Public Health Scotland

Evaluation of the National Mission on Drug Deaths

Feasibility and added value of an ongoing national lived experience feedback survey in Scotland

17 March 2026

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Abbreviations used in this report

ADRS	Alcohol and Drug Recovery Service
ADP	Alcohol and Drug Partnership
DAISy	Drugs and Alcohol Information System
HACE	Health and Care Experience Survey
HIS	Healthcare Improvement Scotland
LGBTQ+	Lesbian, gay, bisexual, transgender, queer and other identities
MAT	Medication-assisted treatment
PHS	Public Health Scotland
SDF	Scottish Drugs Forum

Acknowledgements

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At a glance

What we did

In 2024 we ran a national survey of individuals with experience of using drugs, about the support available to them. This survey was part of the **PHS evaluation of the National Drug Deaths Mission**. We **published the survey findings in July 2025**.

Between July and October 2025, we spoke to 20 stakeholders about their involvement in developing and carrying out the survey, and their use of the survey findings. The PHS Evaluation Team also reflected on their own experience of running the survey. This report presents the findings from those consultations and reflections. It aims to help inform whether an ongoing national lived experience feedback survey should be set up in Scotland, and what it should look like.

What we found

Looking back – lessons from the 2024 pilot

Stakeholders saw the 2024 lived experience survey as impactful. The survey was reported to have provided actionable insights at national and local level, and at strategic and service delivery level. The survey was seen as filling a gap. Its perceived key strength was combining an experiential and quantitative approach. It captures individuals' perspectives on their own lived experience but does so at scale. Being able to present data as percentages was seen as helping the evidence-into-action process.

Stakeholders agreed that commissioning SDF peer research interviewers to reach individuals, and support them to complete the survey, had worked well. They also felt that word-of-mouth approaches to recruitment, and the use of incentives, had made a positive difference.

Looking ahead – potential future iterations of the survey

Topics to include

Stakeholders felt that some questions from the 2024 survey should remain unchanged, to enable tracking of change in survey responses over time. This included the 2024 survey questions modelled on the **Health and Care Experience Survey (HACE)**. There were no suggestions of questions that could be dropped, but there were multiple ideas for new questions. These included further detail on engagement with recovery and community groups and on the quality of the support available. However, stakeholders acknowledged the relatively short length of the 2024 questionnaire as a key strength. They recognised that including too many questions might mean that less people would complete a future survey.

Population groups to target

Some stakeholders felt it was important to achieve (statistical) representativeness (i.e. the sample being representative of the whole population) in future iterations of the survey. Most stakeholders did not, however, think of representativeness in this statistical sense. They framed representativeness as ensuring that a full range of perspectives is available, on a full range of topics. Stakeholders' main ask was for future iterations of the survey to reach more individuals not in contact with services.

Survey governance and practical arrangements

Stakeholders saw clear potential in using the peer research interviewer approach going forward. They also saw an opportunity to have more inclusive lived experience involvement in survey leadership and governance.

Stakeholders felt that PHS was a suitable lead for an ongoing national lived experience survey. They pointed, for example, to PHS' in-house expertise in robust data analysis. Externally commissioning an ongoing survey was also raised as a possibility.

The 2024 pilot survey suggests that an ongoing national lived experience feedback survey would not remove the need for local lived experience engagement. A national survey means, however, that local lived experience findings would no longer need to be reported or synthesised nationally, as previously done as part of the **Medication-assisted treatment (MAT) standards benchmark reporting**. Local lived experience engagement can instead focus on its primary purpose: local quality improvement.

Maintaining clarity of purpose was seen as important, to avoid losing stakeholder buy-in over time. Connecting different iterations of the survey to specific policy developments was seen as one option to provide clarity of purpose.

What we recommend

Setting up an ongoing national lived experience survey would be complex. Further discussion will be needed on the details of different options for going forward, any risks relating to those options, and resourcing. However, based on stakeholder consultations to date, it is possible to recommend that:

1. An ongoing national lived experience survey should be set up in Scotland, filling the data gap that exists in relation to quantified experiential data.

2. The survey should also reach those not in contact with local Alcohol and Drug Recovery Services (ADRS) and capture a full range of perspectives. However, if feasible, the subgroup of individuals engaging with ADRS should be based on a statistically representative sample. Findings that are not based on a statistically representative sample should be clearly marked as such.

