EQUALITY IMPACT ASSESSMENT RECORD

Title of policy/ practice/ strategy/ legislation etc.	Framework for Chronic Pain Management Care and Support	
Minister	Maree Todd MSP	
Lead official	**REDACTED**	
Officials involved in the EQIA	Name	Team
	REDACTED	Healthcare Quality and Improvement
Directorate: Division: Team	Healthcare Quality and Improvement, Planning and Quality, Clinical Priorities Unit	
Is this new policy or revision to an existing policy?	New	

Policy Aim

The aim is to provide timely access to effective, safe and person centred care and support that improves the quality of life and wellbeing of people living with chronic pain in Scotland. Chronic pain is defined as persistent or recurrent pain lasting longer than three months.[1]

AIM A: PERSON-CENTRED CARE
We will improve the consistency and quality of the information and advice received by people with chronic pain, increase healthcare professionals' understanding of the condition and its impact, and deliver better access to a range of local options to support self-management and wellbeing.

AIM B: ACCESS TO CARE
We will enhance access to support for people with chronic pain by improving how local and national services are planned and delivered so they have a more consistent and better coordinated experience of care.

AIM C: SAFE, EFFECTIVE SUPPORT TO LIVE WELL WITH CHRONIC PAIN
We will improve the choice and outcomes from pain management support available to people with chronic pain by evaluating and promoting sustainable delivery of effective and evidence-based care.

AIM D: IMPROVING SERVICES AND CARE
We will invest in pain management services by improving workforce knowledge and skills, enhancing the use of data and research, and developing national standards to deliver more consistent care outcomes for people with chronic pain.

Who will it affect?

Chronic pain is estimated to affect between one third and a half of adults in the UK, while in Scotland it is estimated that 5% report severe chronic pain, which impacts their daily activities and significantly affects all aspects of their physical, psychological and social health.[2,3]

Patients with chronic pain will often have one or more other long-term conditions.[4]

This Framework is for people living with chronic pain and those who treat or support people living with chronic pain.

The majority of formalised care for people experiencing chronic pain is delivered outwith specialist settings, predominantly in general practice, both as a standalone condition or as co-morbidity of another presenting condition.[5]

Public Health Scotland produce quarterly statistics on first appointments to Pain Clinics in secondary care.[6]

Hospital (Secondary Care) - pain clinics[7].

Year	Referrals	Accepted referrals	Seen
2019	20,959	18,120	12,073
2020	12,412	10,479	6,234

The data demonstrates that services were impacted, and continue to be, by measures put in place to respond to the COVID-19 pandemic. After being temporarily paused in March 2020, chronic pain services started to resume in June 2020 as part of the planned remobilisation of services.[8] In September 2020 a Framework for Recovery of the NHS Pain Management Services was published with further guidance on the resumption and continuation of services.[9]

Data is not currently reported centrally for return treatment appointments. Data is also not currently held centrally that can reliably quantify the different interventions undertaken. The range of interventions include infusions, nerve blocks, steroid injections and implantation of pumps and spinal cord stimulators etc.

What might prevent the desired outcomes being achieved?

Achieving the desired outcomes will be dependent on a number of factors not least the ongoing response to the COVID-19 pandemic, which continues to have such an unprecedented impact on society and all public services.

Feedback from across stakeholder groups indicates that workforce and infrastructure capacity, addressing training needs and skill gaps, health literacy, availability of information, associated costs and competing priorities

may present challenges to making progress at pace and achieving the desired outcomes.

Stage 1: Framing

Results of framing exercise

As the Chief Medical Officer has said "We must value and promote an inclusive culture with a diversity of race, age, gender, sexual orientation, religion, and disability. We need to continue to challenge ourselves to learn, to engage in sometimes difficult conversations and listen to those who are experiencing inequalities for any reason".[10]

The following requires further consideration by the Scottish Government to inform the decision-making process during and after consultation on the draft Framework has taken place.

