Long Term Conditions Strategy Consultation

Scottish Government
Riaghaltas na h-Alba

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☒ Yes

☐ No

Questionnaire

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?

Yes/No. Why do you say this?

Please give reasons for your answer.

As the framework currently sits, we neither agree nor disagree that the Scottish Government should move from a condition specific policy approach to one that covers long-term conditions.

We know that the largest patient group within Scotland are those living with long-term conditions (LTCs). As our population continues to age, those with co-morbidities is going to rise and continue to pose a significant threat to the sustainability of our services. This will require transformation of the system to keep up with demand.

We understand the vision and principles behind bringing together condition specific strategies into one cohesive document and the need for wider transformation in the system. We agree with the need for equitable and sustainable services across all long-term conditions. Our Allied Health Profession (AHP) workforce treats the whole person regardless of diagnosis and provides interventions across all conditions and therefore able to manage the whole population. By restructuring services to include generalist clinics, in addition to speciality care, a more efficient service for patients and the NHS in Scotland could be achieved but we must be cognisant of areas where condition specific treatment and care is required. There is potential for improved patient outcomes, but the unintended consequences cannot be lost. We must engage with the public to align public expectation for a disease specific service rather than a generalist service.

We frequently hear from our workforce and service users the challenges around accessing different services when living with multiple LTCs and we hope this strategy will deliver cross-cutting initiatives which will remove some of these barriers. Having a joined-up, person-centred approach is welcomed and one that AHPs are already leading the way on. Genuine engagement with the AHP workforce is vital for cross-cutting improvements. AHPs often work across traditional boundaries (e.g., primary, secondary, community care) and a cross-cutting approach promotes interdisciplinary collaboration, enabling AHPs to contribute meaningfully across various settings and conditions.

Whilst we welcome the vision and priorities, we remain cautious on some areas and would require clarity before fully supporting the framework. It's essential that there remain some conditions specific strategies / action plans within the framework for some of the acute services. Particularly thinking around stroke interventions, heart disease treatments and diabetic care. We appreciate that while there are many areas of commonality between different long-term conditions, there are also areas where specific treatments and a specialist workforce is required.

Furthermore, more information is needed around the implications for the workforce and for service users. Particularly those working in specialist roles, teams and with specific strategy funding. This is essential to ensuring that we have a resilient, adaptable workforce that meets the needs of our population.

Finally, people with long term conditions will invariably have rehabilitation needs - following accident or injury or self-management of a LTC - access to rehabilitation is vital to support recovery, optimise function or enjoy a quality of life.

AHPFS supports the campaign led by the Right to Rehabilitation Coalition. This calls for an end to the postcode lottery in accessing rehabilitation in Scotland and for investment in workforce alongside strategic leadership to ensure everyone gets the rehabilitation they need.

Rehabilitation not only supports people to live independently with LTCs - it also provides vital preventive care, reducing the incidence of acute episodes and hospital admissions, preventing chronicity and enabling self management and independent living. For these reasons the right to community rehabilitation is closely linked to improved provision for people with long term conditions.

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 give reasons for your answer.

AHPs contribute significantly to prevention by identifying risks, implementing tailored interventions, and promoting well-being. We know that it is essential we all work to reduce the long-term burden on health and social care systems before they escalate.

There are a number of excellent examples within our public health compendium available here.

CASE STUDY:
Osteoporosis and fracture prevention.
Introduction of radiographer led osteoporosis screening programmes have the potential to reduce the incidence of hip fractures saving the NHS considerable finances.

DXA radiographers are willing and capable of extending their role into advanced practice within osteoporosis services such as Fracture Liaison Services (FLS) and rheumatology, streamlining patient pathways and reducing the burden on primary and secondary care. By introducing screening of over 50's further cost savings in fracture prevention and early identification of vertebral fractures can significantly improve financial savings. James et al. (2021) identified the following: Osteoporosis and fracture prevention are public health issues that improve patient outcomes following fractures. Fracture Liaison Services have 100% coverage in Scotland and are proven to reduce the risk of re-fracture by between 30 and 40%. Evidence shows that in every 1000 patients cared for through an FLS, 18 fractures (including 11 hip fractures) are prevented, saving the NHS £21,000 per hip fracture. A 2018 analysis shows that up-scaling FLS provision to cover everyone over 50 years in the UK could prevent 5686 fragility fractures every year saving people pain and suffering and achieving net cost savings of £1.2 million to the healthcare economy a year.