3. There should be a recurring module covering the ADRS support experience, maintaining (at least some of) the same questions across survey iterations. The primary purpose of this module would be to present robust, representative data about the ADRS support experience nationally, and any change over time.

4. The purpose of other modules would be determined separately for each iteration of the survey but is likely to be more exploratory. Modules could focus

on a specific initiative (e.g. the MAT standards), service (e.g. primary care), support need (e.g. mental health) or subgroup (e.g. those in recovery).

5. Future iterations of the survey should be co-produced with individuals with experience of using drugs (or alcohol), Alcohol and Drug Partnerships (ADPs), and other key stakeholders.

6. PHS should run the next one or two iterations of the survey, building on its collaboration with SDF. Once the ongoing national survey is well established, external commissioning could be considered.

Introduction

About this report

This report is part of a series of PHS publications relating to the **PHS evaluation of the Scottish Government National Drug Deaths Mission**.

The purpose of this report is to help inform a decision on whether to set up an ongoing national survey of individuals with experience of using drugs in Scotland.

About the 2024 PHS lived experience survey

This report follows on from the **July 2025 PHS Evaluation of the National Mission on Drug Deaths: Lived experience survey** report. That publication presented the findings of a pilot survey of individuals with experience of using drugs, on the support available to them. The survey took place in 2024; 494 individuals took part.

The 2024 survey was set up, in part, as a feasibility study. Stakeholders had highlighted a proliferation of feedback exercises targeting individuals with experience of using drugs. This included, for example, the lived experience engagement done locally by ADPs as part of their reporting on the **MAT standards**. An initial mapping exercise (see page 84 of the **July 2025 report**) had shown that existing data collection exercises left key data gaps. One of the 2024 study aims was to develop a more coordinated approach to collecting lived experience feedback in Scotland.

The feasibility study aimed to explore:

- Whether it is feasible to collect feedback on the support available to individuals with experience of using drugs, in a robust (i.e. at scale) but cost-efficient way, and avoiding a disproportionate burden on local statutory services or ADPs.

- Whether it is feasible to develop a single coordinated national lived experience feedback mechanism which serves multiple purposes: (i) informing local quality improvement, (ii) tracking implementation of national initiatives, and (iii) monitoring whether the support experience is improving over time.

Methodology

This report is based on:

- Semi-structured interviews and group discussions with selected key stakeholders including individuals with experience of using drugs, ADPs, the Scottish Government, third sector partners, academics, Healthcare Improvement Scotland (HIS) and PHS staff. A total of 20 individuals were consulted between July and October 2025. More detail on those interviews and group discussions is presented in **Appendix 1**.

- The stakeholder consultation and option analysis undertaken in 2022 as part of the development of the 2024 pilot survey, and ongoing informal stakeholder feedback about the survey received since 2022. This includes inputs from the National Mission Evaluation Advisory Group. The 2022 stakeholder consultation and option analysis are described in the **July 2025 PHS report**.

- The PHS Evaluation Team's own reflections based on their role in designing, implementing and reporting on the survey.

Findings

We first look back, reporting on lessons learnt from the 2024 pilot survey. We then look ahead at stakeholders' suggestions for possible future iterations of the survey.

Looking back – lesson from the 2024 pilot survey

This section summarises lessons learnt from the 2024 survey. It covers:

- Impact – how the survey findings have been used. This section starts with a brief **reminder about the key topic areas in the survey questionnaire**.

- Feedback on the approach taken to collect data. This section starts with a brief **reminder about the data collection methods used**.

Impact – how the survey findings have been used

Reminder about the key topic areas in the survey questionnaire

The 2024 survey questionnaire included questions about:

- Treatment and care options respondents had received in the last 12 months, and any options they would have liked to access but were unable to
- Their experience of trying to access support, including from ADRS
- Whether they felt that the support they were receiving from services now was better or worse than two years ago.

Enabling lived experience influence on policy and practice

Overall, stakeholders saw the survey as impactful. The greatest benefit they reported was that the survey had provided a platform for people with experience of using drugs to be heard, and a mechanism through which their experiences could influence policy and practice, both at a national and local level.

Actionable insights at national level

At national level, policymakers said the data had identified issues that could help inform future direction of focus or funding. One example quoted was the survey finding that women were more likely to report unmet peer support needs. Other survey findings highlighted as helpful include the data on how the support experience had changed over time and the data on the extent to which support from third sector, recovery and community groups was valued by individuals.

