and GPs
- test results visible in one part of the system but not actioned in another
- repeated retelling of history because clinicians did not share a common record
- different triage and escalation arrangements in each practice
- frustration from partners who “didn’t know where general practice starts and ends anymore”
- risks created when patient responsibility blurred between settings

Phase 2 confirmed that fragmentation is not just inconvenience - it is a safety and capacity issue.

What Phase 3 confirmed

Phase 3 provided lived examples of the human cost of fragmentation:

- people bounced between services with no clarity about who was responsible
- families chasing results that were already visible somewhere in the system
- deterioration missed because there was no coordinated follow-up
- older and rural residents describing exhaustion from holding the burden of coordination
- mixed messages about medication and chronic disease management
- people attending A&E because they could not secure GP review in time

Far from softening, the evidence sharpened:

- fragmentation forces patients to do the work of the system, widening inequity and eroding confidence.
- Integrated interpretation

Across all phases, fragmentation directly undermines

- **Equity** - those with least capacity to chase or navigate are disadvantaged.
- **Integration** - boundaries blur, responsibility leaks, and duplication increases.
- **Sustainability** - inefficiency spreads risk back into workforce and access pressures.

A consistent message from the full evidence base is that coherence is as important as capacity.

Where the system joins up, people feel safe.

Where it doesn't, people carry the cost.

2. Human Connection is the Foundation of Trusted, High-Quality Care

What Phase 1 surfaced

Phase 1 made clear that quality was defined by relational experience:

- being known
- being listened to
- being remembered
- having a clinician who understands the journey
- feeling respected rather than rushed

People repeatedly linked safety, trust and satisfaction directly to human connection.

What Phase 2 added

Phase 2 revealed how human connection interacts with system pressures:

- continuity collapses when workforce is unstable
- MDT value increases when roles are integrated, communicated and understood
- communication quality signals clinical quality - clear advice equals trust
- patients experience relational care as a buffer against pressure

Staff also emphasised that relational work is what keeps morale alive.

What Phase 3 confirmed

Phase 3 reinforced, in personal and emotional language, that human connection is the anchor of quality:

- relief when a clinician took time to understand context
- trust restored when someone remembered a past conversation
- distress when encounters felt rushed, anonymous or inconsistent
- gratitude for receptionists and MDT staff who offered compassion and steadiness
- a strong sense that relational contact is protective, especially during deterioration

Participants across rural and town settings made clear that connection is not a "nice to have" - it is a determinant of safety.

Integrated interpretation

Across all phases:

- Consistency of relational experience matters more than the model.
- Continuity is the mechanism through which human connection is maintained.
- Collaboration strengthens relational care when teams function as one.
- Connection is repeatedly described as the difference between care feeling safe or unsafe.

The evidence across the phases is unambiguous:

Relational care is the heart of quality and the single strongest predictor of trust in general practice.

Overall Consolidation of Emergent Themes

Across the entire engagement period, the two emergent themes act as the structural explanation for the six GMS themes:

- Where the system fragments, access fails, continuity collapses, data becomes unreliable, digital becomes exclusionary, premises become barriers, and quality deteriorates.
- Where human connection is supported - through continuity, stable teams, clear communication, and integrated roles - every theme improves.

These emergent themes provide the deep interpretive lens for the review and underpin the forthcoming feasibility testing and delivery planning.

Cross-Phase Synthesis

Across the full 12 months of engagement, three clear patterns emerge:

1. early signals in Phase 1 were validated and strengthened in Phase 2;
2. Phase 3 sharpened those insights with lived-experience precision; and
3. the combined evidence now forms a coherent and highly stable picture of what matters most, what is breaking down, and what is needed to create sustainable general medical services in Dumfries and Galloway.

1. Early signals (Phase 1) were not only confirmed but amplified

Phase 1 surfaced foundational pressures - variation in access, fragility of workforce continuity, concerns about privacy, travel burdens, digital exclusion, and uncertainty around data follow-up.

Crucially, nothing in the later phases contradicted these early signals.

Instead, the themes that participants raised at the very start became more detailed, more specific, and more clearly connected to the principles of equity, integration and sustainability.

