

OVERVIEW ENGAGEMENT REPORT

WHAT MATTERS MOST: COMMISSIONING INTENTIONS

1. INTRODUCTION

This is an overview of what staff and the public believe should be prioritised across health and care services. An interim report was provided on 17 August and many of the messages about priorities remain, with variations in total amounts now that all research is complete. Responses to the commissioning intentions from voluntary and community organisations, members of the public and patient representatives add further detail and explanation of views. A full report on the findings including detailed demographic breakdowns is being prepared.

We have received a total of 3,343 responses to a survey which was conducted using three different approaches to ensure coverage across the communities of Kent and Medway – an ICB online survey, an independent high-street survey and an independent selected demographic sample survey. 533 of those who responded work in health and care and/or for an NHS organisation.

Method	Respondents	NHS/health/care workers
LAKE – demographic sample survey	1,098	76
EK360 – high-street survey	752	60
ICB - online survey	1,493	397
Total	3,343	533

In addition, we have received 33 responses to the draft commissioning intentions from provider organisations, partners, VCSEF organisations and members of the public.

The strongest overall message is that people want an NHS that is easier to access, better connected, more local where appropriate, more preventative and more responsive to individual circumstances.

The strongest priorities identified were:

- Easier access to GP appointments
- Shorter hospital waiting times
- Improving urgent and emergency care
- Better mental health support

When asked which areas they would most like the NHS to focus on improving over the coming year over 60 per cent of respondents told us that we should prioritise easier access to GPs.

There is also strong support for several elements of system development:

- 85 per cent support greater investment in preventing ill health.
- Over 90 per cent support urgent treatment centres focusing on urgent injuries and illnesses provided alternatives to A&E are strengthened.
- Over 70 per cent express some willingness to receive appropriate care closer to home.
- Nine in ten people are willing to have diagnostics such as scans and blood tests carried out at local centres away from major hospitals.
- Over 50 per cent want telephone, paper or face-to-face routes retained for people who need them.

However, the feedback introduces important conditions to all of this.

Respondents are not simply asking for services to be moved from hospitals into communities or from face-to-face to digital channels. They want those changes to be accompanied by sufficient workforce, capacity, continuity, communication, specialist support and clear ownership of the patient journey with open accountability and patient and public voice built into the changes.

2. STRATEGIC ALIGNMENT

- Commission the right services each year
- To ensure financial sustainability over three years
- Lead strategy and ensure commissioning levers deliver impact
- Develop into a high-performing commissioning organisation
- Renew our culture for long-term sustainability.

3. Demographics

Gender and age

The surveys heard from 2,114 females, 1,135 males with 64 preferring not to say. We were more likely to hear from older people when the total survey numbers were combined:

16-24	194
25-34	280
35-44	398
55-64	654
65-74	663

75+	564
Prefer not to say	72

Health status and caring responsibilities

39.6 per cent respondents identified as having a long-term physical or mental health condition/illness or a disability.

748 respondents, equivalent to 22.4 per cent of all 3,343 survey participants, were reported as having caring responsibilities or as being a carer.

Geography

Respondents reported from across each district in Kent and Medway. An estimation of total numbers across each district is as follows:

Ashford	223
Canterbury	323
Dartford	151
Dover	169
Folkestone and Hythe	206
Gravesham	177
Maidstone	279
Medway	433
Sevenoaks	153
Swale	251
Thanet	283
Tonbridge and Malling	215
Tunbridge Wells	303
None of the above	54

Ethnicity

Across the three surveys there were 3,028 White respondents (93 percent) and approximately 220 ethnic minority respondents (6.8 percent). A further 85 preferred not to say, and 10 had no recorded ethnicity answer.

4. Method collection

4.1 LAKE market research demographic sample survey

A demographically representative sample of 1,067 residents aged 16 and over was targeted for this research component. The final sample size of 1,098 means that the dataset has a maximum confidence level of +/-3 per cent (at a 95 per cent level of confidence).

All interviews were undertaken face to face with residents via door knocking.

Sampling was undertaken using Census Output Areas (COAs) as the primary sampling units. Within each authority area, COAs were ranked by the Index of Multiple Deprivation (IMD) to make sure that the target sample was representative by deprivation. COAs were then selected at random as sampling points but ensured a range of deprivation levels were included.