Actionable insights at local level

At local level, stakeholders reported that the data had helped them to better understand collective challenges Scotland-wide, as well as what works for who. The latter was seen as useful in helping them further develop local person-centred approaches. Local stakeholders pointed to data on the support experience from local ADRS as particularly helpful. One ADP stakeholder confirmed those data would directly feed into service development. Local areas also demonstrated enthusiasm to disseminate findings across staff groups to encourage learning and development. The data had also been used to provide some 'good news' to local staff, as the survey findings also reflect some more positive views about the support experience.

Added value of having quantitative experiential data

Overall, stakeholders suggested that the survey filled a gap and provided intelligence that was not covered by other data sources. The scale of the survey (494 responses), and the use of mostly closed questions, was seen as allowing quantification of experiential data. The data could be presented as percentages (for example, 47% of respondents report an unmet need for mental health support).

This quantitative approach to experiential evidence was seen as more effective in encouraging the evidence-into-action process than other lived experience feedback exercises. Qualitative studies, although providing depth and nuance, were seen as possibly less representative of the overall picture of service engagement, and thus possibly less compelling. The survey was seen as offering something unique in combining a quantitative and experiential data approach.

Confirming perspectives and offering new insights

Survey findings both confirmed perspectives (e.g. that unmet needs around mental health were a priority for individuals with experience of using drugs) and identified new areas that required attention (e.g. differences in naloxone uptake by sex).

Feedback on the approach taken to collect data

Reminder about responses received and data collection methods used

A total of 494 responses were received over a six-month period (July to December 2024). Responses were received from most, but not all ADP areas (27 out of 30).

The most cost-efficient methods of data collection, self-completion or completion with the support of a friend or family member, only secured 67 responses (14% of survey responses). Only 8 responses (just less than 2%) were secured with the support of a worker of the local ADRS.

The bulk of survey responses (85%) were entered online with the help of an SDF peer research interviewer. Funding was provided to SDF to cover incentives for participants, and training and support for the peer researchers.

Added value of working with peer researchers and word-of-mouth recruitment

Stakeholders all agreed that the peer researcher approach had worked well. Some highlighted it as a critical strength of the survey. The face-to-face approach was seen as important, given the sensitivity of the topic area. The positive rapport between peer researchers and participants was cited as key to high survey completion rates.

Stakeholders reflected that the use of word-of-mouth recruitment had been effective. This was seen as particularly the case in gaining access to individuals who were not engaged with services. The use of incentives was also suggested to have had a strong positive effect on recruitment.

Looking ahead – suggestions for future survey iterations

This section reports stakeholders' views about possible future iterations of the survey. This includes suggestions on:

- Topics to include in future iterations on the survey
- Population groups to target
- Survey governance and practical arrangements.

Topics to include

Selected key questions from the 2024 survey should remain

Stakeholders acknowledged the added value of several of the lines of questioning in the 2024 survey (see **Impact of the data**). They felt that some questions should remain unchanged, to enable tracking of change over time. The questions modelled on the **HACE** questionnaire were given as an example in this respect. They include, for example, questions asking participants about their experience the last time they accessed their local ADRS.

Multiple ideas for new lines of questioning to include

There were no suggestions of questions that could be dropped, but multiple ideas for additional lines of questioning. A full list of suggestions is included in **Table 1**.

Table 1. Possible topics to include

Topic	Sub-topic
Wider substance use	• Non-opioid use: alcohol use, polydrug use, cocaine use • Individuals' experience of the changing drug landscape and their understanding of risks • Have people received advice about new substances (e.g. **RADAR** alerts) and are they following this advice
Mental health	• More detail relating to different mental health conditions • Awareness of and access to mental health services • Experience of referral to mental health • Experience of mental health crisis support • Follow-up to reasoning behind quality-of-life answers • Wider wellbeing needs
General service engagement	• Awareness and use of the **Charter of Rights** • Waiting times, in combination with choice of support • Relationships with services, especially key workers • Consistency, quality and frequency of key worker contact • Access to services for other conditions (e.g. cancer)

Topic	Sub-topic
General service engagement (continued)	• Experiences of new initiatives (e.g. **The Thistle**) • Experiences around advocacy • Barriers to uptake of blood-borne virus testing
Recovery journeys	• All parts of the recovery journey, including longer term • Quality of life (e.g. housing, employability, social networks) • More in-depth focus on residential rehab
Non-statutory support	• Experiences with, and impact of, support networks • Impacts of community-based (formal and informal) support
Further subgroup analysis, especially for unmet needs	• Rural vs. urban • Further exploration of differences based on sex • Families • Homelessness • LGBTQ+ communities
Representation	• Whether individuals feel their voice is being heard • Do individuals feel part of the decision-making process? • Why do people take part in the survey?