GGC – Long Covid Service
In Glasgow, the long-covid team is run by occupational therapists, physiotherapists and healthcare support workers. The service supports people to help to improve, manage and live with Long COVID symptoms using a Supported Self Management Approach. Appointments are delivered in a way that suit people by video, telephone or in person at a clinic or home appointments. Members of the team support people to improve the quality of their living and manage their conditions effectively.

It is essential that there is appropriate AHP leadership and visibility within related prevention forums to ensure wide knowledge of the impact of AHPs in public health. By leveraging the expertise of AHPs, the health system can achieve better outcomes, reduce health inequalities and foster a healthier, more resilient population over the next decade and beyond.

3. Do you have any thoughts about how areas for condition-specific work should be selected?

Please give reasons for your answer.

As outlined in our previous answers, it's vital that condition-specific work should remain a priority for the Scottish Government as well as moving to a more coordinated approach for long term conditions.

To ensure that condition specific work isn't lost, we would expect the relevant clinical priorities team within the Scottish Government to be heavily involved in the development of the LTC framework and following implementation. We understand that many of the current priority conditions have a clinical lead and a National Advisory Committee and we would therefore expect them to also be involved in the development of framework / policy. Advisory Committees must remain, whether in the format that currently exists or in a more co-ordinated way but each condition must not lose that strategic representation opportunity. Similarly, where lived-experience engagement groups have been established and worked effectively for those condition specific strategies (e.g. National Stroke Voices), we would encourage learning from these and continuing them where they are improving outcomes.

It is essential that data informs this decision making process to look at where condition-specific work is required. Data both in terms of demand on services, but also variation in outcomes. The burden of disease data tells us despite a projected 1.2% decrease in the Scottish population, the combined annual disease burden from all causes of disease and injury is forecast to increase 21% in the next 20 years. Absolute increases in annual disease burdens are forecast to be largest for cardiovascular diseases, cancers, and neurological diseases – together accounting for approximately two-thirds of the total increase in forecasted disease burden. AHPs work across all these conditions, are dual trained in both mental and physical health and therefore are extremely well-placed to advice on where condition-specific activity is required and where it will be most effective for health and social care services. We know that health services must transform and be more efficient, through investment in AHP-led services, more people will be supported earlier and therefore prevent further decline into ill health.

As with our other responses, it's vital that individuals who are living with and at high risk of developing LTC are involved in this selection process. It is these individuals, alongside the workforce and third sector organisations, who will be able to explain the barriers and challenges of the different aspects of living with a LTC. Particularly important to think about the unheard voices and those communities who traditionally have been neglected within policy making. There are a number of learnings that can also be taken from the transformation within children's services whereby conditions are joined up and delivered effectively by one team. As AHPs work with individuals who have multiple conditions already and they are dual trained, it would be remiss to not include them in the decision-making process. Again, this is why it's so important to have AHPs in strategic leadership position across our health and social care systems.

Finally, specialised care and support work best where individuals have named points of contact; where there are joined up care pathways between the NHS, community and local authority; and when each of these professionals (in particular, those involved in assessments, including Occupational Therapists) have an understanding of condition-specific needs and likely progression (or work closely within a multi-disciplinary team where that information is available).

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

Please give reasons for your answer.

Having a single point of access for rehabilitation services, led by AHPs, would support people living with LTC to manage their condition and improve their mental and physical wellbeing. As aforementioned, rehabilitation not only supports people to live independently with long term conditions - it also provides vital preventive care, reducing the incidence of acute episodes and hospital admissions, preventing chronicity and enabling self-management and independent living. People who with LTCs face a multitude of different services across various settings and having a single point of access (e.g. rehabilitation hub) to easily connect them to the right service at the right time would reduce delays in people accessing services and improve efficiencies in the system. By being AHP led, and having that dual trained expertise, individuals would be signposted and referred to relevant services to aid them in their recovery and long-term management of their condition(s).

The links with acute and community services here are vital, this includes data sharing between different services to ensure a linked up approach of electronic patient records. Fragmented care can often result in individuals becoming less inclined to engage and not seek out care and information which may benefit them.