The number of sampling points selected was proportional to the interviewing target for each authority area. All addresses for each COA sampling point were made available to interviewers to approach for interview. Local authority level quotas were set to ensure the final sample reflected the Kent and Medway's population profile in terms of age, gender, working status and ethnicity (using Census 2021 data).

4.2 EK360 independent high street survey

Between the 23rd of July and the 11th of August, EK360 undertook a series of face-to-face engagement activities at locations within all districts of Kent and in Medway.

Engagement teams positioned themselves on high streets in urban areas or locations with high footfall in rural locations. The teams situated themselves in close proximity to each other to create a visual presence and proactively approached members of the public. Respondents were therefore a random selection of people who were in the location at the time and who agreed to stop and talk to the engagement teams.

Engagement teams used paper copies of the survey and completed the survey in conversation with members of the public. Data was entered into a secure web form for analysis. Engagement locations were:

- Deal town centre
- Dover town centre
- Tonbridge town centre
- Sheerness
- Sittingbourne
- Canterbury town centre
- Herne Bay

- Folkestone town centre
- New Romney
- West Malling
- Snodland
- Ashford town centre
- Tenterden
- Gravesend town centre
- Meopham
- Chatham high street
- Tunbridge Wells town centre
- Horsmonden
- Maidstone town centre
- Sevenoaks town centre
- Edenbridge
- Faversham high street
- Margate high street and Margate old town
- Dartford town centre
- Swanscombe
- Sandwich

4.3 ICB engagement approach and NHS channel performance

An online survey comprising more than 20 questions was promoted to Kent and Medway residents, and NHS staff across the system, through a coordinated mix of ICB channels.

A news release generated 885 views and secured coverage in *Healthcare Leader*. A *News for You* article received 1,500 views and generated 81 click-throughs to the survey. Organic (free) social posts reached a combined total of more than 28,000 individuals.

Promotion through multiple articles and reminders in the GP Update achieved a total of 2,099 views among primary care staff. Internal promotion on KAM generated more than 370 opens from ICB colleagues.

Wider stakeholder reach

To extend reach beyond NHS audiences, the survey was shared with:

- 201 parish councils
- 168 VCSE organisations
- 140 elected councillors at Kent and Medway councils
- 65 patient participation groups
- 28 Men's Sheds
- 25 large businesses
- 8 learning disability support organisations
- 2 chambers of commerce.

The communications and involvement toolkit was shared with communications teams at both Kent County Council and Medway Council, and communication colleagues at each of

the NHS provider trusts. All system partners including district councils were tagged in our social media posts.

Social media

The table below shows organic (non-paid) social media content published from 24 July to 28 August.

	Posts	Reach (total number of people who saw the post)	Views (total number of times our content appeared on someone's screen)
Facebook	10	10,629	17,656
Instagram	7	1,073	1,521
Next Door	3	16,446	Views not measured on this channel, but 20 comments received and logged.

Facebook posts: Tagged district councils, shared by local councils. Shared into local Facebook community groups.

Next Door – one post targeted communities in Medway, DGS and Folkestone.

Social media comments on our posts had similar themes: access to primary care, pressure on hospitals and how both relates to new housing being planned.

"There are too many people for the system to cope with, also a few years ago my Dr knew me, every time you see another Dr you either go through all your history or hope he has read your notes."

"Being able to actually see my GP!"

"Darent valley hospital needs help to keep up with the volume of new housing developments and people moving into the area. Staff do their best under difficult circumstances. Hospital capacity should reflect the population using it."

Paid advertising (stats as of the end of the campaign, 31 August)

Google Display Network

- Impressions: 1,740,043
- Clicks: 69,657
- Click through rate: 4 per cent

Facebook

- Impressions: 182,143
- People reached: 72,171
- Clicks: 2,505
- Click through rate: 1.38 per cent

- Engagement: 68 likes, 19 comments

Spotify

- Impressions: 108,853
- People reached: 58,184
- Clicks: 427
- Click through rate: 0.39 per cent

Overall, the paid advertising has delivered more than 2 million impressions to people within our target audience, resulting in over 72,000 visitors to our survey webpage.

5. Findings

5.1 Prevention and health inequalities

Support is strong for spending more on prevention, but lower when respondents are asked to support transferring money from other NHS services. When asked whether the NHS should spend more on prevention 79 per cent said yes. When asked whether money should be moved from other sources around 60 per cent said yes with 24 per cent unsure.