- ***General Health; Long standing illnesses*** – chronic pain often presents as a comorbidity or element of multi-morbidity[11]. The Framework will therefore consider how care is provided for chronic pain across other clinical pathways.
- ***Mental wellbeing*** – there are links between chronic pain and poor mental health[12] [13] - the Framework recognises this and seeks to benefit people by improving coordination and planning of relevant support and services.
- ***Physical activity, sedentary activity*** – weight may exasperate joint pain as a symptom of other long term conditions[14] and higher impact chronic pain is associated with reduced physical activity and increased inactivity. One study suggests that nearly 40% of people who are obese experience chronic pain, and that the pain they report is more likely to be moderate to severe than chronic pain in those who are not obese.[15]
- ***Employment*** – people with chronic pain are more likely to experience issues affecting employment. (this will be looked at further in the Fairer Scotland Duty Impact Assessment)
- ***Ethnic background*** – there is some data to indicate a higher prevalence and impact of chronic pain amongst certain ethnic minorities.[16]
- ***COVID*** – there is some evidence to suggest pain may arise either as a direct ('Long COVID' symptom) or indirect (reduced activity, poorer mental health) result of the COVID-19 pandemic.[17]
- ***Sex*** – chronic pain is generally reported more frequently in women.[18]
- ***Age*** – reporting of chronic pain increases with age, however some data suggests some increase in reporting amongst young people.[19]
- ***Deprivation*** – conditions associated with chronic pain are also associated with deprivation.[20] (this will be looked at further in the Fairer Scotland Duty Impact Assessment)
- ***Sexual orientation and gender identity*** – data from NHS England indicates that LGB people report higher levels of painful conditions (e.g. arthritis) compared to heterosexual people.[21] There is a limited data on the impact of chronic pain on transgender individuals with some indication that gender identify may play a role in pain sensation.[22]

We should also be aware of the need to consider the intersectionality between each of the characteristic groups. For example:

- Older people from ethnic minority backgrounds may have a different experience than older people in general.
- People with protected characteristics are associated with higher rates of relative poverty, e.g. disabled people.

In order to ensure the voice of people with lived experience of chronic pain are involved in co-producing the Framework and other relevant policies, the Government funded the Health and Social Care Alliance to establish the Chronic Pain Patient Reference Group (CPPRG) in February 2020. The group comprised both people with chronic pain and those who care for them, and currently has ~100 members. The PRG also nominated ten representatives to the National Advisory Committee for Chronic Pain (NACCP) with a responsibility to ensure the voices of the entire group are heard in policy discussions.

Other sources of information on the experience of people with chronic pain in Scotland are provided by regular engagement and feedback from various third-sector organisations, many of whom are also members of the NACCP.

The consultation included a question on impact of the policy the following shows what was submitted. Topics raised were previously identified during this assessment these please see annex A

Extent/Level of EQIA required

Full EQIA. This will continue to be reviewed and updated during the public consultation and implementation of the Framework.

Stage 2: Data and evidence gathering, involvement and consultation

Include here the results of your evidence gathering (including framing exercise), including qualitative and quantitative data and the source of that information, whether national statistics, surveys or consultations with relevant equality groups.

Characteristic[1]	Evidence gathered and Strength/quality of evidence	Source	Data gaps identified and action taken
AGE	Although chronic pain can affect anyone at any time chronic the available literature suggests that older people have a higher prevalence of chronic pain than younger groups of patients. With increasing age comes the possibility of other conditions or experiences that could trigger chronic pain. In 2019, just under one in five people (19%) in Scotland were aged 65 and over. Scotland's population is ageing due to: • People born in the post-war and 1960s baby booms getting older • People living longer due to higher life expectancy than earlier decades • the number of births falling since the 1960s Less than 1% of the older population are in hospital at any given time. But older people are stereotyped as a characterised by passivity,	Prevalence of chronic pain in the UK: a systematic review and meta-analysis of population studies - PubMed (nih.gov) National Record of Scotland, Mid-year population estimates Scotland, mid-2019 (Edinburgh, 2020) pp. 3 https://www.kingsfund.org.uk/publications/age-discrimination-health-and-social-care https://www.gov.scot/publications/evaluation-near-video-consulting-service-scotland-during-covid-19-2020-main-report/	The Framework is aimed at adult services. An approach was made to a third sector organisation working in older people's care and we will continue to pursue engagement and feedback. It is also important to highlight the move towards a more digital delivery and that thought has to be given to people who struggle to access the support they need through such mediums and a blended approach must be used e.g. face to face consultations when appropriate. Feedback was sought from NHS services and third-sector delivery partners on the impact of establishing digital pathways during the COVID-19 pandemic.