Key suggestions included more detailed exploration of:

- Access to support, in particular third sector, recovery and community support
- The quality of the support experience
- The relationship people have with their support providers.

Suggestions for additional lines of questioning were often made because stakeholders wanted to further explore findings from existing intelligence gathering efforts. For example, one request for further information on the quality of the support experience was made against the backdrop of trying to contextualise local area progress reporting (i.e. MAT standards reporting). Stakeholders wanted quantitative experiential data to confirm or complement other existing quantitative service data.

Overall, there was a view that there were further areas of interest to be explored, and that the survey should develop iteratively over time to respond to trends in substance use and developments in the support offer. It was felt that this should be done in close consultation with stakeholders, including individuals with lived experience.

Recognition of the risk of including too many different lines of questioning

Despite offering multiple suggestions for additional lines of questioning, stakeholders recognised that a key strength of the survey was its relatively short length. They acknowledged that including too many questions might mean that less people would complete it. The peer researchers who were consulted felt, however, that there was some scope to extend the survey questionnaire without impacting on engagement.

Population groups to target

While stakeholders were positive about the total number of participants and the diversity of subgroups reached, there were some suggestions for improvement.

Reaching more individuals not in contact with services

The most common suggestion was to include more individuals who were not in contact with services. Recovery journeys were identified as varied and complex and not fully represented by only those in contact with services. Some stakeholders felt that two different surveys might be needed, one targeting those in contact with services and one targeting those not in contact with services.

Recruiting those not in contact with services was recognised as challenging. However, peer researchers consulted suggested that, given enough time, the word-of-mouth approach would allow recruiting more people not in contact with services.

Other population groups or settings to target

Other specific populations to potentially target were suggested in the context of particular settings (e.g. prisons) or demographic characteristics (e.g. ethnic minority or young people participants). Some felt that future surveys could include specific recruitment targets for some of these groups. Others believed that separate qualitative research studies were better placed to capture the views of those groups.

As mentioned in **Topics to include**, there were suggestions to widen the survey to also include those with experience of problem alcohol use.

Different interpretations of the 'representativeness' of the survey findings

Representativeness in the context of a national survey typically means that the views of those surveyed can be taken to reflect the views of the target population as a whole – in more technical terms, it allows for population inference. Representativeness in this sense can only be achieved if the composition of the target population is known. The survey can then sample individuals based on key characteristics of the target population (e.g. proportion of men vs. women) and use weighting in the analysis to correct any over- or underrepresentation in the sample. This was not the case in the 2024 survey.

Some stakeholders felt that it was important to achieve this kind of (statistical) representativeness in future iterations of the survey. They saw this as the only valid route to achieving sufficiently robust data for the purpose of monitoring trends or evaluating the support experience Scotland-wide.

In the context of substance use in Scotland, this kind of representativeness can only be achieved by limiting the target population to those who are accessing ADRS, as the composition of this group is known. The **PHS Drugs and Alcohol Information System (DAISy)** provides information about those accessing ADRS. We do not have sufficient information about the wider population of people with (past or present) experience of using drugs in Scotland.

Any survey also targeting those not in contact with services cannot be representative in this traditional sense. There is thus a trade-off between the wish to reach more people not in contact with services and the wish to achieve (statistical) representativeness.

Most stakeholders did not, however, think of representativeness in this statistical sense. They framed representativeness instead in terms of inclusion. They wanted to ensure that a full range of perspectives is available, on a full range of topics – rather than referring to the technical ability to infer full population conclusions from a sample. They interpreted representativeness as inclusion of individuals based on:

- demographic characteristics (e.g. gender, age and ethnicity)
- an individual's position in the recovery journey
- their position along the pathway of service engagement
- patterns in their substance(s) use
- the extent of exposure to harm.