Staff responses were more mixed – in the ICB survey there was a higher proportion selecting “*don't know*” This suggests that although staff broadly support prevention, they are more cautious about how that investment should be funded and may be aware of the practical implications of diverting resources from existing services.

We asked people about whether NHS funding should be allocated across all areas or targeted towards communities with greater health needs.

There is no overwhelming resistance to targeted funding. Across the three surveys, more than four in ten respondents supported giving additional resources to communities with worse health outcomes, and in the EK360 face-to-face survey a clear majority favoured the “equity” option.

Many people still instinctively favour equal spending. The LAKE and ICB surveys both found around half of respondents preferred spending the same everywhere.

The overall picture is therefore not “equal spending only”, but rather acceptance that need should matter. Staff were even more supportive of a needs-based approach.

5.2 Elective, Maternity and Specialised Commissioning CMDT

Elective care

Over 40 per cent of those who answered the questions on elective choice selected travelling farther within Kent and Medway in return for earlier treatment.

A further 914 respondents (31.2 per cent) preferred treatment close to home even if that meant waiting longer, and 469 (16.0 per cent) said they could not travel farther and therefore needed local treatment.

There is substantial interest in offering earlier elective care elsewhere in Kent and Medway, but it should be an additional choice rather than the default pathway. Nearly half of respondents either preferred local care or reported being unable to travel farther.

Respondents are strongly supportive of simplifying referral and diagnostic pathways, but support becomes more conditional when proposals reduce face-to-face contact or traditional outpatient follow-up.

People appear highly willing to bypass an initial outpatient appointment and go directly to a diagnostic test where clinically appropriate.

There is very strong consensus that referral processes should be coordinated through a single, joined-up system rather than fragmented arrangements managed separately by individual services. Around 90 per cent agreed overall.

Maternity and neonatal care

Keeping mothers and babies safe is the leading priority. In all three reports, the leading priority was “Keeping mothers and babies safe”

LAKE: 371 respondents (33.8 per cent of those who answered the question).

EK360: 506 selections (572 respondents answered the question).

ICB report: 840 respondents (87 per cent of 966 respondents who answered the question).

Ensuring there are enough specialist staff during day and night and better support after birth also scored highly across respondents. Staff responses showed a similar concern with slightly more emphasis placed on continuity of care and postnatal support.

The EK360 researchers reported that many participants commented that safety of mothers and babies should be a given, that it should not be an option.

Fertility and specialised services

The strongest and most consistent message was that **treatments that worked well and fair access for everyone who meets the criteria** mattered most for future fertility services. Over 60 per cent of those who answered these questions ranked these as being the most important above shorter waiting times and good patient experience.

Commissioning recommendations:

- Make elective pathways faster and simpler while retaining safety, choice, fairness and access to specialist expertise.
- Use system-wide capacity where this improves waiting times, with an explicit equality and travel assessment.

- Any maternity configuration change should demonstrate sufficient specialist staffing, clinical expertise, safe escalation and the ability to respond to complications.
- Do not treat diagnosis, speed or location as the sole measure of quality; as fairness, effectiveness and experience are also important.

5.3 Urgent and Emergency Care, Discharge and Flow CMDT

Urgent and emergency care

Urgent and emergency care is a significant public priority: over 30 per cent selected it as one of their priorities for the next year. There is strong support for strengthening alternatives to A&E.

- Over 90 per cent support urgent treatment centres focusing on urgent injuries and illnesses provided alternatives to A&E are strengthened.

Qualitative responses told us that:

- Support for moving urgent care closer to home was conditional on clinically safe local alternatives being fully operational before services moved away from emergency departments.
- Respondents wanted transitions to include named accountability, safe handovers and clear communication with patients and families.
- Community services need enough workforce, infrastructure, funding and social-care capacity before taking on additional activity. People were concerned that existing hospital provision could be reduced before sustainable alternatives were established.
- “Closer to home” wasn’t considered the same as accessible. Travel time, public transport availability and affordability—particularly in rural and coastal communities—must inform service locations.
- Urgent-care pathways should include immediate mental-health assessment, addiction support, follow-up and safe handovers.
- Success shouldn’t be measured through reduced admissions alone. Respondents wanted monitoring of patient outcomes, service gaps, delayed escalation, repeat presentations and any additional burden placed on carers.

Overall: The evidence supports more local urgent treatment, but only where it provides a safe, accessible and properly resourced alternative—not simply a transfer of activity away from A&E.

