

Framework for pain management service delivery

**Analysis of responses to the consultation
exercise**

July 2022

Contents

Executive summary	i
Introduction	1
Background to the consultation	1
Profile of main consultation respondents.....	1
Analysis and reporting	2
Vision	3
Aim A: Person-Centred Care	6
Aim B: Timely access to care	11
Aim C: Safe, effective treatments	17
Aim D: Improving quality of life and wellbeing	22
Training and support for healthcare professionals	22
Using Data to Improve Services and Support	25
Promoting Research and Best Practice.....	28
Implementing and delivering the Framework.....	32
Annex 1 - Organisations responding to the consultation.....	42
Annex 2 – Quantitative results.....	43

Executive summary

This summary presents key findings from the independent analysis of responses to the Scottish Government's consultation on the Framework for pain management service delivery (the Framework). The consultation was launched on 6 December 2021 and closed on 28 February 2022.

In total 114 responses were received. Twenty-six responses were submitted by organisations and 88 by individual members of the public.

In their further comments, a number of individual respondents referred to their own experience of living with chronic pain, sometimes over many years. They spoke of the detrimental impact that living with chronic pain has had on their lives, and sometimes of their difficulties in accessing the healthcare and support they needed.

Chronic pain

We all experience pain as part of a normal response to injury or illness and treatment of the underlying medical issue or condition may resolve the pain. However, pain may persist beyond normal tissue healing time, or in some cases has no identifiable underlying cause. Chronic pain is pain that persists or recurs for longer than three months. It is a separate condition in its own right, and not merely an accompanying symptom of other diseases. Chronic pain is a common condition and estimates suggest it affects between one third and a half of adults in the UK. In Scotland it is estimated that 5% report severe chronic pain, which means it impacts their daily activities and quality of life.

The impact of the COVID-19 pandemic

Development and consultation on the Framework were carried out during the COVID-19 pandemic. As with those in the rest of the UK, pain management services in Scotland were impacted by the pandemic and while most services have now been restarted, Health Boards and pain teams continue to face challenges as the NHS recovers. In the consultation document the Scottish Government set out that they intend for the Framework to guide Boards and other providers in their work to rebuild pain management support.

Overall, while a number of respondents to the consultation acknowledged the impact of the pandemic, most respondents focused on issues they had identified, or which existed, prior to the pandemic. This suggests that most respondents did not consider the status of services during the pandemic as representative.

Vision

Person-centred, effective and safe care that improves the quality of life and wellbeing of people with chronic pain in Scotland

A substantial majority – 93% of those answering the question – agreed with the overarching Vision.

In explaining their support for the Vision, a number of respondents who noted that they themselves live with chronic pain, highlighted the impact that chronic pain can have on people's lives. Some expressed a hope that the Framework and Vision will lead to positive change.

An emphasis on enabling people to make changes and take ownership of their own health was seen as key. It was noted that providing person-centred care, including shared decision making, should be at the heart of everything health professionals do. Focusing on quality of life and wellbeing was also seen as crucial, including because it creates a focus on reducing the impact of chronic pain on patients and their families.

Aim A: Person-centred care

A substantial majority – 96% of those answering the question – thought that Aim A should be a priority. A substantial majority – 90% – also thought that Commitment 1 should be included.

In their comments a number of respondents, including individuals with lived experience of chronic pain, commented on the importance of being able to access the right information. However, some respondents reported that they have not received the information and ongoing support they needed. Improving quality and consistency was seen as beneficial to both patients and healthcare professionals. The importance of information being available and accessible to all was also stressed.

Aim B: Timely access to care

A substantial majority – 97% of those answering the question – thought that Aim B should be a priority. Commitments 2 and 3 were supported by 95% and 91% respectively.

In terms of offering the right care, how services should work together was a central issue for a number of respondents. There were references to the development of referral pathways. A number of respondents highlighted the importance of adopting a multidisciplinary team (MDT) approach in primary care. However, there was a concern that it is not clear which mechanisms will be used to ensure that NHS Boards take steps to improve their planning and delivery of services.

Although digital services – including consultations – were seen as bringing real benefits, a number of respondents also commented that patients should also have the option of face-to-face appointments. It was acknowledged that technical or personal issues will mean that the digital approach is not right for all and there was support for the reference to using digital technology 'where appropriate'.