[1] Refer to Definitions of Protected Characteristics document for information on the characteristics

Characteristic[1]	Evidence gathered and Strength/quality of evidence	Source	Data gaps identified and action taken
	failing physical and mental health, and dependency. Historically, clinical trials and medical research have tended to exclude older patients. Although this is changing, knowledge about the impact of treatments on older people is often limited and older patients may be unfairly denied access to some interventions as a result. There is also evidence to suggest that older people can also be viewed negatively by GPs because they are perceived to generate a disproportionate amount of work. There are also examples of indirect discrimination that can impact on older people's experiences or health care. For example, the pressure to minimise inpatient stay in hospitals can adversely affect patients who take longer to recover from surgery or illness, such as older people. It is recognised that older people are less likely to have access to the internet or may be less confident or knowledgeable in the use of technology. This could have an adverse effect to them with the use of digital models of care and support. During the pandemic a blended approach was used and this is likely to continue for some while.		Consideration must be given how to reach people unable to access digital sources – e.g. printed leaflets, accessible formats. Evaluation was carried out of existing Government policies on access to care and support including Health Literacy activity, the Digital Health and Care Strategy refresh in order to reflect relevant action in the draft Framework.

Characteristic[1]	Evidence gathered and Strength/quality of evidence	Source	Data gaps identified and action taken
	Children and Young People Epidemiological studies indicate a prevalence of chronic and recurrent pain in children of 15-30%, with 8% of children reported as having severe and frequent pain	Management of chronic pain in children and young people: summary - gov.scot (www.gov.scot)	The Framework is aimed at adult services however we are aware the very small numbers may be referred to adult services. We have convened meetings with clinicians who have a special interest in Paediatric chronic pain. We will also take cognisance of the ongoing work on transitions policy to inform our implementation.
DISABILITY	Effective communication and information exchange is essential within all healthcare settings – for example, providing information in an easy read format. However, communication difficulties can present a particular barrier for many people with learning disabilities and limit the ability to share information regarding their health concerns and health needs. Additionally, health professionals may lack confidence and experience in communicating with and identifying the needs of people with learning disabilities in health care settings and require further education, training and support. In the absence of appropriate support, chronic pain can be a contributory factor to disability. Conditions associated with persistent pain, such as low back and neck pain, osteoarthritis and other musculoskeletal disorders, are estimated to	Vos T. Allen C. Arora M. et al. Global, regional, and national incidence, prevalence, and years lived with disability for 328 diseases and injuries for 195 countries, 1990–2016: a systematic analysis for the Global Burden of Disease Study 2016. Lancet. 2017; 390: 1211-1259 Scottish Burden of Disease study (2016). Kovacs FM, Seco J, Royuela A, Barriga A, Zamora J. Prevalence and factors associated with a higher risk of neck and back pain among permanent wheelchair users: a cross-sectional study. *Spinal Cord*. 2018;56(4):392-405. doi:10.1038/s41393-017-0029-z	There is guidance available on treating chronic pain in patients with complex communication needs such as down syndrome or dementia. To ensure full engagement consideration has to be taken of the following: accessible venues, e.g. for people who use wheelchairs or have sight loss • information available in accessible formats and languages or BSL • elimination of other communication barriers; • the provision of quieter spaces, allowing more time for appointments, smaller clinics and

Characteristic[1]	Evidence gathered and Strength/quality of evidence	Source	Data gaps identified and action taken
	be among the largest contributors to years lived with disability in Scotland. One study found that 60.8% of people with chronic pain had severe depression.	Rayner L, Hotopf M, Petkova H, Matcham F, Simpson A, McCracken LM. Depression in patients with chronic pain attending a specialised pain treatment centre: prevalence and impact on health care costs. Pain. 2016;157(7):1472-1479. doi:10.1097/j.pain.00000000	appropriate staff training to support the needs of people with Learning Disabilities, Autism, Sensory Impairments and mental health conditions; • consideration of the needs of people with mobility impairments or mental health conditions who may be unable to leave their home to attend an appointment; • provision for the needs of people who may require to attend the appointment with a support (paid/unpaid carer, family member, friend, interpreter, guide support etc.); • access to digital and non-digital information and services;
SEX	Men are less likely to report chronic pain than women, several reviews have studied how gender (role) and sex (biological) differences are related to the way men and women experience pain. A 2018 review of evidence concluded that the reason for the mechanisms behind these sex-specific differences in pain perception and pain prevalence is unclear there is some evidence for the role of oestrogens and genetics, including sex-specific differences in the contribution of pain-related genes.	Chronic pain: a review of its epidemiology and associated factors in population-based studies. Sarah E. E. Mills, Karen P. Nicolson and Blair H. Smith Women's health plan - gov.scot (www.gov.scot) Transvaginal Mesh Removal (Cost Reimbursement) (Scotland) Bill	We will work collaboratively with other partners to ensure there are appropriate pathways for women with pain/ painful conditions.

