

The Future of MS Care: *a consensus statement*

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Foreword

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Multiple sclerosis (MS) care is at a critical juncture. As the NHS navigates profound changes such as increasing demand, workforce pressures and a shift towards integrated, community-led care, we must re-examine how to equip MS services for the future.

Recent advances in the treatment of MS - particularly for relapsing forms - have not yet translated into equitable care for all. Too many people still experience delays in diagnosis, fragmented care and inadequate personalised support - especially those with progressive MS.

This consensus process is rooted in the belief that change must be collaborative, informed by lived experience, and focused on the full spectrum of MS. Through a series of roundtables bringing together clinicians and patient advocacy groups, we have sought to build a shared understanding of the challenges in MS care today and the changes required to improve it for the future.

These discussions take place during a major transition for the NHS, ahead of the planned abolition of NHS England and as integrated care boards (ICBs) take on greater responsibility for commissioning, including through the delegation of many specialised services. These changes are reshaping how services are commissioned and delivered. In addition, new national ambitions have increased focus on neighbourhood health, prevention and population health management. This presents a real opportunity to embed more responsive, joined-up MS services within local systems – but only if we act now.

The Government's 10 Year Health Plan and the Neurology Transformation Programme have established the strategic direction and ambition for improving neurological care. The new Specialised Neurology Service Specification translates this ambition into expectations for service delivery. Alongside this, the Optimal Clinical Pathway for Adults with MS provides an MS-specific framework for delivering high-quality care across the patient journey. Aligning improvements in MS care with national healthcare ambitions is essential. But this requires action in many areas: embedding an optimal clinical care pathway that supports timely diagnosis, rapid access to specialist multidisciplinary care, equitable access to disease-modifying therapies (DMTs), proactive monitoring, coordinated long-term management and rehabilitation and smooth transitions between services.¹

The recommendations in this consensus statement are a call to action from across the MS community. To meet the needs of people living with MS in an NHS under strain, we must rethink what good care looks like and how we deliver it.

Introduction: developing MS recommendations based in expert insights

To understand challenges in the MS care pathway and identify opportunities for improvement, leading voices from the MS clinical and patient community have come together with Sanofi's support.

Their goal is to develop an evidence-informed consensus statement that reflects current MS care and enables change. From the outset, the group has prioritised addressing the full disease spectrum, including progressive forms – where symptoms worsen over time without relapse or remission – which are often underserved and under-recognised in current care pathways.

This work coincides with the implementation of the Neurology Specialised Services Strategic Specification and its Appendix A, which details minimum service requirements for specialised and core neurology care across specific neurological conditions, including MS. It represents a critical opportunity to ensure that MS services are delivered consistently across the country, with clear expectations on workforce, pathways and equitable access.²

It also builds on the work of the Neurology Transformation Programme and complements the Optimal Clinical Care Pathway for MS, supporting the ambition to deliver high-quality, timely and equitable MS care. While these initiatives have established important principles and requirements for service delivery, significant variation in implementation and persistent inequities in access remain.¹

For this reason, there is growing support across the neurological community for the development of a Modern Service Framework (MSF) for neurological conditions.³ This would provide a long-term, national blueprint to bring existing initiatives together, set clear expectations and drive consistent implementation across the country.

Across three roundtables, the group identified key priorities for improving MS care, including earlier diagnosis, better community-based support, improved care for progressive MS, a more sustainable workforce, and greater attention to the psychological and wider wellbeing needs of people living with MS. The group also explored practical barriers, such as fragmented services, inequitable access to resources, unclear professional roles and responsibilities and insufficient prioritisation by ICBs.

The group recognised that the next challenge is understanding how good MS care can be delivered consistently across different systems. This updated consensus statement therefore includes case studies showcasing innovative models of MS care and recommended actions that local and national actors can take forward. These practical examples demonstrate how services have successfully redesigned pathways and improved patient care, providing a blueprint that other systems can adapt to their own local context.

This statement sets out a vision for what gold standard MS care should look like across the entire patient journey, underpinned by an optimal clinical care pathway that delivers timely diagnosis, coordinated multidisciplinary support, equitable treatment access, proactive monitoring, and smooth transitions between services.