Stakeholders believed that, due to challenges in recruiting disadvantaged individuals on a sensitive topic, a perfect representative sample was unlikely to ever be reached. However, they felt that conversations on representativeness were important. They suggested that it would be helpful to clarify a definition of representativeness, and an approach to recruitment that would meet agreed requirements.

Any findings based on a different definition of representativeness, would need to be clearly marked as not statistically representative – as was done in the 2024 survey.

Survey governance and practical arrangements

Frequency of a national lived experience survey

Stakeholders discussed the potential frequency of future iterations of a lived experience survey (e.g. yearly or every two years). They considered pragmatic resource factors such as cost and time. A yearly survey would allow more in-depth understanding of trends over time, and more responsive use of survey data, but would come at substantially higher resource costs. Higher costs were seen as potentially affecting sustainability. A yearly survey was also seen as resulting in greater risk of survey fatigue in target populations.

Ongoing involvement of SDF

Stakeholders acknowledged the added value of working with the SDF peer research interviewers and saw the potential in using this approach going forward. It was felt that some adjustments might be needed. Further training and support might be required to refine the approach or to accommodate change if, for example, specific populations were targeted, or other topics, such as alcohol use, were covered.

Some stakeholders reflected that other networks could be used for recruitment, for example local staff. Even if this had been less effective in the 2024 survey, for potential future iterations it was suggested that this could be revisited. It was felt that barriers to this approach could be explored, to further increase survey participation.

Ongoing close collaboration with local and national networks was seen as important to help reach individuals at all stages of recovery.

Lived experience involvement in survey governance

It was suggested that there was potentially a need to have more inclusive lived experience involvement in survey leadership and governance. Stakeholders felt further discussion was needed to understand how this might work in practice.

Support for PHS as lead organisation for a national lived experience survey

Stakeholders all suggested that PHS was a suitable lead for an ongoing national lived experience survey. They cited a range of factors including:

- robust governance processes at the organisation
- being at arm's length from stakeholders, in particular the Scottish Government
- having in-house expertise allowing for robust data analysis
- well-established relationships with key stakeholders, including local ADPs.

The role of HIS as provider of lived experience feedback was acknowledged but not commented on in detail. HIS colleagues consulted agreed that PHS was well-placed to lead on this work. Externally commissioning a national lived experience survey from an experienced survey research group was also raised as a possibility.

A better coordinated approach to collecting lived experience feedback

One aim of the 2024 feasibility study was to help contribute to a better coordinated approach to collecting lived experience feedback in Scotland (see **About the 2024 PHS lived experience survey**). This included the question whether a nationally managed lived experience feedback survey could sufficiently support local quality improvement, or whether locally run lived experience engagement is necessary.

The 2024 pilot survey results did not provide in-depth ADP-specific intelligence: 22 out of 30 ADP areas secured fewer than 20 responses[i]. For most ADP areas, the added value of the 2024 national survey lies in providing a better understanding of challenges Scotland-wide, as opposed to in-depth ADP-specific intelligence. The 2024 pilot seems to confirm that a national survey does not remove the need for local lived experience engagement.

However, stakeholders felt that local lived experience engagement is less effective in delivering sufficiently robust and actionable national intelligence. Its added value lies instead in supporting local improvement.

According to some, local areas should continue to undertake local lived experience engagement, but simply for their own improvement purposes. Reporting the detail of their local lived engagement feedback to the national level, as previously required in the context of reporting on MAT standards, was seen as less relevant going forward.

A nationally run lived experience feedback survey could then instead address national experiential data needs in a more robust, coordinated and efficient manner.

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[i] Nine of the 14 Health Board areas secured more than 20 responses.

Clarity of purpose

If the survey is to be repeated, multiple stakeholders, particularly in strategic roles, emphasised that a transparent statement of purpose would be vital. Without this there was a risk that a survey would lose focus and stakeholder buy-in over time. It was felt that it might otherwise be difficult to justify resource allocation on an ongoing basis.

One option suggested in this respect was to tie different iterations of the survey findings to specific policy developments. This would mean that impacts could be demonstrated to stakeholders, including survey participants. This could help mitigate potential survey fatigue. Among the suggested policy initiatives that could be linked to an ongoing survey were continuation of the **MAT standards implementation** and the National Collaborative and **Charter of Rights**.

Conclusions and recommendations

Conclusions

Is it possible to collect lived experience feedback in a robust and cost-efficient way?