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

Please give reasons for your answer.

As outlined in our previous answer, improved data sharing and collaboration between both systems and service users will help people access care and support for LTCs more easily.

A well-designed single point for access is a strategic enabler for delivering genuine person-cantered holistic care. AHPs are best placed to lead on this as they are delivering the services and embedded in the systems already. Increased training and support for the workforce on LTCs would also be required to ensure parity across conditions.

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

Please give reasons for your answer.

As referenced already, a single point of access, improved IT systems and shared care records will all lead to the improvement of sharing of health information between medical professionals. Ensuring that there is one IT system across systems, professions, health boards and social care providers is essential for the current barriers to be removed.

It's essential that IT and digital systems aid and encourage efficiencies for service delivery rather than add to the healthcare professionals workload.

Data sharing must be done in collaboration with our population. Patients should have access to a single, secure patient record via technologies, e.g. an app.

Case study: Borders Community Equipment Service Project

The Community Equipment Service in the Scottish Borders currently works with Occupational Therapist, Physiotherapy and District Nurse equipment prescribers to issue equipment to clients across the region. In line with Scotland's Digital Health and Care Strategy (Scottish Government and COSLA 2021), this project looked to ensure one single and secure way for staff to request equipment for their clients across the health and social care partnership.

This project focused on developing the digital platform with key feedback from clinicians to align the system to clinical standards. Whilst this project has been focused on the existing digital platform and aligning this to the needs of prescribers of equipment, this will also be of benefit to the clients requiring assistive aids as a more efficient process with relevant questions for prescribers allows for more efficient decision making and provision.

The one single digital platform is now in use and allows multiple professionals to use the platform and benefit from the shared records.

(reference: https://www.gov.scot/binaries/content/documents/govscot/publications/strategy-plan/2021/10/scotlands-digital-health-care-strategy/documents/enabling-connecting-empowering-care-digital-age/enabling-connecting-empowering-care-digital-age/govscot%3Adocument/enabling-connecting-empowering-care-digital-age.pdf)

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 give reasons for your answer.

AHPs are uniquely positioned to manage long term condition(s) and prevent them from worsening. They work primarily in this space. Long term conditions require coordinated, multidisciplinary care and that's largely delivered by AHPs.

AHPs assess patients to understand their needs but also monitor condition(s) and disease progression. AHPs are so essential as they educate patients about their condition and empower them to manage their symptoms and condition. This can include supporting individuals to make positive lifestyle changes, improve medicine adherence, enable better use of telemedicine. All of these help to live well with their condition and help to limit the progression.

Rehabilitation is a lifeline for people living with LTCs. It involves a range of professionals and interventions which are often thought of being outside of medical care. The purpose of rehabilitation is to restore or maintain physical, cognitive and or emotional function and without the rehabilitation they need, people are at risk of readmission to hospital, likely to need repeat visits to GPs, need additional care from their family or providers, and may struggle to return to work or live their lives to the full. AHPs often act a strong link with 3rd sector partners which often involves things like social prescribing to support people with self-management which is often an integral part of an individual's rehabilitation.

Art Therapy, Dramatherapy and Music Therapy offer psychologically and trauma-informed, person-centred interventions that support mental wellbeing and emotional regulation, as well as functional rehabilitation. While often underutilised in acute care, these professions have a recognised role by supporting patient recovery, improving engagement in treatment, and reducing psychological distress that may delay discharge, in particular in complex cases where emotional, physical, cognitive and neurological needs impact timely recovery and discharge.

Music Therapy can be a valuable tool in the rehabilitation process for individuals with long-term conditions. It can help manage chronic pain (cancer), improve motor skills and coordination (stroke, Parkinson's disease), reduce stress and anxiety (mental health conditions and post stroke), and enhance emotional well-being for people living with various LTC's.

Music Therapy has a well-established evidence base for neurological conditions, including stroke and acquired brain injury rehabilitation, which highlights that interventions delivered by Music Therapists increased efficacy of treatment. Given that music elicits a multimodal response in the brain and has been demonstrated to support neuroplasticity , the inclusion of Music Therapy alongside standard care can holistically support each patient to achieve functional physical, cognitive, communication and psychological goals to increase their ability to engage in everyday life.