Local systems must now translate this vision into action. We call on ICBs and clinical networks to review how their MS services are commissioned and delivered within their footprint. This includes identifying where pathways can be strengthened to improve coordination between primary, community and specialist services and ensure all patients get the right expertise at the right time. This conversation should widen locally to include GPs, physiotherapists, psychologists, menopause specialists and other professionals essential to delivering holistic, person-centred care. The West Yorkshire case study later in this report demonstrates how NHS services have successfully implemented these approaches in practice.

At the same time, national policymakers must ensure MS remains a strategic priority within NHS reform. We call on the Department of Health and Social Care (DHSC) and NHS England (NHSE) to provide national leadership through the development of a Modern Service Framework for neurological conditions.

The Future of MS Care Group

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Why is change needed in MS care and treatment?

More than 150,000 people in the UK live with MS, with over 7,100 diagnosed annually.⁴ MS affects each person differently and, as a progressive condition, requires flexible, personalised services built around individual patient needs at each stage of their journey.⁵ Patients need the right care, at the right time, in the right place. More than 1 in 7 people with MS in England had an unplanned admission in 2023/24 – this is 2.3 times more likely than people without MS.⁶

As demand on neurological services continues to rise, we must tackle persistent inequalities in care and ensure services reflect the diverse and evolving needs of the MS community.³

While some progress has been made in faster access to DMTs and some improved service models, this remains inconsistent. In some areas, a lack of specialist nurses and neurologists, combined with delays in access to treatment, mean some patients wait months or even years for the right support. Research suggests up to 80% of MS patients live in areas where MS nurses are handling unsustainable caseloads,⁷ leaving many without the care they need. People with MS also currently wait longer for their first neurology appointment than in previous years.⁶ In 2023/24, the average wait in England was 22 weeks, compared with 13 weeks in 2019/20.⁶ Despite recent updates to the McDonald criteria,⁶ a set of guidelines that neurologists use to diagnose MS, there are still challenges in the diagnosis of MS.⁶

Retention and capacity of the MS workforce is a growing challenge. MS nurses are central to continuity of care, yet retention is undermined by heavy caseloads, limited career progression and insufficient protected time for training and development. Additionally, almost half (46%) of UK consultant neurologists are expected to retire over the next decade.⁸ Formal recognition of advanced nursing and allied health professional (AHP) roles is therefore essential for long-term workforce resilience. Clarity on roles across the multidisciplinary team (MDT) – the group of health professionals who collectively manage a patient's care – is vital, particularly as new professions become more closely involved in MS care.

There is also a need to ensure equitable care for people with different types of MS. Patient groups highlight inequalities in care for people with progressive MS compared to relapsing MS. For example, those with progressive MS are often less likely to receive neurologist care when needed.⁹

Our understanding of MS is also evolving. How symptoms and disease progression are measured often misaligns with the experiences of people living with MS, particularly regarding 'hidden symptoms', due to limitations in terminology and clinical practice.

As treatments improve, so do patient needs. The goal is no longer just to manage relapses – care must also prevent disability, protect independence and enable meaningful lives. This also supports the Government's commitment to remove barriers that prevent people with disabilities from fully participating in society, including efforts to help people stay in and thrive at work.

To meet the rising and evolving needs of people with MS, services must keep pace with scientific and digital innovation.

Our MS Care Consensus Statement

MS care in the UK is not keeping pace with our current knowledge about the condition. Too many people face delays in diagnosis, fragmented care, and limited access to appropriate support, particularly those with progressive MS. We believe there is a clear and urgent need to redesign services around what matters most to people with MS. We have identified three immediate priorities for change:



1. Increase accountability and empowerment of MS multidisciplinary teams (MDTs) to manage patient need:

- Redefine MS MDT roles, responsibilities and purpose. This includes empowering a broader range of health and social care professionals, such as pharmacists, physiotherapists, nurses, and neuro navigators (professionals who help guide patients through the health system), with clear responsibilities so patients see the most appropriate clinician at the right time.
- Separate routine treatment coordination and administrative processes – such as DMT monitoring, prescription management and treatment logistics – from multidisciplinary clinical decision-making and holistic clinical case discussions focused on DMT initiation and switching, symptom management, psychosocial needs and coordinated care planning.
- By streamlining processes and enabling delegation, MS MDTs can work more effectively across the patient journey, ensuring that each professional contributes their expertise at the right stage. This frees up consultant neurologists' time to focus on newly diagnosed and more complex cases.



2. Transform MS services to increase effective use of clinicians' time across the MS clinical network:

- Improve diagnostic speed and the quality of early conversations with newly diagnosed patients.

