The Neurological Alliance of Scotland

Long Term Conditions Framework

Consultation opened: 23 Apr 2025
Consultation closed: 20 July 2025

Questions - part 1 of 2

1. *Do you agree that Scottish Government should move from a condition-specific policy approach to one that has a balance of cross-cutting improvement work for long term conditions alongside condition-specific work?*

No

Please explain your answer below:

NAoS opposes the proposed move to a single long-term conditions framework at the cost of condition specific frameworks, particularly for neurological conditions which are growing in prevalence and are estimated to impact more people than cardiac illnesses and cancer, and which cost the UK economy £96bn/year. It is not at all clear where neurological conditions would sit within a wider LTC framework and furthermore there's a risk that a LTC framework would focus on better known conditions, leaving rarer and less prevalent neurological conditions without any framework.

Removing or reducing funding for neurological conditions which have a devastating impact on those affected, and which require specific pathways and access to specialists, will remove rather than widen access to support. A single LTC framework creates the need to group similar conditions together, leading to certain groupings inevitably being deprioritised and not getting the resources they need.

Moving all single condition strategies into a single long term conditions framework has the unintended consequence of pitting single conditions against each other for priority and resourcing. How will the Scottish Government protect people with a condition that has been deprioritised in this process?

Whilst creation of a single LTC framework may address the commonalities across long term conditions, it misses the nuances across conditions and will dilute the impact of available support as has already been evidenced by the reduction in specialist nurses and the detrimental impact that has had on patients’ quality of life and wellbeing.

A single long-term conditions framework risks conditions which are excluded (despite being long term conditions under a different definition) from getting the resources they need, either now or in the future. Condition pathways exist to support people with that diagnosis access the right pathways, treatment and support, so this generalised approach is unlikely to work for everyone.

Long term conditions need a condition specific approach due to the complexity of their nature and the vulnerability of those affected. It is not clear how a LTC framework approach can cascade effectively to a local level where services are delivered.

It is also unclear what the agreed definition of a ‘long term condition’ is and which conditions would therefore be included in or excluded from the scope of the framework. It’s difficult to comment on the value of moving from condition specific frameworks to a LTC framework when we have to imagine what it may or may not include:

- Would it include fast progressing neurological conditions which can, but which don’t always lead to death within a year, such as MND, CBD, MSA and PSP? Would it include fluctuating conditions?
- Would it include rare conditions which currently fall under a Rare Diseases Action Plan?
- How would it include people without a clear diagnosis?
- How will it integrate with frameworks and strategies for single conditions that are ongoing such as the dementia strategy and the mental health and wellbeing strategy? There is a danger that these existing strategies will be undermined.

The LTC framework doesn’t address the well-known link between poverty and disease, but references that the ‘reduction of health inequalities is an area flagged for development in future approaches’.

There is a strong link between poverty and development of epilepsy as evidenced by comparing prevalence with the seven different domains of deprivation through the Scottish Index of Multiple Deprivation.

Nor does it address the link between brain injury and the criminal justice system- Up to 60% of adult prisoners have an ABI and ‘evidence shows that early access to specialist neurological rehabilitation can increase a person’s chance of making a meaningful recovery after ABI. However, we are aware that for many people the effects of ABI can be misdiagnosed or overlooked.’[1]

Whilst it has been made explicit that one of the main drivers for a LTC framework is that of efficiently and impactfully allocating finite resources, and that ‘whilst the burden of disease is growing, public finances are increasingly challenged’, it is unclear what budget if any, has been allocated to deliver this framework including funding of any condition specific ‘actions’. How many conditions will merit their own ‘action plan’ within the LTC framework, and what will happen for people whose condition does not have an action plan but for whom specialist rather than generic services are critical?

We would like to know what the return on investment on a restructure of this nature would be in terms of health improvement generally and a reduction in A&E admissions.

2. *Are there any improvements in prevention, care or support you have seen in a long term condition you have, or provide care and support for, that would benefit people with other long term conditions?*

Please answer below:

Primary prevention is key for some long-term conditions, where a good diet, an active lifestyle, a sense of connectivity and community, limited alcohol intake, limited stress, good sleep and a non-smoking lifestyle gives us a good chance of staying healthy. However, these lifestyle habits alone cannot prevent disease, sickness and injury.

Furthermore, it is nearly impossible to prevent neurological conditions, many of which have unknown causation, or a cause which cannot be prevented. Therefore, irrespective of good public health messaging, neurological conditions will continue to have an impact on us, particularly with an increasingly elderly population demographic.