Characteristic[1]	Evidence gathered and Strength/quality of evidence	Source	Data gaps identified and action taken
	There is some evidence to indicate that chronic pain can be more common in the female population. Additionally, they also suffer from female-specific pains; particularly in their pelvis, including period pain (dysmenorrhoea) and the pains associated with diseases such as endometriosis. The Women's Health Plan includes activity to improve access for women to appropriate support, speedy diagnosis and best treatment for endometriosis; improve access to information for girls and women on menstrual health and management options. The Transvaginal Mesh Removal (Cost Reimbursement) (Scotland) Bill was introduced in the Scottish Parliament on 23 June 2021. The purpose of the Bill is to give power to the Scottish Ministers to reimburse persons who have entered into arrangements privately and have paid to have transvaginal mesh removed from their body, in relation to the costs of removal surgery and also reasonable connected expenses.		
PREGNANCY AND MATERNITY	A 2018 literature review concluded that the management of chronic pain associated with pregnancy is understudied. The overall prevalence of pregnant women with pre-existing chronic pain disorders was unknown. Likewise, the general course of chronic pain conditions during pregnancy had not been studied. Pre-existing chronic pain disorders have	Chronic pain during pregnancy: a review of the literature (nih.gov)	We will ensure that opportunities to shape models of care are carried out collaboratively with relevant partners

Characteristic[1]	Evidence gathered and Strength/quality of evidence	Source	Data gaps identified and action taken
	a negative impact on pregnancy and are associated with increased sick leave use, insomnia, and depressive symptoms during pregnancy.		
GENDER REASSIGNMENT	It is not possible to find a precise estimate on the number of trans people in Scotland however a ~~ScotPHN~~ report estimated the number in 2018 as 0.5% of the population, which equated to around 27,000 people in Scotland We are aware that people who identify as trans may face similar challenges in accessing health care as those identified within the sexual orientation section. However, these may be amplified. While wider societal attitudes towards LGB people has shifted positively in the last two decades, this is not reflected within attitudes towards trans people. Trans people report a number of barriers to accessing health care including prejudice and bias among health care staff, a lack of understanding of trans experience and health issues. In particular, trans people report particular challenges in engaging with primary care, who are often seen as 'gatekeepers' to other health services. There is a reported reluctance for trans people to reveal their identity due to fear of reprisal. This anxiety can be present even for non sex specific procedures.	https://www.scotphn.net/wp-content/uploads/2017/04/2018_05_16-HCNA-of-Gender-Identity-Services-1.pdf House of Commons, Women and Equalities - Transgender Equality	There is a lack of comprehensive evidence on the experience and impact of chronic pain on transgender people. We will identify opportunities in the implementation of the Framework to increase the data available on the impact and experience of transgender and other LGBI people of chronic pain and associated services. We will work with third-sector and other expert groups such as the Scottish Trans Alliance and carry out engagement activity to ensure trans patients are treated with dignity and respect as part of the implementation of the Framework.

Characteristic[1]	Evidence gathered and Strength/quality of evidence	Source	Data gaps identified and action taken
SEXUAL ORIENTATION	In 2019, 2.7% of adults in Scotland self-identified as lesbian, gay, bisexual or other (Scottish Surveys Core Questions 2019 (SSCQ)). This is similar to the UK figure (2.7%) for 2019 from the Annual Population Survey. Results from a US study indicated sexual orientation disparities in chronic pain frequency among both female and male youth, with sexual minorities generally reporting greater frequency of chronic pain compared to completely heterosexuals. Prospectively examined factors accounted for a sizable portion of these disparities, but more research is needed to understand why these disparities are occurring. Sexual orientation disparities in chronic pain have important implications for clinical practice. Chronic pain is longitudinally associated with increased risk for suicidality among youth, particularly when comorbid depressive symptoms are present (van Tilburg et al., 2011). Health care providers should take underlying psychological factors into account when presented with somatic complaints from adolescent and young adult patients, rather than simply addressing the pain itself. Awareness of sexual orientation disparities in chronic pain and associated factors is crucial to efforts to reduce these disparities.	https://www.scotpho.org.uk/population-groups/sexual-minorities/key-points/ Factors associated with sexual orientation and gender disparities in chronic pain among U.S. adolescents and young adults (nih.gov)	We will work with third-sector and other expert groups and carry out engagement activity to ensure LGB patients are treated with dignity and respect as part of the implementation of the Framework.
RACE	There is some evidence to suggest that chronic pain disproportionately affects some minority ethnic groups. In England, 44% of Black people	Versus Arthritis. (2021). Chronic pain in England: Unseen, unequal, unfair.	An approach was made to a third sector organisation working with minority ethnic groups and we will