2. Phase 2 transformed early insight into structured system-level understanding

Phase 2 added the infrastructure:

- detailed accounts from GP teams and MDT staff
- system partner perspectives
- locality-specific nuance
- comparative evidence across practices
- deeper articulation of risks, gaps and opportunities

This phase confirmed that the pressures identified by the public were mirrored internally across the workforce and system - strengthening the legitimacy and consistency of the themes.

3. Phase 3 completed the experiential picture, sharpening the "real-world" view

Phase 3 added depth rather than novelty.

It brought forward:

- lived descriptions of how fragmentation plays out
- how people experience access variation from day to day
- emotional and practical impacts of travel, privacy, digital systems and inconsistencies
- the protective effect of relational care
- the cumulative toll when continuity collapses

Phase 3 did not generate new themes - instead, it strengthened the evidence base, validated the earlier phases, and provided the narrative detail needed for delivery planning.

4. The six themes remained stable and robust across all phases

Service Delivery, Workforce, Digital, Data, Premises and Quality did not shift.

Their content deepened - but their relevance never wavered.

This level of stability across three distinct phases (with different question sets and different engagement methods) provides strong assurance that the review's thematic structure is both accurate and durable.

5. The underpinning principles were reinforced, not invented

Equity, Integration and Sustainability consistently emerged as the organising lens through which people made sense of their experiences.

These principles were not imposed by the review; they were drawn from what people and partners emphasised repeatedly.

Phase 3 confirmed again that these principles act as the test of whether general medical services feel fair, coherent and viable.

6. The Four Cs were validated as an authentic cross-phase pattern

Consistency, Continuity, Collaboration and Connection - first clearly visible when Phase 2 was synthesised - were strongly reinforced in Phase 3.

They appear naturally in descriptions of what works, what fails, and what people want.

They act as the bridge between experience and design: the conditions under which the six themes function well.

7. The trajectory of insight is clear and coherent

When the three phases are read together:

- Phase 1 generated the early map.
- Phase 2 provided the structure and system explanation.
- Phase 3 added depth, specificity and emotional legitimacy.

Nothing contradicts across the phases.

Instead, each layer strengthens the next, producing a consolidated evidence base that is unusually stable for a 12-month, region-wide review.

8. The consolidated picture is one of variation as the core risk - and coherence as the core solution

Taken as a whole, the evidence shows:

- Quality is highest where teams are stable, communication is clear, digital supports rather than replaces, data flows, premises enable privacy and dignity, and roles are integrated.
- Quality deteriorates where these conditions fail - not because people do not care, but because the system does not join up around them.

The consolidated thematic analysis therefore provides the essential foundation for the review's next stage: testing feasibility, shaping the emerging vision, and developing the first delivery plan for IJB consideration.

What This Means For The Review - Bridging Analysis

Across Phases 1, 2 and 3, the picture is now unequivocal. The experiences of patients, communities, clinicians and partners converge on a single, consistent conclusion: the current system contains the components of high-quality general medical services, but these components do not reliably connect, and therefore cannot reliably deliver. Access, continuity, communication, coordination, digital

pathways, data flow and premises all operate well in some places and poorly in others. The result is widening variation, strained equity, fragile integration and increasing pressure on sustainability across the region.

The evidence shows that people do not experience “themes” in isolation. Access is shaped by digital design. Digital design is shaped by workforce capacity. Workforce capacity is shaped by premises. Data flow shapes safety, confidence and continuity. Continuity shapes quality. And the pressure points are intensified or softened depending on how well different parts of the system work together. This interdependence explains why the same issues appear repeatedly, across all three phases, regardless of setting, geography or stakeholder group.

Participants continually returned to the same core expectations of general practice: to be able to get through to their practice, to receive a timely and understandable response, to be cared for by people who know their history, to avoid repeating the same story, to trust that results will be followed up, and to navigate a joined-up system that does not place additional burden on them when they are unwell. Where these expectations were met, confidence was high. Where they were not, people compensated for system gaps, often at personal cost, and often in ways that ultimately reduce sustainability.

For clinicians and practice teams, the evidence reflects the cumulative strain of delivering care in a system where demand, complexity and administrative burden have risen faster than the resilience and stability of the workforce. Stability in MDT roles, protected time for coordination, clear communication channels, and manageable digital and data processes all emerged as essential for safe, sustainable practice. These factors are not “nice to have”; they are enablers of equity, integration and sustainability.