- A national survey can reach a sufficiently large and diverse group of individuals with experience of using drugs to allow for meaningful analysis of the support available to them. The 2024 survey reached 494 individuals. Stakeholders confirm that the survey delivered actionable insights.
- It is not possible to achieve this reach without the support of dedicated (peer) researcher time to undertake proactive outreach and support individuals to complete the survey. Working only with self-completion or support from staff in local ADRS would be more cost-efficient but does not appear to be a viable option.

- Achieving a (statistically) representative sample starts from working with a target population of which the composition is known. This would mean only those individuals with experience of using drugs who are in contact with services. There is a trade-off between inclusivity (i.e. also including those not in contact with services) and the (statistical) robustness of survey findings.

Is it feasible to work with a single coordinated lived experience feedback mechanism?

- A single coordinated national data collection mechanism can serve multiple objectives: the 2024 survey results have been used to help inform national policy development, local quality improvement and the evaluation of the National Drug Deaths Mission.
- It is possible to work with a relatively short national survey and still capture a wide range of topics. There are, however, limits to the range of topics and depth of insight that can be achieved. A short single national lived experience survey cannot capture all the topics of interest identified by stakeholders.
- The 2024 survey results do not provide in-depth ADP-specific intelligence. A national survey does not remove the need for local lived experience engagement. A national lived experience feedback survey means, however, that local lived experience feedback no longer needs to be reported or synthesised nationally as previously done as part of **MAT standards benchmark reporting**. Local lived experience engagement can instead focus on its primary purpose: local quality improvement work.

Recommendations

Setting up an ongoing national lived experience survey would be complex. Further discussion will be required on the details of different options for going forward, any risks relating to those options, and resourcing. However, based on stakeholder consultations to date, it is possible to recommend that:

1. An ongoing national lived experience survey should be set up in Scotland, filling the data gap that exists in relation to quantified experiential data.

2. The survey should also reach those not in contact with local ADRS and capture a full range of perspectives. However, if feasible, the subgroup of individuals engaging with ADRS should be based on a statistically representative sample. Findings that are not based on a statistically representative sample should be clearly marked as such.

3. There should be a recurring module covering the ADRS support experience, maintaining (at least some of) the same questions across survey iterations. The primary purpose of this module would be to present robust, representative data about the ADRS support experience nationally, and any change over time.

4. The purpose of other modules would be determined separately for each iteration of the survey but is likely to be more exploratory. Modules could focus on a specific initiative (e.g. the MAT standards), service (e.g. primary care), support need (e.g. mental health) or subgroup (e.g. those in recovery).

5. Future iterations of the survey should be co-produced with individuals with experience of using drugs, ADPs, and other key stakeholders. This should include clarifying the target population (e.g. also including those with experience of problem alcohol use).

6. PHS should run the next one or two iterations of the survey, building on its collaboration with SDF. Once the ongoing national survey is well established, external commissioning could be considered.

Appendix 1. Semi-structured interviews and group discussion – methodology

A range of stakeholders involved in the development and dissemination of the survey, or engagement with the survey findings were consulted. Stakeholders included ADPs, the Scottish Government, PHS, third sector and recovery organisations, academics, HIS and those with lived and living experience of using drugs.

Three interviews, and nine group sessions were carried out between July and October 2025. Stakeholders who could not attend were invited to provide comments by email if they wished to do so. One stakeholder did this. More informal discussions were held with two additional stakeholders, based on a draft version of this report.

Consultation sessions were structured around key themes: participation burden; robustness of findings (including numbers reached and profile of participants); cost-efficiency; usefulness of the findings for different purposes (including local quality improvement, tracking of implementation and scope to monitor changes over time).

The consultation set out to address three questions:

- To what extent were the findings of the pilot lived and living experience survey useful and used by stakeholders?
- What worked well in the pilot survey and what can we learn from this process?
- If an ongoing national feedback mechanism is developed, what if any changes would need to be made, for example in relation to purpose, scope or process?

Note-takers worked with facilitators during consultations to record important parts of the discussion. Thematic analysis was carried out to identify the most common aspects of feedback, but also counterpoints, to capture the range of perspectives. NVivo software was used to organise themes emerging from consultation notes. Themes were sense-checked and reviewed by the three PHS Evaluation Team staff involved in the 2024 lived experience survey exercise and two other Evaluation Team colleagues not involved in the 2024 exercise.