Neurologic Music Therapy is a specialist field, informed by neuroscientific research and comprises of 20 standardised techniques to support patients across these domains. Utilising music-based activities to address functional challenges, the inclusion of Neurologic Music TherapyTM within neurorehabilitation has resulted in patients reported increased motivation to engage in their recovery, earlier functional recovery and discharge as well as improved relearning or regaining of skills.

Music Therapy also has a significant and robust evidence base for supporting Mental Health such as Anxiety, Depression and Schizophrenia, meaning that the inclusion of Music Therapy services can directly support the whole person within a single intervention.

Finally, it is important to note that in the case of several conditions, there is a limited amount an individual can do to stop condition(s) getting worse (e.g. in the case of MND). However, it is possible to look instead at how people can be supported to live as well as possible, with the right services and care: timely care packages for social care, supported social care staff, well-funded and effective adaptations processes and greater amounts of accessible housing.
This proactive and preventative approach can reduce unplanned and emergency care needs and hospital admissions and ensure an individual lives the best life that they can.

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

Please give reasons for your answer.

Further clarity and understanding is needed around what constitutes “non-medical” services.

With too much of a focus on doctors and nurses and not enough on AHPs, patients may not get the holistic support and follow-up they need to prevent them returning to NHS frontline and emergency services.

Key Challenges:

- Workforce capacity and training gaps:
    - AHP shortages mean that many services are overwhelmed, leading to inconsistent care and longer wait times. A comprehensive workforce plan that addresses recruitment, retention and wellbeing of AHPs is essential to enable effective community care.
    - Access to AHPs across the country is inconsistent, creating significant inequalities in both employment opportunities and patient care.
    - We need a unified national approach to workforce planning and service provision to ensure that everyone, regardless of location, can access the expertise of AHPs.
- Limited access to AHPs within community and primary care settings
    - Many GP surgeries and local authorities don't have access to a full range of AHPs, even though embedding AHPs within primary and social care has been shown to reduce hospital admissions and support early intervention.
    - To enable a smooth transition from acute to community, patients need to retain access to the therapies they had access to in the acute sector, to avoid a decline in health, rather than then waiting for community treatment.
- Funding resource allocation for community rehabilitation
    - Community rehabilitation services are often under-resourced and the lack of consistent investment in community resources restricts the ability of AHPs to fully support patients prepare for hospital admission, after hospital discharge and prevent readmissions.
- Physical Space
    - Many GP surgeries are at full capacity and are saying no to other community services using their spaces e.g. mental health workers. Consideration needs to be given to the expanding space provision to ensure different AHPs can support care in the community.

To remove these barrier, we must establish greater leadership and accountability of AHPs within Health Boards and HSCPs (including social care).

Key aspects of the problems the workforce is experiencing, such as staff retention, haven’t been addressed. It’s also hugely disappointing to see no reference at all to social care and housing as a critical part of integrated care for patients. It’s essential to get this right to improve people’s health and overall wellbeing, helping people live well for longer.

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

Please give reasons for your answer.

As mentioned throughout the consultation response, having siloed working, poor or lack of data sharing and lack investment in MDTs leaves it challenges for individuals to manage their various conditions.

Again, having a single point of access to a rehabilitation hub, led by AHPs, would alleviate some of these challenges.

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

Please give reasons for your answer.

As aforementioned, having a single point of access and shared records between professionals and person in question would strengthen links between professionals. There would be confidence between healthcare professionals that they all have access to the same information and shared understanding of the patient's need. The shared patient records must be linked with community based serviced and involve all professionals involved within the MDTs.

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

Please give reasons for your answer.

For some patients being in control of their own health is an important part of effective management of conditions. For those people, the MyDiabetesMyWay is an excellent example of a digital tool enabling self management. Similar tools could be effectively used in other long term conditions, promoting increased awareness, self management and consequently delivering prevention and early intervention.

CASE STUDY: Near Me @ RIE

Implementation of NearMe in the acute hospital setting to complete Environmental Home Assessments as first choice, rather than Occupational Therapy (OT) staff attending the patient's house. NearMe is the approved NHS video consulting service which enables staff to assess inside a patient's house without leaving the hospital. The additional benefit is that patients present throughout these video consultations. From the pilot, average time per visit of 1hr 55mins and an average travel mile saved per visit was 25.5miles. Patient representatives rated the service 4.5/5 stars. In total the 9 visits have saved an average of 17 ¼ hours of time, 230 miles of travel and 18 taxi journeys and 5 "ready to go" days saved.