Characteristic[1]	Evidence gathered and Strength/quality of evidence	Source	Data gaps identified and action taken
	have chronic pain, compared with 34% of white people, 35% of Asian people, 34% of people of mixed ethnicity and 26% of people from other ethnicities. Chronic pain and depression reporting varies across ethnic groups. Differences in health seeking behavior between ethnic groups may impact on the results reported. Clinicians, particularly in primary care, need to be aware of the cultural barriers within certain ethic groups to expressing concern over mood and to consider their approach accordingly.	https://bmcfampract.biomedcentral.com/articles/10.1186/s12875-015-0343-5	continue to pursue engagement and feedback. We will continue to engage with organisations to ensure everyone can participate.
RELIGION OR BELIEF	In a 2016 survey, 60% of Church of Scotland members were over 60; half of Muslims were under 35. The same survey found that there were slightly lower levels of good or very good general health among those identifying with the Church of Scotland (68.8%) than those identifying as Roman Catholic, Muslim and Other, who reported at 71.9%, 71.0% and 70.4% respectively. The perceived role of religion in illness and recovery is a primary influence upon health care beliefs and behaviours which may differ by religion. Most religions have traditional beliefs and practices relating to healthy living, illness and death. An example of a religious belief that can have a particular impact on the care	Scottish Surveys Core Questions 2016 - gov.scot (www.gov.scot) pp. 40 – 41	We will work with partners in collaboration with local communities, including those centred around religious belief.

Characteristic[1]	Evidence gathered and Strength/quality of evidence	Source	Data gaps identified and action taken
	delivered is that neither organ transplantation nor blood transfusion is permitted within the Jehovah's Witness religion. Incorporating spirituality or religion into health care requires the same skills that competent practitioners already use in the delivery of person-centred care. These skills are underpinned by the principles of respect and collaboration. Such an approach underpins the ethos of realistic medicine which is reinforced throughout the strategy.		
MARRIAGE AND CIVIL PARTNERSHIP (the Scottish Government does not require assessment against this protected characteristic unless the policy or practice relates to work, for example HR policies and practices - refer to Definitions of Protected Characteristics document for details)	The Framework does not cover marriage or civil partnership therefore no assessment is required. There is no evidence to suggest that this group will be affected by the Framework.	-n/a	n/a

Stage 3: Assessing the impacts and identifying opportunities to promote equality

Having considered the data and evidence you have gathered, this section requires you to consider the potential impacts – negative and positive – that your policy might have on each of the protected characteristics. It is important to remember the duty is also a positive one – that we must explore whether the policy offers the opportunity to promote equality and/or foster good relations.

Do you think that the policy impacts on people because of their age?

Age	Positive	Negative	None	Reasons for your decision
Eliminating unlawful discrimination, harassment and victimisation			X	Our policy does not specifically address unlawful discrimination, harassment and victimisation.
Advancing equality of opportunity	X			Through our commitment to implementing our policy, supported by a robust lived experience structure, we seek to amplify the voices of people who may face inequality of on the basis of age.
Promoting good relations among and between different age groups			X	Our policy does not specifically address relations among different age groups.

Do you think that the policy impacts disabled people?

Disability	Positive	Negative	None	Reasons for your decision
Eliminating unlawful discrimination, harassment and victimisation			X	Our policy does not specifically address unlawful discrimination, harassment and victimisation.
Advancing equality of opportunity	X			Through our commitment to implementing our policy, supported by a robust lived experience structure, we seek to amplify the voices of people who may face inequality on the basis of disability.

Promoting good relations among and between disabled and non-disabled people			X	Our policy does not specifically address relations between disabled and non-disabled people.

Do you think that the policy impacts on men and women in different ways?

Sex	Positive	Negative	None	Reasons for your decision
Eliminating unlawful discrimination			X	Our policy does not specifically address unlawful discrimination, harassment and victimisation.
Advancing equality of opportunity	X			Through our commitment to implementing our policy, supported by a robust lived experience structure, we seek to amplify the voices of people who may face inequality on the basis of their sex.
Promoting good relations between men and women			X	Our policy does not specifically address relations between disabled and non-disabled people.

Do you think that the policy impacts on women because of pregnancy and maternity?

Pregnancy and Maternity	Positive	Negative	None	Reasons for your decision
Eliminating unlawful discrimination			X	Our policy does not specifically address unlawful discrimination, harassment and victimisation.
Advancing equality of opportunity			X	Through our commitment to implementing our policy, supported by a robust lived experience structure, we seek to amplify the voices of people who may face inequality.
Promoting good relations			X	Our plan does not specifically promote good relations.