Aim C: Safe, effective treatments

A substantial majority – 93% of those answering the question – thought that Aim C should be a priority. Commitments 4 and 5 were supported by 94% and 95% respectively.

A number of the respondents addressed what is meant by ‘effective’. It was seen as important that treatment provision is based, as far as possible, on best available evidence of effectiveness. A common theme was that it will be important to share information about which treatment options are effective, and in particular to share messages that self-management is an effective treatment.

Some of the comments addressed current variations in the treatment people receive. For example, it was suggested that as a patient, your treatment will depend on where you live. It was considered essential that patients should have equitable access to effective treatment regardless of their Health Board area.

With reference to effective treatment options, there was support for the Framework identifying a range of options and it was suggested that everyone should be offered choice. There was a view that, if a patient has a choice of treatments, and they are involved in decisions, they are more likely to comply with the treatment.

Aim D: Improving quality of life and wellbeing

A substantial majority of respondents – 92% of those who answered the question – thought that Aim D should be a priority. Support for Commitments 6 to 11 ranged from 98% to 85%.

General comments included that a national approach to training and sharing of best practice will be important to ensuring equity of access and consistency of services. However, it was also argued that ‘quality of life’ and ‘wellbeing’ need to be defined.

Training for healthcare professionals

Respondents emphasised that healthcare professionals need up-to-date education on chronic pain, including with respect to the side effects of medication and the alternatives to drugs. Some respondents expressed a view that not all professionals are sufficiently knowledgeable about chronic pain or do not understand the debilitating effects of living with ongoing pain, and there were calls for better training and support for both specialist and non-specialist staff. Although there was broad support for sharing best practice, there was a concern that this has a top-down feel.

Education of patients in pain management was also highlighted, with a suggestion that providing in depth, accessible information about things people can do help themselves may be empowering.

Data on chronic pain

In relation to using data to improve services and support, some thought a data driven approach makes sense, but there were also reservations, including that time might be spent on reporting and evaluating data at the expense of treating patients. With respect to the collection of data, the point raised most frequently was that this must include patient experience feedback.

Comments on reporting of data included that this must be honest and transparent to be useful in holding services and authorities to account, and that data can be gathered and reported but must also be shared to drive improvement.

Reasons given for thinking there should be national standards for pain management included that these could drive consistency and quality of care, ensuring everyone can access the same support and care no matter where they live. It was also suggested that national standards would provide clear indicators of what people with chronic pain should expect in relation to treatment and services. An alternative perspective was that no two people are the same, and that setting national standards may negate a person-centred approach.

Research on chronic pain

There was wide support for further research on chronic pain, although also a suggestion that research could be at UK level. It was suggested that research could improve delivery of personalised medicine, with references to person-centred treatments that ensure people get the right treatment at the right time. With respect to the type of research that might be carried out there was a suggestion that discussion is needed around priorities and inter-disciplinary collaboration.

Implementing and delivering the Framework

Barriers and opportunities

In terms of barriers, many respondents saw funding as a potential barrier to implementation of the Framework. Some referenced historical underfunding of services and plans to reduce pain management services, and it was noted that the draft Framework does not identify how funding will be addressed.

Low staffing levels and lack of time were frequently identified as barriers to implementation of the Framework. While it was acknowledged the draft Framework offers support to implement a workforce plan, it was argued the solutions need to be more robust to ensure effective person-centred care can be delivered. Significant difficulties in recruitment of allied health professionals in chronic pain were also reported.

Some respondents commented on the potential impact of COVID on implementation of the Framework, including in relation to the effects of the pandemic on staff – their redeployment, fatigue, low morale and lack of training opportunities.

Specific points were also made about primary care and the role of GPs including a view that not all GPs are willing to refer patients to specialist pain management services, or that GPs may decide to prescribe medication to treat pain without investigating the underlying cause.

The opportunities referenced most frequently were to improve quality of life for patients and to engage with, listen to and involve people with lived experience and carers. Some respondents saw the Framework as an opportunity for a change in culture and practice, a chance to do things differently, or to change attitudes and beliefs in relation to chronic pain and its management.

Respondents also saw opportunities for improved education and training for healthcare and social care staff, including opportunities for healthcare professionals in other specialities to develop their skills around pain management.