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

Please give reasons for your answer.

See answer to Q11

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

Please give reasons for your answer.

Detecting long-term conditions earlier—and more easily—relies on a mix of improved technology, better data, a preventative based healthcare system, and greater public awareness.

More efficient use of radiography lead services, particularly in community settings, increase adoption of AI to analyse patient records and identify patients at risk of LTCs. Community health initiatives, with AHP involvement, for evidence-based screening initiatives, particularly in underserved communities, could help identify people earlier. Similarly, by expanding our primary care occupational therapy teams we will be able to support people to self-manage and make positive lifestyle changes earlier to avoid or delay the onset of LTCs.

Generally, upskilling, training and supporting clinicians working as a first point of contact on LTC and their symptoms will ensure LTCs are detected earlier. And having a person-centred approach with people who already have one LTC will help to detect people at risk of developing another by having an understanding of their symptoms.

Case Study: CTCA Radiography led service

Williams et al. 2025 published from a Randomised Control Trial in Scotland finding that after 10 years, CCTA-guided management of patients sustained reduction in coronary heart disease, improving cardiovascular disease prevention. CT coronary angiography (CTCA) radiographer led service – Radiographer Led CTCA's are delivered more quickly, without requiring medical practitioner time or input. This leads to greater efficiency and allows medical practitioners to be reallocated to other service areas, thus reducing cost and increasing efficiency within those other service areas, whilst maintaining the quality of all services. There are already award-winning CT Cardiac services in England run by a Radiographer led team and radiographer led services for guidewire insertions for stents and feeding tubes.

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

Please give reasons for your answer.

Scotland's NHS and Social Care systems face a growing challenge from an ageing population, frailty and rising number of people living with multiple long-term conditions. Addressing this requires not only investment in prevention but also alignment across key policy frameworks. As the document exists, there is little understanding of how the long terms conditions framework will be aligned with Population Health Framework and the Service Renewal Framework. Policy coherence is just as important as continuity of care on the ground. As was identified in the population health framework, an individual's health and wellbeing is impacted by more than just the health system. And not all LTCs can be prevented through individual responsibility.

Housing, social-economic factors and commercial determinants of health is a clear barrier to someone making healthy decisions. Access, equity, prevention, partnership working, and funding have been persistently identified as priority areas within housing adaptations over the last 25 years but yet little progress and collaboration has been made. Upcoming research from Stirling University found that the following recommendations have been made numerous times across various stakeholders and yet little progress has been identified.

- Make adaptations more accessible through clear signposting and simplified processes (e.g Scottish Government 2012; RCOT 2019; Age Scotland 2023)
- Prioritise preventative and early intervention models, including self-assessment options (e.g. Age Scotland 2023; EHRC 2018)
- Establish integrated governance and delivery across housing, health, and social care (e.g. Audit Scotland 2004; Scottish Government 2020)
- Address inequalities in access to adaptations across tenures and geographies (e.g. MND Scotland 2022; Equality and Human Rights Commission 2018)
- Improve funding mechanisms to ensure timely, needs-based provision (e.g. Scottish Government 2021; Age Scotland 2023)

We need to show investment, both financial and capacity wise, to turn the tide on this and ensure that our homes are safe and accessible.

Through having a single point of access to an AHP led services, individuals will be offered a holistic service which serves their needs rather than their condition. AHPs are well integrated across all heath and social care systems and therefore are best placed to help people overcome the barriers they face and make healthier decisions.

References:
Scottish Government (2012) https://www.gov.scot/binaries/content/documents/govscot/publications/advice-and-guidance/2012/12/adapting-for-change-final-report-adaptations-working-group/documents/adapting-change-final-report-adaptations-working-group-pdf/adapting-change-final-report-adaptations-working-group-pdf/govscot%3Adocument/Adapting%2Bfor%2BChange%2B-%2Bfinal%2Breport%2Bfrom%2Bthe%2BAdaptations%2BWorking%2BGroup.pdf
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Scottish Government (2020) https://www.gov.scot/publications/protecting-scotland-renewing-scotland-governments-programme-scotland-2020-2021/#

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

Please give reasons for your answer.