- Ensure patients see the right clinician, at the right time, in the right place, through clearer referral pathways and better triaging. Provide more effective engagement with a range of clinicians, including more face-to-face time.
- Promote more effective multidisciplinary working across the MS pathway to maximise the existing workforce, reduce pressure on specialist clinicians and increase capacity for face-to-face care where it adds most value.



3. Strengthen access to and availability of community-based services, that appropriately respond to patient need:

- Empower patients with access to appropriate digital tools, adapted patient-initiated follow-up (PIFU) and local support services through a simplified self-management toolkit, provided at diagnosis and reviewed at every clinical appointment as part of a structured self-management checklist. The toolkit should set clear expectations from the start, clarifying which professionals will contact patients, when, and why.
- Use digital tools to identify deterioration early and triage care. Embed this proactive care into routine workflows.
- Formalise partnerships with charities and the voluntary sector to improve signposting and referral to wellbeing, employment, peer and psychosocial support.
- Improve management of symptoms that affect quality of life, including fatigue, bladder and bowel dysfunction, pain, cognition, sexual wellbeing, mobility and spasticity.

As this work continues, our focus will be on translating insight into action. Future discussions will seek to identify practical, high-impact changes that can be implemented quickly within existing system structures. Central to this will be defining what a ‘gold standard’ patient journey looks like – from diagnosis through to ongoing support – and ensuring that funding models are aligned to deliver this consistently across all regions, reducing variation and setting clear expectations for the system.

Our collective ambition is to help build a more responsive and equitable MS care pathway, one that empowers people to manage their condition confidently and protects what matters most: independence, wellbeing, and quality of life.

Immediate priorities in more detail

The following sections set out the three priority areas in more detail. The group will continue to work together to implement best-practice approaches across these areas, which over time will establish a clear agenda for meaningful, system-wide improvement.

Increase accountability and empowerment of MDTs to manage patient needs

Well-functioning MDTs are critical to MS care given the complex, long-term and individualised care required.¹⁰ However, the current implementation and accessibility of MDTs vary widely across the country.¹¹

MDTs play a critical role in making complex clinical decisions. This includes initiating or switching DMTs, managing changing symptoms and coordinating social and psychological support. These decisions are usually split between MDTs focused on overall MS care and MDTs focused specifically on treatment options, which have different but equally important purposes. They draw on broad expertise, from neurologists, MS nurses and pharmacists, to physiotherapists, occupational therapists and psychologists. MDT structures should support both administrative treatment processes and holistic care planning, with these functions clearly defined and, where appropriate, separated to improve efficiency.

Empowering this wider group of health and social care professionals with clear responsibilities can ensure patients see the most appropriate clinician at the right time.

However, there are several barriers to effective MDTs: workforce capacity constraints, geographical variation resulting in unequal access and overly complicated processes that undermine consistency. In some areas, consultant neurologists do routine assessments, even where other clinicians could provide appropriate care. This limits system capacity and creates unnecessary delays in the patient pathway. There are also areas where community MS and neurological services are not available. Alongside clinical roles, community-based support – including health coaches, social prescribing link workers and peer group support – can play a valuable part in helping patients manage their condition while also easing pressure on specialist teams. Clear terms of reference for different MDT forums, with defined outputs and triggers for escalation, would support greater accountability and reduce duplication.

To improve the efficiency of multidisciplinary care and deliver more responsive, sustainable follow-up, we recommend:

1. Expand virtual MDTs to improve access in remote or under-resourced areas and reduce the logistical burden of in-person meetings.
2. Clarify professional roles within MDTs so patients see the most appropriate clinician based on clinical need, rather than default pathways or availability.
3. Implement tailored follow-up schedules, informed by disease stability, treatment status and individual patient preferences, to ensure ongoing access to specialist MS expertise. Embed MS-specific follow-up within broader neurology clinics where appropriate.
4. Review MDT structures so routine treatment administration and coordination are managed efficiently, with dedicated nurse, pharmacist and coordinator capacity for ongoing DMT safety monitoring and risk management.

This would allow specialist teams to focus time and resources on those with the greatest need, while ensuring all patients feel supported and connected to their care team. Setting clear expectations at diagnosis around the team-based model, and who patients are likely to see and why, can reduce pressure on all members of the MS MDT and improve patient experience. By clearly defining professional roles and optimising team capacity, MS services can deliver more efficient, patient-centred care, even in the face of growing workforce and system pressures.