As an example, Post Polio Syndrome, cannot be prevented in those who caught the polio virus fifty years ago.

Genetic conditions with a de novo mutation cannot be prevented in families.

FASD is nearly impossible to completely prevent given many people are unaware of their early stage of pregnancy.

This is why it’s so important that people have access to specialist support services and it is why those with a condition who have access to specialist support, can cope better than those who don’t.

We are sceptical that adopting a ‘one size fits all’ approach for care and support for long term conditions collectively will work. Currently there are huge barriers to accessing neuropsychology, counselling, neurophysiology, respite care and speech and language therapy due to massive shortages in the workforce. Those who can access these specialists and Allied Health Professionals have a cap on how many sessions they receive (which is normally set at 6). It is important that people get access to the right specialist at the right time for the right period of time.

Over the past few years, we have also seen a downgrading of specialist support, with highly skilled band 7 nurses being replaced by generalist band 5s. Training has been de-prioritised and specialist skills are rapidly being lost. This also makes the retention of critical knowledge (ROCK) incredibly difficult as experienced people leave with all the information/experience/knowledge they have amassed.

The third sector is a critical partner in the delivery of care and support, but needs fair funding to meet the growing demand of our services. Many of our member charities employ specialist nurses who have expert knowledge of the condition and the skills to be able to support people to live well with their condition through navigating services, signposting and referring to other support when needed. This is incredibly valuable for people who have an increasingly complex set of professionals involved in their care.

The MS Trust employs an Advanced MS Champion in Scotland, providing a single point of contact to monitor the person with advanced MS, assess and treat issues as they arise, support the wider family and refer promptly for further care. This role has led to demonstrable cost savings and avoided hospital admissions.

We have substantial concerns about the proposed move to a more generalist medical profession. The LTC framework will dilute specialist skills. If we create a purely generalist approach to long-term conditions, the burden on primary and secondary care as well as social care will only increase. How will a LTC framework address this?

3. *Do you have any thoughts about how areas for condition-specific work should be selected? This means work which is very specific to a health condition or group of health conditions, rather than across conditions.*

Please answer below:

This is an unhelpful question which creates competition between conditions to be recognised as sufficiently important to deserve a condition specific approach. Furthermore, it is unclear what level of funding any condition specific ‘actions’ will have, if at all. Actions cannot be implemented, monitored and evaluated for impact, if there is no funding for them.

There are an estimated 600 neurological conditions, and each one presents unique symptoms for the individuals affected. No two people with the same condition experience the same journey. This is why support for people with neurological conditions must be tailored. The proposed framework's limited scope for condition specific work fails to reflect this complexity. A move to a single LTC framework is likely to lead to the loss of condition specific skills and therefore it risks an erosion of support for people in Scotland.

Conditions with highest prevalence rates such as neurological conditions which impact 1 in 6 people in Scotland should be considered more strategically, than simply being rolled into a single LTC framework.

We would hope that rare conditions would be grouped together in order to receive some attention and focus which would otherwise risk being completely lost if having to compete against more common conditions. Where expert requirements are similar, expertise can be safely shared across conditions.

Irrespective of any groupings made, implementation of health strategies need to be made at a local level, in recognition of the population health dynamics of that area, based on population need.

4. *What would help people with a long term condition find relevant information and services more easily?*

Please answer below:

Information provided by the NHS needs to be proactively distributed in accessible formats, which means it needs to be available in multiple forms (digital, print, auditory, visual, face to face, via telephone etc), providing people with choice.

Information needs to be relevant to their condition, rather than general wellbeing advice, including insights about what will specifically help or support people with that condition.

Information needs to be tailored for different conditions and different needs – medication, family planning, exercise, genetic testing, research opportunities etc.

Information needs to be available in multiple places such as libraries and GP surgeries. This is particularly important for those in rural areas as well as those in Orkney, Shetland and Western Isles which have patchy internet access. Information also needs to be provided in multiple formats including aural and video recordings.

A mapping exercise needs to be done so GPs know what services are available locally (including third sector and private sector services) and they can then signpost people to these locally accessible services.

5. *What would help people to access care and support for long term conditions more easily?*

Please answer below:

Funding more services, for instance scans, specialist nurses, pain services, neuropsychologists and neurophysiotherapists, as well as orthotics, wheelchair services and housing adaptations will help people access care and support for long term conditions more easily. Waiting lists are far too long and this is a significant barrier to accessing care and support.