Do you think your policy impacts on people proposing to undergo, undergoing, or who have undergone a process for the purpose of reassigning their sex? (NB: The Equality Act 2010 uses the term 'transsexual people' but 'trans people' is more commonly used)

Gender reassignment	Positive	Negative	None	Reasons for your decision
Eliminating unlawful discrimination			X	Our policy does not specifically address unlawful discrimination, harassment and victimisation.
Advancing equality of opportunity	X			Our policy specifically identifies the need to ensure that trans people are included within our lived experience structure that will underpin implementation of the plan.
Promoting good relations			X	Our plan does not specifically promote good relations.

Do you think that the policy impacts on people because of their sexual orientation?

Sexual orientation	Positive	Negative	None	Reasons for your decision
Eliminating unlawful discrimination			X	Our policy does not specifically address unlawful discrimination, harassment and victimisation.
Advancing equality of opportunity	X			Our policy specifically identifies the need to ensure that people who are LGB are included within our lived experience structure that will underpin implementation of the plan.
Promoting good relations			X	Our plan does not specifically promote good relations.

Do you think the policy impacts on people on the grounds of their race?

Race	Positive	Negative	None	Reasons for your decision
Eliminating unlawful discrimination			X	Our policy does not specifically address unlawful discrimination, harassment and victimisation.
Advancing equality of opportunity	X			Through our commitment to implementing our policy, supported by a robust lived experience structure, we seek to amplify the voices of people who may face inequality on the basis of their race..
Promoting good race relations			X	Our plan does not specifically promote good relations.

Do you think the policy impacts on people because of their religion or belief?

Religion or belief	Positive	Negative	None	Reasons for your decision
Eliminating unlawful discrimination			X	Our policy does not specifically address unlawful discrimination, harassment and victimisation.
Advancing equality of opportunity			X	Our plan promotes the delivery of person centred care, in line with Realistic Medicine, which involves ensuring that care is delivered in line with what matters to people – including their religion or belief.
Promoting good relations			X	Our plan does not specifically promote good relations.

Do you think the policy impacts on people because of their marriage or civil partnership?

Marriage and Civil Partnership[2]	Positive	Negative	None	Reasons for your decision
Eliminating unlawful discrimination	N/A	N/A	N/A	N/A

[2] In respect of this protected characteristic, a body subject to the Public Sector Equality Duty (which includes Scottish Government) only needs to comply with the first need of the duty (to eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under the Equality Act 2010) and only in relation to work. This is because the parts of the Act covering services and public functions, premises, education etc. do not apply to that protected characteristic. Equality impact assessment within the Scottish Government does not require assessment against the protected characteristic of Marriage and Civil Partnership unless the policy or practice relates to work, for example HR policies and practices.

Stage 4: Decision making and monitoring

Identifying and establishing any required mitigating action

If, following the impact analysis, you think you have identified any unlawful discrimination – direct or indirect - you must consider and set out what action will be undertaken to mitigate the negative impact. You will need to consult your legal team in SGLD at this point if you have not already done so.

Have positive or negative impacts been identified for any of the equality groups?	Yes, positive impacts have been identified for a number of groups relating to the advancement of equality of opportunity
Is the policy directly or indirectly discriminatory under the Equality Act 2010[3]?	No
If the policy is indirectly discriminatory, how is it justified under the relevant legislation?	n/a
If not justified, what mitigating action will be undertaken?	N/a

Describing how Equality Impact analysis has shaped the policy making process

The EQIA has allowed to show that the Framework will not have any negative impact on equalities but has allowed us to think about how we engage with people living with chronic pain and making the Framework accessible to a greater number of people.[23,24]

We will continue to work with stakeholders to ensure that equality continues to be considered during the consultation and implementation phases.

The EQIA has identified that we should continue to engage with equality organisation to understand the needs e.g. do some groups with protected characteristics tend to experience more with chronic pain than any other – for example religious beliefs (or lack of) marriage status or sexuality?

Over Autumn 2021, officials collaborated with the Health and Social Care Alliance (the ALLIANCE) to design and deliver a survey of people with lived experience of chronic pain (including those who may be in a caring role for someone with the condition).[25]

[3] See EQIA – Setting the Scene for further information on the legislation.

This survey was web-based and developed to increase the input of people with chronic pain across Scotland in policy development activity, including those who were not already part of formal structures such as the NACCP or CPPRG.

The survey included questions which sought to identify priority areas for action for people with chronic pain in relation to the services they use, the wider impact of their condition on their quality of life and wellbeing and their expectations of support and care.

The survey also included demographic questions in order to better understand the respondent cohort and to identify and target 'gaps' in any future engagement activity.