Case Study: Transforming MS Care in West Yorkshire through a Networked Service Model

Leeds Teaching Hospitals NHS Trust has worked with neighbouring trusts to redesign MS care around a networked model that delivers specialist expertise closer to home while optimising workforce capacity. The West Yorkshire MS Treatment Programme now spans Leeds, Bradford, Harrogate, Huddersfield and Halifax. Through outreach clinics, local MS nurses, virtual MDTs and shared prescribing arrangements, patients can access specialist care within their local area while also remaining connected to a regional neurosciences centre.¹²

A key feature of the model has been investment in workforce transformation. Leeds has developed dedicated MS Treatment Coordinator posts to support the growing complexity of MS care.

Two Band 5 coordinators support approximately 1,200 people receiving DMTs across Leeds and Bradford.¹ The coordinators serve as a direct point of contact for people with MS, handling 40-50 patient enquiries each week, coordinating treatment monitoring and prescription renewals, helping to manage non-clinical queries and liaising with neurologists, pharmacists and homecare providers to ensure timely treatment and care.¹

Expanding advanced nursing roles has enabled nurse-led DMT management clinics and transition clinics for people moving from relapsing-remitting MS to progressive MS.¹² This was made possible by promoting a Band 7 MS nurse to an independent Band 8 nurse prescriber, increasing service capacity and supporting a growing treatment population.¹²

By making better use of multidisciplinary expertise and streamlining care coordination, this model has helped the network meet key targets for referral to diagnosis and treatment initiation, in line with the 12-week standards in the Optimal MS Care Pathway.^{1,12}

Enabling this at scale

The **DHSC** should:

- Establish robust national monitoring against the Neurology Service Specification, including its requirements for networked and multidisciplinary care, with clear accountability for addressing variation in delivery.
- Ensure national workforce planning reflects the full requirements of MS care, including sufficient MS coordinator, specialist and advanced nursing, pharmacist, AHP and Advanced MS Champion capacity.
- Support the development and implementation of nationally consistent neurology workforce standards, including appropriate staffing levels and caseload benchmarks.

NICE should prioritise its identified research gap on care coordination models to support the development of more defined, evidence-based service models.

ICBs should design and coordinate networked MDT models across their population, connecting specialist, local and community services, with clear roles, referral and escalation routes.

Immediate priorities in more detail (continued)

Transform MS services to increase effective use of clinicians' time across the MS clinical network

Diagnostic delays risk irreversible disease progression and contribute significantly to patient anxiety and poor long-term engagement with services.¹³ Addressing both the speed and quality of diagnosis should be a top priority in improving the MS care pathway.

We believe delays in diagnosis cause avoidable distress, inefficiency and inequity, and result in unnecessary loss of function for people living with MS. Despite longstanding recognition of the importance of prompt diagnosis, systemic barriers continue to cause delays. This is particularly concerning given evidence that early treatment can delay disability progression and improve quality of life.¹⁴ These include:

- Long waiting times for specialist neurology appointments.
- Inconsistent referral pathways from primary care.
- Limited local access to diagnostic tools, particularly MRI scanning.

Diagnoses have been reported to be delayed by ICB-level decisions to restrict MRI referrals as a cost-saving measure, resulting in regional variation in access and further compounding inequalities.¹⁵

Beyond speed, patient experience of diagnosis is also a concern. Members of our group have examples of individuals receiving an initial diagnosis of MS via a letter, without adequate clinical explanation or the immediate access to support that a newly diagnosed patient requires. We know such experiences are unacceptable, distressing and harmful, with lasting implications for how patients relate to healthcare providers.

Diagnosis is a pivotal moment in a person's MS journey and must be handled with clarity, compassion and appropriate support to set the foundation for lifelong engagement with care. Poor communication and insufficient psychological or informational support at this stage can:

- Erode trust in the healthcare system.
- Limit future engagement with services.
- Negatively affect treatment adherence and wellbeing.
- Cause unnecessary harm to patients.

Improving diagnostic communication is essential, not just from a compassionate care perspective, but as a foundation for effective, long-term disease management. Early engagement with a range of clinicians - neurologists, MS nurses, pharmacists, neuro navigators and others - can ensure patients feel supported and know what to expect.