Eligibility criteria for social care is too high to be accessible for most people in need of support. Social care needs to be strengthened with an effort made to build system awareness of neurological needs. The value of good social care cannot be underestimated for people with neurological conditions. Unfortunately, those who do have access to social care are receiving minimal support against their actual needs.

Education programmes for GPs to learn about different neurological conditions will support their understanding of when and where to refer. Delayed referral to specialist support is a particular challenge with neurological conditions.

There's a desperate need for Care Co-ordinators to support access across health and social care and to provide consistency in support. This is particularly necessary for people with co-morbidities and for young people moving into adult services for which no specialist services exist.

Individuals would benefit from their own specific care plan which would include a single point of contact for questions. This would be a positive step towards ensuring optimal care and support.

Access to care and support depends on an integrated health and social care system as it is evident the current model is not working.

6. *How could the sharing of health information/data between medical professionals be improved?*

Please answer below:

In terms of sharing patient information between medical professionals, clinicians need to have access to patient records to be clear on all the investigations underway; all specialists or AHPs being seen; medication and any other pertinent information. Currently specialists only see information about the patient that comes through the GP referral letter.

Investment needs to be made to IT systems to allow different departments and teams across health and social care services talk to each other. Where people are seeing more than one specialist, as a result of comorbidities, it is essential that this information, particularly information about prescriptions and medication, is shared in real time, without any time lags.

It needs to be acknowledged that medical professionals work outside of the NHS within third sector. Yet data sharing from NHS to third sector happens infrequently, if at all. The pervading view of NHS clinicians of 'their patients' and 'their data' presents a significant barrier to joined up, person centred care, limits the patient experience and reduces positive outcomes.

7. *What services outside of medical care do you think are helpful in managing long term condition(s)? You may wish to comment on how these services prevent condition(s) from getting worse.*

Please answer below:

The limitation of our fragmented health and social care services has a negative impact on so many people. Moving towards a more integrated system is critical.

Social care, housing and education are all services central to supporting someone to manage their long-term condition. However, there are barriers for accessing legal aid and difficulties accessing suitable housing which limits access to other services.

Provision of a Care Co-ordinator for everyone with a long-term condition would be a very useful step in managing the time-consuming logistics of appointment planning as well as providing consistency of care. This would be particularly valuable for people with co-morbidities, children transitioning through to adult services, as well as for carers, and would likely result in a reduction in emergency hospital admissions.

Appointment of Care Co-ordinators would also support people's mental health and wellbeing, reducing anxiety and depression which often grows from a sense of powerlessness, fear and isolation. This in turn would decrease both the demands on mental health service provision.

Inclusion of AHPs who have expertise in acute and community settings, and provide continuity of care, in all Multi-Disciplinary Teams.

The third sector is a strategic delivery partner for the NHS but can be taken for granted by central and local government and the NHS. Steps taken to move towards a more integrated partnership approach would be beneficial for everyone.

General reliance by the NHS on charities to provide support is problematic for people with conditions for which there is no charitable support.

Without Government or NHS funding support, charities rely on voluntary donations and fundraising – usually from the people they support. This in effect can create 'pay to access' healthcare – Gordon Aikman described this as "people shouldn't have to hold bake sales and run marathons so that I can die with dignity".

There's a significant barrier with the cost to charities of providing social and peer support, including help with accessing benefits and housing. Local authorities and the NHS frequently signpost people to the third sector but without funding to follow the extra demands on charities. There's an expectation that third sector will manage, but it is not coping with the increased demand, particularly following the peak COVID years.

Furthermore, where patients are signposted, this leaves them responsible for initiating contact and coordinating their own access to support. This shift in responsibility risks creating barriers to care, particularly for many people who are already vulnerable or overwhelmed by their health circumstances.

8. *What barriers, if any, do you think people face accessing these (non-medical) services?*

Please answer below:

The fact that access to self-directed support is extremely restricted across Scotland. There are also long waiting times to access services like wheelchair services, limiting people's ability to remain independent.

The limited availability of accessible housing and the lack of funding available to support people with housing adaptations.

Lack of appropriately funded Third Sector support organisations across Scotland, particularly for those in rural areas.

Lack of community transport links, particularly in rural areas.

The difficulties of having an invisible illness like migraine or epilepsy and public attitudes towards you.