Over 450 people participated in the survey and its findings were published by the ALLIANCE in November 2021[26] with outputs intended to inform the content of the draft Framework ahead of formal public consultation.

Monitoring and Review

This is a living document. We included a draft in the public consultation document to ensure that we had the opportunity to hear from people with protected characteristics and to identify further evidence and groups who may be impacted by the policies in the Framework and who's specific needs should be taken into account. An Implementation Lead has been appointed to take forward the work on the Framework which will include monitoring of the EQIA.

Stage 5 - Authorisation of EQIA

Please confirm that:

- ♦ This Equality Impact Assessment has informed the development of this policy:

  Yes ☒ No ☐

- ♦ Opportunities to promote equality in respect of age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex and sexual orientation have been considered, i.e.:

  - ○ Eliminating unlawful discrimination, harassment, victimisation;
  - ○ Removing or minimising any barriers and/or disadvantages;
  - ○ Taking steps which assist with promoting equality and meeting people's different needs;
  - ○ Encouraging participation (e.g. in public life)
  - ○ Fostering good relations, tackling prejudice and promoting understanding.

  Yes ☒ No ☐

♦ If the Marriage and Civil Partnership protected characteristic applies to this policy, the Equality Impact Assessment has also assessed against the duty to eliminate unlawful discrimination, harassment and victimisation in respect of this protected characteristic:

Yes ☐ No ☐ Not applicable ☒

Declaration

I am satisfied with the equality impact assessment that has been undertaken for [insert policy title here] and give my authorisation for the results of this assessment to be published on the Scottish Government's website.

Name:
Position: [Deputy Director level or above]
Authorisation date:

Annex A

Extract from consultation

Fear of not being taken seriously; Vulnerable people such as those with mental health, the elderly and those living in poor social and demographic areas; addiction issues, homeless; travelling community; Mesh survivors; People may well have turned to alternative substances;

persistent pain on children and families, isolated people, those admitted to hospital in acute emergency; https://www.pslhub.org/learn/patient-engagement/patient-stories/how-can-patients-voices-be-heard-and-acted-upon-when-they-attempt-to-report-incidents-of-harm-r5700 ; Special consideration needs to be made for cancer patients, those with life limiting conditions . The document does not address the pain needs of those undergoing surgery and those admitted to hospital with flare ups of chronic pain. A million surgeries are performed every year in Scotland and 5 million in the UK annually. This is a significant number of people with acute pain issues. The implementation framework is completely silent on this issue

Health inequalities are very apparent in chronic pain. That is why access to good care should be free, local, timely, compassionate, empathetic and person centred.

This Framework will benefit whole families.

Secondary impact on other service users if vision isn't resourced properly.

People in contact with the criminal justice system requiring input for pain management.

I note you use 'race' as a protected characteristic. Ethnicity/ ethnic background is more helpfully used in health and this should be self-identified.

Suicide risk is a reality - worsened by lockdowns

Family whiprounds sent some to England for private infusions, etc. as private hospitals here were used for other matters by Govt. Lives are at risk while this waffle goes on.

health inequalities and specific work programmes for all target groups. The Framework should reflect this approach, committing to the development of a strategy to tackle inequalities, focusing on programmes related to women, ethnicity and social deprivation.

For women living with chronic pain, the Scottish Government's Women's Health Plan is an opportunity to connect with a broader framework tackling inequalities. The Framework should commit to engaging (when appointed) with the national Women's Health Champion and Health Board leads to inform and develop their understanding of chronic pain on women with the aim of including chronic pain in the next iteration of the Plan.

There is potential for groups who are digitally excluded to be impacted by this framework, together with people who may have language or communication barriers.

Women are more likely to experience medical gas lighting than men and their genuine complaints about chronic pain are more likely to be ignored.

A lot of healthcare practice is still centred around male physiology and women's experiences of chronic pain are often belittled, misunderstood, or mistreated.

There are many chronic pain conditions that affect women more than men including fibromyalgia, migraine and chronic tension-type headache, irritable bowel syndrome, temporomandibular disorders, and interstitial cystitis.

There is a lack of research and support for conditions primarily affecting ethnic minority communities, such as sickle cell anaemia.

In rural and island communities, access to effective, joined up services is a lot more difficult.

Women with childcare or other caring responsibilities are often disadvantaged in accessing services and there needs to be better support to enable them to attend appointments.

Accessibility of services needs to look at how people on low incomes are disadvantaged e.g., a lack of local health services in areas of high deprivation, or people not being able to afford to travel to health appointments.