We believe there are several key reforms needed to improve both the speed and quality of MS diagnosis:

1. Develop locally agreed pathways that enable timely access to MRI scans for people with suspected MS, supported by clear referral criteria and specialist advice where appropriate.
 - This could be supported by consultant neurologist developed guidelines on MRI use and criteria.
2. Develop "red flag" systems or clinical prompts to support GPs to identify potential MS symptoms earlier and make more targeted referrals – an approach already established in some areas, including Southampton.
3. Introduce minimum standards for diagnostic delivery, including in-person communication of diagnosis and immediate signposting to the MS clinical network for support.

Ensuring patients are seen by the right professional at the right time can make better use of existing workforce capacity, reduce unnecessary pressure on consultants and create more responsive services.

Enabling this at scale

The **DHSC** should:

- Support rollout of standardised triage and referral pathways, including red-flag algorithm-supported systems that can be embedded locally in GP software and are aligned to the Optimal Care Pathway.
- Enforce the 6-week diagnostic standard for neurology pathways across ICB areas.

NICE should:

- Update its guidance on suspected neurological conditions (NG127) to strengthen referral pathways for suspected MS, including clearer criteria for appropriate use of MRI and specialist referral.
- Define and implement minimum standards for diagnostic delivery, building on current MS guidelines, to encourage:
 - In-person communication of diagnosis.
 - Provision of clear information, named contacts and next steps.
 - Timely follow up.

ICBs should consistently measure and track MS time-to-diagnosis and referral-to-treatment metrics to understand variation and delivery gaps.

Strengthen proactive, coordinated care closer to home that responds to patient need

We recognise the urgent need to move away from hospital-centric models of care and towards more proactive, coordinated care closer to home, aligned with the Government's ambitions for neighbourhood health. For people with MS, this should mean better access to community-based support, greater opportunities for supported self-management and digital innovation, and earlier intervention when needs change.

In practice, services often lack the infrastructure, visibility and coordination to deliver the Government's ambition for care closer to home. We acknowledge that both patients and clinicians often lack awareness of available community services, how to access them, and where responsibilities sit across the system. This contributes to gaps in care, duplication, avoidable reliance on secondary care teams and unplanned emergency admissions. We have concerns that "care closer to home" risks becoming an empty policy slogan unless it is supported by genuine investment in infrastructure and workforce.

We therefore believe there is a pressing need to establish clear care footprints across local systems, setting out available MS, neurology and neurorehabilitation services, how specialist care is connected and who is responsible for delivery. Networked models should also be supported to enable seamless transitions between specialist, community and primary care services throughout the disease course.

This shift is particularly urgent for people with progressive MS, who often experience a lack of structured care. Progressive MS can too often be treated as a 'dead-end' in service design, with limited pathways, fewer interventions and insufficient proactive care.

Immediate priorities in more detail (continued)

This means changes in symptoms can go unnoticed or be seen as inevitable, despite opportunities to improve quality of life through more active symptom management. This active management should consider a broad range of symptoms and needs, including fatigue, bladder and bowel dysfunction, pain, cognition, mood, sexual wellbeing, mobility and spasticity. Patients may also underreport changes or avoid raising concerns due to a perception that little can be done.

Monitoring should reflect the full impact of MS on day-to-day life. While the Expanded Disability Status Scale (EDSS) – a standard measure of MS-related disability – remains a useful measure of disability, it should not be relied on in isolation. Patient-reported outcomes and assessment of cognition, fatigue and mood can help identify deterioration that may not be captured through EDSS alone and should inform personalised care plans, proactive follow up and escalation.

Proactive support is also particularly important when a person's care needs change, such as when starting or switching DMTs, transitioning from relapsing-remitting to progressive MS or transferring from paediatric to adult services.

Patient-initiated follow-up (PIFU) could support more responsive care when adapted to reflect the complexity of MS. Tailored approaches, supported by appropriate clinical oversight, could give patients greater control over when they access support while helping teams respond more effectively to changing needs.

Digital tools can also play a significant role in bridging this gap, empowering patients to self-monitor symptoms, providing clinicians with early-warning data and helping to triage clinical contact based on real-time need. We identified strong potential in patient-reported outcome measures (PROMs), pre-clinic questionnaires and triage tools, particularly when embedded into clinical workflows and electronic patient records.

In addition, setting clear expectations at diagnosis about who patients will hear from, when, and how they can re-access support, can improve long-term engagement and reduce avoidable demand.