Lack of awareness of non-medical services prevents people from being referred, e.g. to Long Covid clinics.

Lack of support towards people who are bedbound and who cannot access medical or non-medical services unless home visits are provided.

Stigma and self-stigma, denial and fear of being considered a burden may prevent people from accessing their rightful benefits.

Progression of conditions whilst people are on a waiting list means by the time medical care is accessed, a condition is likely to have progressed to the point that greater interventions are needed against a worse prognosis.

Older adults with disabilities are more likely to report unmet support needs.

There are common misunderstandings held around the fluctuating nature of conditions. When it comes to benefits claims, there can be a disconnection between how someone appears or reports their health to be on that day, against other days, and against a doctor's report of their condition.

Digital exclusion and financial exclusion are major barriers. Many services like welfare, online banking, and applications for housing are channelled online. Libraries and local infrastructure hit by cuts are closing or reducing opening hours making it harder for people to find out about support and services. 9% of households in Scotland do not have internet access in 2025.

The digital switchover will impact many older people with a landline who may not know about it as well as the cost involved with replacing their phones. Furthermore, hard to reach and vulnerable people won't know to register their vulnerability with their provider. We are concerned about power cuts, which would impact the refrigeration of medication and ability to power mobility furniture particularly for those in rural and island areas.

Many people don't know about the Priority Services Register and those who do know about it have to register online or on the phone. It is unclear that this service exists, and there's a general lack of information about what it does and how it can support people. All information about it is online.

9. *What should we know about the challenges of managing one or more long term conditions?*

Please answer below:

38% of Scotland-based adult respondents from the 2024/5 National Neurology Patient Experience survey had a mental health comorbidity, and 41% had a physical health comorbidity. There is a broad correlation between living with a comorbidity and impact on ability to cope.

Common challenges across all neurological conditions are impacts on mental health and wellbeing, sleep, pain, fatigue, communication difficulties, breathing difficulties, speech and swallow, movement, sensation, sexual function, vision, thinking and memory, hearing and eating & drinking. Once you add a second or third condition into the mix, these functions become even harder, making life even more challenging.

Many people struggle to access support in a reasonable timeframe, whether that's housing adaptations to cope with a fast-progressing condition, access to wheelchair services or support in schools to help with a child who has developed PANS following a strep infection.

Our healthcare system is fragmented and good communication between healthcare professionals is limited by the way information is able to be shared between them. Living with one long term condition requires the same commitment as a full-time job in scheduling appointments, discussing issues with disconnected healthcare providers and not having a consistent point of contact. Furthermore, mental healthcare is separated from physical healthcare, meaning people have to fight twice to get support from each service. Living with more than one long term condition means people are having to cope with even more administration on top of the additional symptoms that a second condition will present.

People want information that is relevant to them, rather than mainstream general wellness insights.

There needs to be downstream consideration on the shaping of services for people with multiple conditions needing multi-disciplinary teams.

Think about the challenges of medications and where there are contraindications. For instance, mental health medications can trigger migraine, and some local anaesthetics can't be used in people who have had polio.

The lack of easily accessible info for clinicians about rare conditions means that doctors might attribute a new symptom to the existing long-term condition when it might be caused by something else. This commonly happens with urinary tract infections.

Transitions are a major flare-point for people moving from child to adult services for any condition. Once you are dealing with multiple conditions, the loss of paediatric services may occur over different time frames which makes adjusting to co-ordinating things yourself much more complicated. Further complications arise around the move from child to adult benefits causing a lot of uncertainty for young people.

Big challenges exist for those with complex multi-system conditions like myalgic encephalomyelitis (ME), long covid, chronic fatigue syndrome / Postural tachychardia syndrome and fibromyalgia. There are long waiting lists and staggered access to support as well as an absence of multi-disciplinary teams. There is no single service for multi system conditions so people are having to see various specialists one at a time.

10. *What would strengthen good communication and relationships between professionals who provide care and support and people with long-term condition(s)?*

Please answer below:

People with long term conditions need a good care plan in place. This needs to be shared with their multi-disciplinary team and be accessible to all. The patient needs to be at the heart of their care plan and to have agency over it.

Resources and patient information need to be shared between and amongst different support providers and agencies, including third sector organisations who provide clinical support, to allow for a joined-up approach.

Deliver appointment formats that work for everyone, ensuring people who are housebound have access to good health care via provision of GP home visits.