Opportunities for improved multidisciplinary team working were highlighted, with a suggestion that shared patient care models that exist for other health conditions could be extended. There were calls for improved connections between primary and secondary care, for better links between health and social care, and for improved links to mental health and addiction services.

Opportunities to provide greater consistency of care and standardise service delivery were suggested, including an opportunity to standardise and rationalise both pharmaceutical and non-pharmaceutical prescribing across NHS Scotland.

Assessment of impact

In relation to the groups who will be directly or indirectly impacted by the Vision, aims and commitments, general comments included that the Framework should adopt a cohesive approach to tackling health inequalities, in line with the recommendations of Audit Scotland's report NHS in Scotland 2021. It was suggested this should be reflected in development of a strategy to tackle inequalities, focusing on programmes related to women, ethnicity and social deprivation.

With respect to protected characteristics under The Equality Act 2010, respondents highlighted potential issues relating to older people, people with life limiting conditions, and women, including women with caring responsibilities or who may experience cultural barriers that prevent them coming forward with concerns about chronic pain. There was also reference to the traveller community, people who require translation services and those from ethnic minority communities.

With respect to the Fairer Scotland Duty, respondents made reference to economically disadvantaged communities, homeless people and those disengaged from services, people experiencing digital exclusion, people with drug or alcohol issues and those in contact with the criminal justice system.

Introduction

Background to the consultation

This report presents the independent analysis of responses to the Scottish Government's consultation on the Framework for Pain Management Service delivery (the Framework).

Chronic pain is estimated to affect 30 – 50% of the adult UK population, with an estimated 5% of the Scottish population experiencing disabling, high-impact pain. Support for people with chronic pain should be available in a range of health and care settings depending on its impact on their quality of life. Despite considerable policy and service-related improvement activity in recent years, people with chronic pain continue to report difficulties in accessing and navigating formal and informal support to help them manage their condition. Services and access to support have also been impacted by the COVID-19 pandemic.

These issues were recognised by the Scottish Government's Programme for Government in 2020 which outlined a commitment to develop a new Framework for Pain Management Service Delivery in 2021. The public consultation has been carried out on a draft of the Framework which has been developed through analysis of past reports and recommendations, analysis of available service data and engagement with those with lived experience and clinical, NHS, research and other key stakeholder groups.

The consultation document sets out a draft vision for chronic pain services in Scotland in addition to key priorities, commitments and early actions identified to address the issues identified during development of the Framework. It also offers the opportunity for stakeholders to identify opportunities and barriers to implementing its aims, and to highlight key groups who may be impacted directly, or indirectly by the policies therein.

The consultation was launched on 6 December 2021 and closed on 28 February 2022. The consultation paper can be found [here](#).

The consultation asked 26 questions, with 16 closed questions and 10 open questions inviting comment.

Profile of main consultation respondents

In total 114 responses were received. Where consent has been given to publish the response it can be found on the [Scottish Government's Citizen Space](#) public consultation portal.

Respondents were asked to identify whether they were responding as an individual or on behalf of a group or organisation. Twenty six responses were submitted by organisations and 88 by individual members of the public.

Organisational respondents were allocated to one of four groups by the analysis team and the Scottish Government.

A breakdown of the number of responses received by respondent type is set out in Table 1 below and a full list of organisational respondents can be found in Annex 1.

Table 1: Respondents by type

Type of respondent	Number
Organisations:	
NHS	12
Representative body	6
Third sector	6
Other	2
Organisations	26
Individuals	88
All respondents	114

In their further comments, a number of individual respondents referred to their own lived experience of chronic pain. Other individual respondents identified themselves as being clinicians, and sometimes as working or as having worked in pain management services.

In addition to the responses received from individuals and organisations, the Scottish Government held two discussion groups drawn from those working in pain specialist services. The feedback from these discussions has also been included within the analysis.

Analysis and reporting

The remainder of this report presents a question-by-question analysis of the comments made to the main consultation.

A small number of respondents did not make their submission on the consultation questionnaire but submitted their comments in a statement-style format. This content was analysed under the most directly relevant consultation questions.