To support effective self-management and care closer to home, we recommend:

1. Establish clear local service maps and proactive care models for progressive MS within each ICB to define available support and referral pathways.
2. Upskill and resource community teams to manage stable patients within networked MS services, coordinate wider wellbeing support, and ensure timely escalation back to specialist services when required.
3. Provide enhanced support at key transition points, including starting or switching DMTs, progression of disease, and transfer between paediatric and adult services.
4. Expand access to digital self-monitoring tools, PROMs, and pre-clinic triage questionnaires that enable teams to identify and prioritise care based on need.
5. Provide structured self-management education and support throughout the disease course, including health literacy, symptom recognition and management, and clear information on how and when to access services.

Case Study: The Advanced MS Champion Programme

MS Trust estimated that around 32% of people diagnosed with MS in the UK have advanced MS and often lose contact with specialist services as their condition progresses.¹⁶ This means they may only become known to healthcare professionals when they reach crisis point, leading to avoidable deterioration.¹⁶ To reduce preventable disability, MS Trust established its Advanced MS Champion (AMSC) Programme, working with NHS organisations to fund specialist practitioners.

Leeds Teaching Hospitals NHS Trust introduced an AMSC role in September 2024, delivered by a senior neurological physiotherapist embedded within the MS MDT.¹⁷ The role works across specialist neurology, rehabilitation, primary care, palliative care, social care and voluntary sector services to identify unmet need, coordinate support and intervene before problems escalate.

Within the first 15 months of the programme, the Leeds AMSC role supported approximately 100 patients and helped avoid approximately 60 emergency hospital admissions.¹⁸ Interventions provided by the AMSC ranged from supporting bladder/bowel management, to ensuring the correct equipment was in place, and coordinating social care and benefit support.¹⁸

On respiratory-related admissions alone, there have been significant improvements following implementation of the AMSC role in Leeds. Between 2024 – 2025:

- Respiratory-related hospital admissions fell by 50%
- Total bed days reduced from 551 days to 301 days, a reduction of 250 bed days
- This equated to an estimated £90,250 saving in hospital bed costs.¹⁷

Moreover, evidence from the initial AMSC pilot saw an estimated £465,000 reduction in emergency admission costs, per site, per year.¹⁹

Importantly, the model has also enabled targeted support for groups who often face additional barriers to accessing care, including people experiencing homelessness, individuals with substance dependency and those who struggle to attend routine outpatient appointments.¹²

Since the first AMSC was appointed in 2018, MS Trust has continued to invest in and develop the programme, with a number of posts subsequently made permanent and the recruitment of additional partner sites providing an opportunity to further expand this model. The AMSC Programme demonstrates how targeted investment in proactive, symptom management and community-connected support can address unmet needs for people living with advanced MS, while reducing pressure on acute services.

To find out more about the Advanced MS Champion Programme, please visit:

<https://mstrust.org.uk/health-professionals/programmes/advanced-ms-champions-programme>

Enabling this at scale

The DHSC should:

- Require systems to establish clear neurology pathways with defined roles for community, secondary and specialist services.
- Ensure investment and workforce planning for the Neighbourhood Health Framework recognises the requirements of neurological care, including access to community and rehabilitation professionals and the digital tools needed to connect community and specialist teams.
- Support the development of a Modern Service Framework for neurological conditions.

NICE should embed EDSS within national data collections, service specifications, and digital standards to ensure it is consistently recorded and visible via the NHS app.

ICBs should ensure community services are visible, accessible and actively used. This should include local directories of support and direct referral routes from both primary and specialist care.

In summary, the time for change is now

Our understanding of MS has changed, but the healthcare system has not fully kept pace. We now know progression can start early without visible signs and that delays in care can have life-altering consequences. It is time to build a service model that reflects modern science, protects independence and meets the real needs of people living with MS today.

During a period of ongoing health system reform at a national and local level, it is the right time to improve MS care.

Long-term system change requires collaboration across sectors, bringing together industry, healthcare and patient voices, to create a future where MS care is as innovative and dynamic as the people it serves. This requires government policies that reflect the latest scientific understanding.

We remain committed, alongside Sanofi, to working towards a future of MS care which is proactive, personalised and preventative.

Together, we will continue to call for action on the areas outlined in the statement to deliver a care pathway that helps people living with MS retain their independence in the ways that matter to them, for as long as possible.

*This statement has been developed by
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