Adopt principles of good communication - for example all patient information should be timely, relevant, tailored, provided at a time and place convenient to the individual, delivered by an expert, and joined up with the appropriate services.

Third sector organisations need to be fully embedded into support pathways, not merely mentioned as a potential option.

Questions - part 2 of 2

11. *What digital tools or resources provide support to people with long term conditions?*

Please answer below:

Digital platforms don’t work for everyone particularly where there’s a cost involved. 15% of people in Scotland don’t have the skills to access the internet and 9% of people in Scotland have no access to the internet.

Health and social care services need better digital systems for the sharing of information.

Digital platforms like NHS Inform need to remain up to date, yet there are capacity problems with adding or updating information to the site.

There’s a demand for specialist learning resources which are hugely valuable because they overcome some of the barriers to accessing information. However, toolkits are expensive to develop, and more condition specific digital resources need to be made freely available.

12. *What new digital tools or resources do you think are needed to support people with long term conditions?*

Please answer below:

We have three points to make here. The first point is that poor literacy in Scotland means that not everyone is able to access digital resources. This means that other options must continue to be provided to ensure that everyone has access to health information and support. Furthermore, with a move to digital tools and resources, assistance will need to be provided to help people access these, including:

- Provision of face to face support services to enable everyone to get access to digital tools and resources.
- Expansion of staffed NHS and NearMe hubs for video consultations for those who have no access to the internet or smartphones or computers at home.
- Expansion of accessible and free transport systems across Scotland to get people to the NearMe and NHS Hubs.

Secondly, the NHS should investigate apps under development and support the availability of free apps for people to help with self-management. There’s a role for the

NHS in signposting to highly rated apps, including them in a list of digital resources that support conditions, rather than duplicating this work.

Thirdly, the NHS should develop more digital remote condition monitoring tools (including wearables like bracelets) so clinicians have a record of how a patient is managing over time. Remote condition monitoring tools can also be used for treatment, where clinicians receive real-time information to make prescribing decisions. This requires specific training for the clinician who also needs time to interpret the data.

There is evidence that wearables improve adherence to treatment, for example glucose monitors for people with diabetes.

We need a clear route in Scotland to get innovative technology wearables adopted and funded in the same way that pharmaceuticals are provided. Clarity is needed on how med tech can be successfully rolled out.

13. *How do you think long term conditions can be detected earlier more easily?*

Please answer below:

Neurological conditions are challenging in general practice because of the nature of their symptoms. Neurological diagnoses are often a diagnosis of exclusion which makes decision-making difficult for GPs, who need specialists to refer on to.

Primary care knowledge of condition specific pathways is likely to be limited and in the absence of secondary care for conditions (like ME), GPs need to know how, when and where to refer.

Funding more services across remote and rural areas will help detect conditions earlier. Waiting lists for scans, mammograms, blood tests, smear tests, biopsies and other tests like nerve conductivity tests are far too long and this is a major barrier to early detections of a long term condition.

Availability of newborn testing for genetic conditions (as standard) and development of population incidence data would help with earlier detection of long term conditions.

Limited availability of neurologists in Scotland means that waiting lists are far too long. NHS Highland currently has a median 33 week wait for a first appointment to see a neurologist, NHS Ayrshire & Arran and NHS Fife both have a median 32 week wait for a first appointment to see a neurologist. All boards other than NHS Forth Valley have more than 10 week waits.

There is a shortage of usable MRI machines in Scotland. Having regular MRI scans allows people with conditions like MS to determine whether or not they have active disease and allows their neurologist to practice a more proactive management regime to reduce progression. We have a shortage of neurologists per head in the UK, and shorter waiting times to access a neurologist to then get a diagnosis would allow faster treatment initiation.

There needs to be a provision of more support for decisions around genetic testing across all genetic conditions, and make people aware of genetic conditions that may affect them.

14. *What barriers do people face making healthy decisions in preventing or slowing the progress of long term condition(s)?*

Please answer below:

From our 2024/5 National Neurology Patient Experience Survey, we know that 46% of our respondents with essential tremor had to wait more than 5 years to get a diagnosis, similarly long 5 year + waits occurred for those with dystonia (39% respondents) and fibromyalgia (29% respondents). Not having a diagnosis is a primary barrier in being able to make healthy decisions or slow the progress of a LTC.

Neurological conditions that can be treated with medication like some types of MS, can be slowed down if medication is available as soon as possible after symptom onset. Not getting a diagnosis in good time, and therefore not having access to medication means people are not able to slow the progression of their LTC.