The feedback from the two discussion groups was also included within the analysis. The groups discussed the aims and commitments of the Framework, meaning their feedback was relevant to Questions 5, 9, 13 and 17.

The results of the closed questions are covered within the main body of the report and are presented in full in Annex 2.

As with any public consultation exercise, it should be noted that those responding generally have a particular interest in the subject area and the views they express cannot be seen as representative of wider public opinion.

Vision

The consultation paper explains that while the expectations set out by the existing Scottish Service Model for Chronic Pain may be appropriate, and reflect best practice, people with chronic pain say they still do not experience consistent, high-quality care when seeking support for their condition.

For the first time, the new Framework set out a national vision for enabling people to manage chronic pain; to improve their well-being and quality of life.

Vision

Person-centred, effective and safe care that improves the quality of life and wellbeing of people with chronic pain in Scotland

Question 1 – Should this be the overarching Vision?

A substantial majority – 93% of those answering the question – agreed with the overarching Vision. A small number of individuals and a representative body respondent disagreed.

Question 2- Please explain your response

A total of 95 respondents provided a comment at Question 2.

In explaining their support for the Vision, a number of respondents who noted that they themselves live with chronic pain, highlighted the impact that chronic pain can have on people's lives. It was described as very isolating and having the capacity to destroy lives. It was also noted that chronic pain can impact more widely, including on carers and healthcare services.

Reflections on the current situation included that chronic pain is poorly managed in a medical model, and that current levels of resourcing are a concern for many of the patients who access chronic pain services. This issue is returned to at Question 24, but in relation to the Vision the broader point was that it will have no practical application or impact if not resourced. Nevertheless, some respondents expressed a hope the Framework and Vision will lead to positive change

Although most comments were supportive of the Framework and/or Vision, some respondents voiced their concerns. For example, the Vision was described as generic, perhaps too idealistic, or as lacking ambition. There was also a concern that some of the language used, such as 'wellbeing', 'person-centred' and 'safe care' lacks clarity and is not meaningful.

Person-centred care: In either their opening remarks, or elsewhere within their responses, a number of respondents commented on the importance of person-centred care, with individualised approaches that recognise that everyone's circumstances and experiences of pain are different. An emphasis on enabling people to make changes and take ownership of their own health was seen as key.

There were also references to ensuring that people are genuine partners in their care or to people being encouraged to work in partnership with pain services.

It was noted that providing person-centred care, including shared decision making, should be at the heart of everything health professionals do and that this is especially true of those living with long term conditions such as chronic pain. Giving the same prominence and commitment to supporting patients to manage their pain, as is given to managing other conditions, was seen as key. Another perspective was that all health-based visions and aims should have a similar focus to those proposed for chronic pain.

Although supportive of the sentiment, a representative body respondent thought that the Vision does not reflect the involvement and participation of the individual in the management of their own pain. Their concern was that it appears to describe services that “do things” to patients, and they were one of the small number of respondents that suggested revising the Vision to recognise clearly the self-care aspect of pain management. The specific wording proposed was “Person-centred, effective and safe services which support people living with chronic pain in Scotland to improve their quality of life and wellbeing.”

On a similar theme, others suggested that there should be more emphasis on patient empowerment, including that the Vision should reference people being ‘empowered to live well’. Ensuring that the approach to health and social care empowers people, including through co-production in the design and delivery of services, was seen as key to creating equitable outcomes and a shift towards prevention.

There was also a suggestion that a further aim should be added to the Framework, that ‘Chronic pain is minimised through prevention and early intervention strategies.’

Effective and safe care: In relation to this aspect of the Vision, the importance of safety and not causing harm was highlighted, with other general points including that any approaches or interventions must be evidence-based and that it is important to reduce harms associated with pharmacological management.

One perspective was that, whilst patients should have a say in their care, it needs to be within the parameters determined by the evidence base. It was suggested that this not only supports the best use of limited resources but also ensures no unnecessary physical and psychological harm is done.

Quality of life and wellbeing: Focusing on quality of life and wellbeing was seen as crucial, including because it creates a focus on reducing the impact of chronic pain on patients and their families. It was also noted that it is important to promote both physical and psychological wellbeing.

Other related points included that improved quality of life can encompass people becoming more engaged within the local community and being supported to access meaningful occupation or a return to work.