Discharge and flow

Respondents have said the following are issues with discharge and flow:

- Late discharge decisions
- Delays with prescriptions and medicines
- Transport availability and family collection arrangements
- Lack of downstream capacity
- Social care pressures
- Poor coordination between teams
- Responsibility mustn't be transferred to unpaid carers without identifying and supporting them.
- Safe discharge and aftercare should be a core requirement, with timely discharge information, clear responsibility for follow-up and prompt referrals to onward support.
- "Supported referrals" were recommended: the receiving service should be contacted directly and confirm the next step with the patient, rather than leaving patients to navigate services themselves.
- Better integration is needed between hospitals, community services, social care, housing and VCSE organisations. Respondents warned that fragmented services allow people—particularly those with complex needs—to fall through gaps.

The feedback therefore describes discharge as both a capacity problem and a process problem. Respondents described late discharge decisions, delays with prescriptions and medicines, transport and family collection arrangements, lack of downstream capacity, social care pressures and poor coordination between teams.

For example:

"In my experience of four recent hospital stays in six months... discharging of patients, which is often left quite late, and prescriptions also delay patients getting home."

A staff respondent similarly called for patients to be *"safely and quickly discharged from hospital"* with rehabilitation and care packages in place rather than waiting in an acute bed.

Commissioning recommendations

- Strengthen alternatives to emergency departments alongside primary and community capacity.
- Start discharge planning earlier and improve coordination of medicines, transport and family/carer communication.
- Strengthen community and reablement capacity and the integration with social care.
- Treat urgent care, discharge and flow as one whole-system pathway rather than separate organisational problems.
- Redesigning the hospital front door without strengthening other services risks moving pressure rather than reducing it.

5.4 Mental Health, Learning Disability and Autism CMDT

Mental health

The strongest message from the public and staff response is prevention and early intervention rather than a system focused mainly on crisis response.

Provide help earlier, before people reach crisis. This was the leading mental-health improvement in the surveys, narrowly ahead of faster access to services.

Make advice and treatment faster to access. Respondents highlighted long waits, high referral thresholds and people receiving help only after their needs become severe.

Improve referral pathways and ongoing support. People wanted more referral options, fairer access and continued help rather than discharge after limited contact.

Make mainstream services more accessible to autistic people and people with ADHD. This includes staff understanding communication needs, making reasonable adjustments and offering clear, neurodivergent-friendly communication.

Strengthen support around the individual. Respondents valued support for carers and families, schools and colleges, talking therapies, loneliness and social isolation, and community services.

Autism and ADHD

Respondents do not want diagnosis to be the sole gateway to meaningful support.

Views were almost evenly divided between prioritising a quicker diagnosis and receiving needs-based help regardless of diagnosis, suggesting both are important and one shouldn't replace the other.

Around half of the total respondents prioritise practical help and support while people wait, even if diagnosis takes longer.

Learning disability and complex communication needs

Feedback highlights the need for more accessible ongoing medical support for people with learning disabilities, particularly where communication needs are complex.

Neurodiversity and mainstream services

Better NHS staff understanding of autism, PDA and ADHD, with appropriate staff training. Neurodivergent-friendly clinics and sensory awareness.

The feedback suggests that improving autism and ADHD services is not only about diagnosis; NHS services need to become more accessible and flexible for everyone.

Commissioning recommendations:

- Strengthen prevention, early intervention and community support before crisis.
- Provide meaningful support while people wait for Autism/ADHD assessment or diagnosis.
- Improve referral pathways and reduce administrative burden where possible.
- Build accessibility for learning disability and neurodivergent people into mainstream pathways, not only specialist services.

5.5 Primary, Community and Neighbourhood Care

Care closer to home: Over 70 per cent express some willingness to receive appropriate care closer to home.

Respondents are highly willing to consider home-based support using technology and professional input, emergency response teams visiting people at home, and diagnostics at local centres.

We asked people which factors would give them most confidence when receiving care away from hospital. Across the three surveys, the strongest common message is that confidence in receiving care away from hospital depends on:

1. rapid escalation and face-to-face help if a person deteriorates;
2. access to specialist advice;
3. being listened to and involved in decisions;
4. joined-up access to medical records;
5. confidence that care will be safe and clearly connected to hospital services.

Continuity with the same team, evening/weekend availability and a named contact were still valued, but were generally less prominent than safety, involvement and rapid clinical support.

Community pharmacy and dentistry

The survey findings all support high confidence in pharmacies for vaccinations, blood pressure checks, medicines advice, minor illness and healthy living support.