There are numerous examples from across the country of AHPs working within an MDT to prevent and manage people's LTCs. An example of this is included below.

Case study:

The NHS Ayrshire & Arran musculoskeletal physiotherapy service are implementing Community Appointment Days, allowing people to access a range of services in one place. By working with Public Health and Health and Social Care Partnerships, they are tailoring each Community Appointment Day to the needs of each community they serve, providing timely access to assessments, health promotion, rehabilitation and voluntary sector support.

Community Appointment Days aim to reduce waiting times and improve access while promoting early self-management. They also provide an opportunity to focus on prevention, bringing services closer to people to assist with their wider health needs. A personalised approach is taken for each attendee, starting with a "What matters to you?" conversation. Smoking cessation, weight loss and dietetic advice are also available, with a view to preventing ill health and inactivity and not compounding the chronicity of the person's initial problem. Feedback from those who attended the first Community Appointment Day in East Ayrshire showed the event was valued by those who attended: "Brilliant! I saw four experts in one day – this would have taken four visits to hospital!" "Excellent! Increased understanding of condition."

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

Please give reasons for your answer.

We agree that genuine involvement and engagement from communities is essential for any framework to be effective. Hosting and supporting various patient advisory groups, in a way that is accessible to those populations, is vital. Carrying out that engagement – whether it be in person events, online forums, 1:1 meetings – must happen alongside development of the framework and not once it has been finalized. Ensuring representation within the group to ensure it is representative of the Scottish population is also important.

Establishing an AHP workforce group to drive forward relevant actions alongside those with lived experience would also be worthwhile.

17. Are there additional important considerations for people with long term conditions:

- **who live in deprived areas and rural and/or island areas?**
- **with protected characteristics e.g. race, disability (see paragraph 84 above)?**
- **who are in inclusion health groups e.g. homelessness?**
- **who experience stigma due to perceptions of their long term condition e.g. people with dementia?**

Yes. All of the factors listed in the question are important considerations and must be considered. As mentioned throughout this response, there must be continuity with other Scottish Government documents (such as the population heath framework, service renewal framework) when looking at all the factors that affect someone health and risk of long-term condition(s).

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

Please give reasons for your answer.

As was mentioned in previous questions, it's vital that there is meaningful population involvement within the delivery of healthcare. If people are not included and services are not delivered around the local population then people are less likely ot engage and therefore the impact that services can have will be limited.
Things to be mindful of:

- Patient advisory groups being fully representative
- Actively include the voices of the unheard
- Work with and involve the workforce who are working within the local services
- Ensure communication is delivered in languages appropriate for local population

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

We understand the vision and principles behind bringing together condition specific strategies into one cohesive document and wider transformation in the system. We frequently hear from our service users the challenges around accessing different services when living with multiple long-term conditions. Having a joined-up, person-centred approach is welcomed and one that AHPs are already leading the way on.

We know that if the Government is serious about rebalancing the system and shifting that burden of care from acute to the community then there must be a clear prioritisation and emphasis on the role of early intervention and prevention with key actions to address this. Genuine integration across health and social care system is very much needed but we need the right people in the right positions to see that happen. AHPs are paramount to this and are already working to address public health challenges, reduce inequalities and ensuring care is coordinated between all health and social care professionals. Additionally, this type of whole system change requires commitment to funding being appropriately re-directed to support early intervention and prevention.

Having a sustainable, appropriately trained and resourced workforce is essential to achieving the vision of equity of care. We need to see a corresponding workforce strategy which brings together the ambitions of both this framework but also being mindful of the other documents being produced by the Scottish Government on health and social care renewal. It's vital that we have the right leadership structures in place to ensure success. AHPs are the individuals who are managing and supporting people to live well with their long-term conditions and therefore must be championed, included and supported to lead the transformation necessary.

We believe this framework can be a turning point for health and social care in Scotland—but only if it is bold, clear, and inclusive in its execution. I would welcome the opportunity to meet with you to discuss this consultation. We believe this would be most useful in the near future to be able to incorporate views into the next iteration of this framework.

We welcome the opportunity to continue to work with the Scottish Government on the development of this framework.