Medication for chronic pain can affect women's bodies differently to men's e.g., women developing osteoporosis as a result of other long-term medication.

Women for whom English is not their first language need to be given extra support such as translation services but also better outreach in communities to overcome the cultural barriers that might prevent them coming forward with their concerns about chronic pain.

[1] International Association for the Study of Pain. Classification of Chronic Pain, Second Edition (Revised). https://www.iasp-pain.org/publications/free-ebooks/classification-of-chronic-pain-second-edition-revised/

[2] Fayaz A, Croft P, Langford RM, Donaldson LJ, Jones GT. Prevalence of chronic pain in the UK: a systematic review and meta-analysis of population studies. BMJ Open. 2016 Jun 20;6(6):e010364. doi: 10.1136/bmjopen-2015-010364. PMID: 27324708; PMCID: PMC4932255.

[3] Smith BH, Elliott AM, Chambers WA, Smith WC, Hannaford PC, Penny K. The impact of chronic pain in the community. *Family Practice* 2001 **18** 292 – 299

[4] Barnett K. Mercer S.W. Norbury M. Watt G. Wyke S. Guthrie B. Epidemiology of multimorbidity and implications for health care, research, and medical education: a cross-sectional study. Lancet. 2012; 380: 37-43

[5] Pain Proposal. Improving the current and future management of chronic pain. European Pain Federation (2016).

[6] Chronic pain waiting times - Quarter ending 30 June 2021 - Chronic pain waiting times - Publications - Public Health Scotland

[7] https://publichealthscotland.scot/publications/show-all-releases?id=20547

[8] https://www.gov.scot/publications/re-mobilise-recover-re-design-framework-nhs-scotland/

[9] Framework+for+the+Recovery+of+NHS+Pain+Management+Services.pdf (www.gov.scot)

[10] Chief Medical Officer - annual report: 2020 to 2021 - gov.scot (www.gov.scot)

[11] Epidemiology of multimorbidity and implications for health
care, research, and medical education: a cross-sectional study. Barnett et al. Lancet. 2012 Available on-line: https://www.thelancet.com/action/showPdf?pii=S0140-6736%2812%2960240-2

[12]Expectancy, fear and pain in the prediction of chronic pain and disability: a prospective analysis. Boersma et al. Eur J Pain. 2006. Available on-line: https://onlinelibrary.wiley.com/doi/abs/10.1016/j.ejpain.2005.08.004

[13] Comorbid Depression, Chronic Pain, and Disability in Primary Care Arnow et al. Rheumatology. 2006. Available on-line: https://journals.lww.com/psychosomaticmedicine/Abstract/2006/03000/Comorbid_Depression,_Chronic_Pain,_and_Disability.13.aspx

[14] Comorbidity of Obesity and Pain in a General Population Hitt at al. Pain. 2007. Available on-line: https://www.sciencedirect.com/science/article/abs/pii/S1526590007000065

[15] Coaccioli S. Masia F Celi G.Grandone I. Crapa M.E. Fatati G. Chronic pain in the obese: a quali-quantitative observational study.Recenti Prog Med. 2014; 105: 151-154

[16] The unequal burden of pain: confronting racial and ethnic disparities in pain. Green et al. Pain Med. 2003. Available on-line: https://pubmed.ncbi.nlm.nih.gov/12974827/

[17] https://data.gov.scot/coronavirus-covid-19/

[18] Prevalence of chronic pain in the UK: a systematic review and meta-analysis of population studies https://pubmed.ncbi.nlm.nih.gov/27324708/

[19] Prevalence of chronic pain in the UK: a systematic review and meta-analysis of population studies https://pubmed.ncbi.nlm.nih.gov/27324708/

[20] Scottish Burden of Disease: Deprivation Report (scotpho.org.uk)

[21] Health Survey for England. Health and health-related behaviours of Lesbian, Gay and Bisexual adults. 2021. Available online: https://digital.nhs.uk/data-and-information/publications/statistical/health-survey-england-additional-analyses/lesbian-gay-and-bisexual-adults

[22] Strath et al. Sex and Gender are Not the Same: Why Identity is important for people living with HIV and Chronic Pain. *J Pain Res.* 2020. Available on-line: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7187934/

[23] https://www.gov.scot/publications/planning-people/

[24] Lightbody, R. (2017) 'Hard to reach' or 'easy to ignore'? Promoting equality in community engagement, Edinburgh: What Works Scotland.

[25] https://www.alliance-scotland.org.uk/wp-content/uploads/2021/11/My-Path-My-Life-My-Right-to-Live-Well-November-2021-1.pdf