Across all three surveys, there is a **consistent and very strong public acceptance of community pharmacy delivering routine clinical and preventative services**, particularly:

- Blood pressure checks.
- Advice on prescribed medicines.
- Vaccinations.
- Minor illness treatment.
- Healthy living and smoking cessation advice.

Overall over 70 per cent were confident in receiving blood pressure checks and nearly 80 per cent confident in vaccinations and medicines advice.

The results all show caution in community pharmacy providing **sexual health services and especially substance misuse support** are less readily accepted in pharmacy settings than routine clinical care.

The single biggest dentistry concern is the availability of NHS dentists—specifically, being unable to find a practice accepting new NHS patients. It ranked first in every survey clearly ahead of affordability, urgent access and waiting times. Affordability is also an issue, but less important, and timely access—especially urgent care in pain and appointment waits—comes after that.

Staff comments revealed the extent to which even NHS employees often struggle to access NHS dentistry. Many respondents reported paying privately due to a lack of NHS provision. *"I have gone private for my family because NHS dentistry service was poor"*

Several respondents stated that they no longer attempted to access NHS dental services at all, while others described concerns about appointment availability, local access and the overall quality and sustainability of NHS dentistry.

Commissioning recommendations:

- Improve GP access and continuity while building neighbourhood capacity for prevention, long-term conditions, frailty, urgent care and appropriate care closer to home.
- Make sure there is always a non-digital option for those who need it.
- Ensure community pathways - services outside acute hospitals, including primary care, community services, rehabilitation/reablement, urgent response and pharmacy - are adequately staffed and connected to specialist and hospital services.
- Do not equate 'closer' with 'more accessible' without testing transport, affordability, disability and carer impacts. Respondents gave practical examples: one said: "The buses in my area have had route changes, I can no longer access the local hospital or even my GP service by bus. And "I have mobility problems." Another highlighted "cost of travel, availability of public transport" and the need for better communication and appointment arrangements.

5.6 Digital

There is a clear message that digital **shouldn't be the only route into care**. People support digital options, but want **telephone, face-to-face and paper routes retained**, particularly for those who need them.

Between 55 and 70 percent wanted phone, paper or face-to-face services retained. The main concern is **digital exclusion**. People said digital-only access could disadvantage older people, disabled people, those with sensory or learning difficulties, people lacking devices or reliable internet, those with limited digital confidence, and people facing language barriers. EK360 recorded **168 mentions** relating to internet access, equipment, skills and confidence.

6. Single biggest improvement

When given the option to tell us, in their own words, what would make the single biggest improvement to the NHS there were some common themes:

- **Access to GP services.** The most common theme related to access to GP services. Respondents frequently described difficulties obtaining appointments, long waits, barriers created by online systems and a lack of face-to-face consultations. Many felt that improving access to primary care would also help reduce pressure on other parts of the NHS, particularly urgent and emergency care. One respondent stated, *"Actually being able to see a GP"*, while another called for *"easy access to GP services within 48 hours"*.
- **Reducing waiting times.** Many respondents highlighted long waits for appointments, diagnostic tests, specialist referrals and treatment. Concerns were raised about delays affecting health outcomes, quality of life and anxiety levels. Respondents commonly called for faster diagnosis and treatment, with one commenting that the NHS should focus on *"cutting waiting in every area at every stage"*.
- **Urgent and emergency care.** Respondents frequently referred to the challenges facing urgent and emergency care services, particularly long waits in A&E departments, overcrowding and corridor care. Many linked these pressures to wider problems accessing GP and community services. There were also calls for additional urgent treatment centres and improved local emergency provision.
- **Capacity, workforce and local services.** Many comments reflected concerns that health services have not kept pace with population growth across Kent and Medway. Respondents called for more GPs, nurses and other healthcare professionals, as well as additional hospitals, health centres and diagnostic facilities. Several specifically referenced pressures on Medway Hospital and the impact of new housing developments on local services.
- **Better joined-up care and communication.** Respondents wanted health services to work together more effectively. Common suggestions included shared patient records, improved communication between organisations and better coordination between GPs, hospitals, community services and social care. Respondents also wanted clearer communication about appointments, referrals and waiting times. One respondent called for *"one centralised system whereby all medical professionals can access patient records"*.
- **Prevention, mental health and community support.** A smaller but significant group of respondents highlighted the importance of preventing ill health, improving mental health services and strengthening support within communities. Comments included calls for earlier intervention, support before crisis point, better social care and greater investment in community-based services to help people stay well and independent for longer.