For everyone else, access to ongoing rehab is essential for symptom management and maintaining condition. That's also relevant to many other conditions, but the issue is that accessing appropriate rehab is almost impossible.

Getting the right advice as quickly as possible after any infection can make the difference with outcomes.

Lack of sleep and high levels of stress are correlated with a number of serious long-term conditions from cancers to neurological conditions like Alzheimer's. Anxiety, which is known to disrupt sleep, can be caused by long waiting lists to see a specialist when symptoms first develop. It is probable that many incidences of LTC could be avoided entirely if stress and anxiety from what should be largely benign symptoms, were to be avoided by investing in the healthcare workforce and reducing waiting lists.

The stress of having to face long waiting times for appointments could also be a contributing factor to self-sabotaging behaviours like smoking, drinking excessive alcohol or recreational drug taking, all of which are known risks for serious disease.

The socioeconomic determinants of health – proximity and access to clean air, affordable facilities for sports and leisure, affordable healthy food and avoidance of stigma – impact everyone.

Being unwell or disabled is a further barrier. Initiatives that reference and support long term conditions, such as e.g. free swimming sessions or wellness walks/wheels for people with LTC, would be helpful.

15. *Is there anything currently working well within your community to prevent or slow progression of long term conditions?*

Please answer below.:

16. *How can the Scottish Government involve communities in preventing or slowing the progress of long term conditions?*

Please answer below:

The additional responsibilities given to pan-neurology specialist nurses in boards like NHS Western Isles and Shetland risks the ability of people in island boards to get access to treatment, care and support for the more complex neurological conditions like MS, Parkinson's and epilepsy.

Provision of healthcare services in rural communities will help slow the progress of long term conditions. For instance, people in Argyll have to travel to Glasgow for kidney dialysis because there is no service in Oban. Long travel times, involving ferries and car transport, every single week, prevents people from living well at home. This is particularly problematic for those with neurological conditions with a co-morbidity.

17. *Are there additional important considerations for people with long term conditions? For example people who; live in deprived areas and rural and/or island areas, have protected characteristics e.g. race, disability, who are in inclusion health groups e.g. homelessness, or who experience stigma due to perceptions of their long term condition e.g. people with dementia?*

Please answer below.:

18. *Given that racism and discrimination are key drivers of inequalities, what specific actions are necessary to address racism and discrimination in healthcare?*

Please answer below.:

19. *Is there anything else you would like to raise that was not covered elsewhere in the consultation paper?*

Please answer below.:

Based on recent discussions we believe that the Scottish Government intends to progress with a Long Term Conditions framework irrespective of the responses to this consultation. This somewhat reduces engagement and minimises opportunities to meaningfully shape the framework. This is compounded by asking questions throughout this consultation which have already been answered in considerable detail through the lengthy consultation on the National Care Service in 2024, which raises the possibility that civil servant teams are either not communicating with each other, or are choosing to ignore the feedback and experience of people with lived experience who have taken the time to provide feedback to the NCS consultations.

Along with other third sector organisations, we are concerned that there has been no meaningful engagement with us about the introduction of a long-term conditions framework. The lack of clarity about how proposed changes will be implemented and resourced hinders meaningful feedback. This is frustrating as the third sector is both a delivery partner and patient advocate.

We also want to make the point that it is challenging for third sector organisations to engage with this consultation when we have very little capacity but also when have seen very little support for real change in the past.

The framework lacks defined responsibilities, timelines and monitoring mechanisms. Without these, there’s a risk of diminished focus and ambition, undermining service improvement and long term NHS efficiency. We are particularly concerned about the absence of a National Advisory Committee and Task Forces, which are instrumental in delivering strategy and clinical oversight.

The design and format of this consultation will limit the range of individuals who are able to respond, particularly those with energy limiting conditions who suffer from fluctuating cognitive function and other neurological impairments.

However, we will do everything we can to ensure that people with neurological conditions are supported as best they can be through the development of this framework notwithstanding the continued harsh financial climate for the third sector.

About you

What is your name?
Alice Struthers

Are you responding as an individual or an organisation?
Organisation

What is your organisation?
Neurological Alliance of Scotland

Further information about your organisation's response
Please add any additional context:

Our response was informed through regular meetings with our charity members where we ran through each of the consultation questions. The initial draft was shared with our policy group who then further shaped our response to create this final version.