For partners and system leaders, the analysis reinforces the same message: GMS does not sit apart from the wider health and social care system. It is deeply shaped by interfaces with hospital services, community teams, mental health, third-sector services, digital infrastructure and data systems. The variation observed in general practice is therefore a system issue, not an individual practice failing. Participants emphasised that the system will only improve at the pace that interfaces improve.

Against this backdrop, the thematic analysis provides a clear evidential mandate for the next stage of the review. The six themes and the three underpinning principles have held across all phases. The Four Cs - Consistency, Continuity, Collaboration and Connection - emerged unprompted across stakeholder groups and geographies, reinforcing their legitimacy as the organising framework for planning. Taken together, the evidence points toward a strategic future where sustainability depends on reducing variation, strengthening interfaces, stabilising teams, implementing hybrid access models, improving digital and data flow, and enabling practices to work more collaboratively across clusters and localities.

Crucially, the evidence does not prescribe specific delivery models at this stage. What it does provide is a rigorous, triangulated foundation from which feasibility testing, options analysis and delivery planning can proceed with confidence. The combined insights now enable the development of the emerging vision and planning framework, the high-level outcomes and the strategic objectives that will be brought to the Integration Joint Board for consideration.

This bridging analysis therefore marks the transition point in the review. The work of Phase 3 completes the experiential evidence base. The task now is to move from understanding to shaping: to use this consolidated thematic analysis to define the future direction, test collaborative approaches with practices and clusters, and build the year one delivery plan that will take the system from variability toward coherence, from fragmentation toward integration, and from fragility toward sustainability.

Conclusion

The consolidated thematic analysis of Phases One, Two and Three presents a coherent, evidence-rich account of how General Medical Services are currently experienced across Dumfries and Galloway. Despite the breadth of engagement, the consistency of what people, professionals and partners described is striking. Variation - in access, continuity, communication, integration and experience - is the defining pattern across the system. Where relational contact, stability, collaboration and clear communication are present, confidence and trust are high. Where they are absent, people encounter avoidable barriers, fragmented pathways and confusion about responsibility.

The six themes remain the correct organising structure for understanding system performance. Service delivery is hampered by inconsistent access routes and variable communication. Workforce fragility continues to shape every other theme, with loss of continuity a major concern for both the public and professionals. Digital tools are valued only when they enhance relational working and choice, and become exclusionary when they replace human contact or demand capabilities not everyone has. Data challenges undermine safety, trust and integration, with patients frequently compensating for gaps in follow-up and information-flow. Premises constrain the ability of teams to deliver private, accessible, modern MDT care. Quality, above all, is experienced through relationships, continuity, clarity and compassion - and collapses when these elements break down.

Across all phases, the underpinning principles of Equity, Integration and Sustainability are repeatedly validated by lived experience and professional feedback. Equity is compromised by unwarranted variation and digital, geographic and socio-economic barriers. Integration falters where interfaces are unclear or unsupported. Sustainability is challenged by workforce instability, estate limitations and demand outstripping capacity. At the same time, the Four Cs - Consistency, Continuity, Collaboration and Connection - emerge not as design choices but as the

essential system conditions required for safe, trusted, person-centred general practice.

Most importantly, this analysis provides the experiential foundation for the next stage of the Review. It clarifies what must be protected, what must be redesigned and where the greatest gains can be made for patients, practices and the wider system. The findings point towards a future model that is more collaborative, more consistent, more relational and better connected. They also provide the anchor for the emerging vision and planning framework that will now be tested through feasibility work and developed into the Year One Delivery Plan for IJB consideration.

Taken together, the evidence demonstrates both the scale of challenge and the opportunity for meaningful, system-wide improvement. The task ahead is not to re-state problems already understood, but to translate these insights into a coherent, realistic and collectively owned plan that strengthens equity, rebuilds continuity, supports integration and creates the conditions for sustainable general practice for the next decade and beyond.

These consolidated findings now provide the evidence-base that will directly inform the transition phase, where the emerging vision will be tested, refined and developed into the Year One Delivery Plan for submission to the Integration Joint Board in March 2026.