7. VCSEF feedback

Feedback from 18 voluntary, community, social enterprise and faith organisations, alongside a Be One workshop involving 29 people from grassroots groups, showed broad support for the focus on prevention, neighbourhood health, integrated care and reducing inequalities. However, respondents said the sector must be recognised as an equal

strategic and delivery partner, with a formal role in governance, neighbourhood teams and pathway design—not simply consulted or used as additional support. As Medway Voluntary Action put it, “the sector largely appears as a supporting partner rather than a strategic delivery partner.”

A central message was the need to invest sustainably in prevention, early intervention and community capacity. VCSEF organisations said they already provide trusted, culturally appropriate support that helps people before they reach crisis, particularly those affected by poverty, poor housing, isolation, digital exclusion, addiction, neurodiversity and other complex needs. They called for longer-term and more accessible funding, formal referral routes and better integration across NHS, social care, housing and community services. Respondents stressed that “successful neighbourhood health models require communities to be active partners, not simply recipients of services” and warned that voluntary organisations can fill gaps in preventative provision but “need to be funded appropriately to do so.”

8. Cross cutting themes

Several themes from the feedback go beyond NHS services and could be useful.

Performance measures

Some respondents explicitly challenge an emphasis on targets and waiting-list performance. They describe patients being moved between services or waiting lists without necessarily experiencing better care.

The underlying message is:

Reducing a performance metric is not necessarily the same as improving the patient's experience or outcome.

Commissioning should consider measures of:

- patient outcomes
- patient experience
- continuity
- whole-pathway waiting time
- and whether patients feel someone has taken ownership.

Patient pathways

Respondents describe being passed between GPs, hospitals, specialists, community services, mental health services and other organisations.

Some specifically call for a named contact, particularly when someone is waiting a long time or their condition changes.

The suggestion is: Patients should know who owns their journey, even when multiple organisations are involved.

"Don't transfer activity without transferring capacity."

This is one of the strongest cross-cutting messages, particularly from staff.

Respondents support care closer to home but simultaneously describe pressure within:

- general practice
- community services
- pharmacies
- specialist services
- and social care.

The concern is that new responsibilities may simply be added to already stretched services, and it's suggested to "not transfer activity without transferring capacity, workforce and resource".

Local care is not automatically accessible care

There is strong support for care closer to home, but the equality feedback provides an important qualification. Here, "equality feedback" means respondents highlighted practical and personal factors that can make a service harder to use even when it is geographically closer — including poor public transport, parking, unfamiliar locations, mobility or sensory impairment, travel costs and reliance on a carer. One respondent described a partially sighted older relative being moved to a location that was difficult to reach from the car park, creating additional pressure for the family carer.

Moving a service can make access worse for some people if:

- public transport is poor
- parking is difficult
- the location is unfamiliar
- the person has mobility or sensory impairment
- the person cannot afford travel
- or they rely on a carer

Therefore: "closer" should not automatically be equated with "more accessible".

Social care is under-represented

Several respondents raise:

- integration with social care
- reablement
- respite
- dementia
- end-of-life care
- care for older people
- support after discharge.

One explicit concern is that there is too little mention of integration with social care.

This is important because the respondents view health and social care as one connected system, even where commissioning structures remain separate.

Communication and patient experience

The feedback repeatedly refers to:

- being listened to
- having enough time
- understanding what will happen
- receiving information while waiting
- clear explanations
- communication needs
- being able to contact somebody when circumstances change.

Communication therefore appears to be more than a patient-experience issue.

For some respondents, poor communication creates a barrier to safe and effective care.

Population growth and infrastructure

Some respondents link service pressure to:

- new housing
- population growth
- insufficient GP capacity
- lack of local facilities
- pressure on hospitals and dentists.

This suggests that some respondents see access problems as a capacity and infrastructure issue, rather than simply a problem of how existing services are organised.

This should be tested against population projections, estate plans and local capacity data.

Conclusion

Submissions from the public and surveys provide a strong but conditional mandate for transformation.

The public is willing to support significant change, but they want that change to feel like better care rather than simply different care.

The strongest test of the commissioning intentions should therefore be whether they deliver better access, better outcomes, better experience and greater equity, while ensuring that workforce, capacity and accessibility are designed into the model from the outset.