Fit with other relevant strategies, plans or principles: Respondents identified a good between with the Framework and/or Vision and a range of other key national or local statements. These included Scotland's Quality Ambitions and a Health Board's own objectives.

The Vision was also described as being in line with the principles of Realistic Medicine.

Other suggestions for change or addition: In terms of specific aspects that could be clarified, suggestions were that the Vision's scope is adults only.

There was a call for the Vision to establish clear leadership and governance arrangements, and not give the impression that the Framework exists in a vacuum. The connected suggestion was that the Vision should include a clear statement of the responsibility that sits with the commissioners of chronic pain services for making improvements to those services.

Other suggestions were that the Vision could reference and/or emphasise:

- That many people live with pain, and that living with chronic pain needs to be seen as the same as any other neurological condition. There was also reference to the importance of those who live with chronic or persistent pain being identified.
- One suggestion was that the Vision should be framed around the resources (both in terms of services and staffing) that will be made available. Issues associated with current and future resourcing on chronic pain services are discussed further under questions relating to the implementation and delivery of the Framework.

Finally, it was suggested that the Vision could helpfully be underpinned by a commitment to prioritising research. A connected point was that improving our understanding of the factors that are associated with good and poor outcomes for people with chronic pain should be an important research priority going forward.

Aim A: Person-Centred Care

The consultation paper explains that feedback from services and people with chronic pain indicates that challenges remain in ensuring consistent access to appropriate information, advice, treatment and support at the point where it could be most effective for an individual's needs.

Aim A: Person-Centred Care

Ensure access to appropriate information and support based on an individual's needs.

Question 3- Should this aim be a priority

A substantial majority – 96% of those answering the question – thought that Aim A should be a priority. A small number of individuals did not think so.

Commitment 1

We will improve the quality and consistency of information on chronic pain and make it more easily accessible. We will empower people to understand their condition and better manage its impact on their physical and mental wellbeing.

Question 4- Should commitment 1 be included in the Framework

A substantial majority – 90% of those answering the question – thought that Commitment 1 should be included in the Framework. All organisations thought Commitment 1 should be included, with 88% of individuals supporting its inclusion.

Question 5. Please explain your responses to Questions 3 and 4.

A total of 95 respondents provided a comment at Question 5.

An initial query was whether Aim A - and by extension Question 3 – refers to information that is self-directed or provided via primary care services, and who is responsible for assessing the needs of those receiving this information.

In their further comments a number of respondents, including individuals with lived experience of chronic pain, commented on the importance of being able to access the right information. However, some respondents with lived experience also reported that they have not received the information and ongoing support they needed. There were also references to the currently available information being variable in quality and content, including from Individual and NHS respondents.

From a clinician's perspective, it was stressed that primary care workers need access to information, knowledge and training in order to provide a consistent message that supports patients. From a patient's perspective, being able to access good quality information was seen as key to their wellbeing and long-term self-management.

Although most were supportive of Aim A and Commitment 1, there was also a view – including from some of those who had not agreed that Commitment 1 should be included – that the focus should be on services and treatment rather than on information. Other concerns included that the consultation paper:

- Reads as if the intention is to tell people about their own conditions when, in fact, people living with a long-term condition are well versed in their abilities, limitations, and have tried everything to help themselves to deal with it.
- Talks about empowering patients but does not address the issue some respondents reported of medical professionals not considering their experiences as serious enough for referral or telling them there is nothing that can be done to support them.

Others commented that, while providing good quality information is important, achieving Aim A and Commitment 1 in isolation will not move services forward. Specifically, it was suggested that the provision of information to existing health services that are already ill-equipped at dealing with chronic pain, is unlikely to drive improvement.

Person-centred information and support

Some respondents noted their support for ensuring that people have access to appropriate information and support based on their individual needs. As at Question 2, some respondents also highlighted that everyone's situation will be different and that a one-size-fits-all response is not appropriate. Patients being able to access information tailored to their needs, along with the support to use it, was expected to help to reduce inequalities across Scotland.

Connected comments were that information should be customised to the individual and that this requires input from health care professionals. There was also reference to recognising that patients may need time to understand their own needs and to consider their options. Where options exist, and especially if there is no good basis for a choice between two or more care options, there was a call for the patient to be made fully aware of all their options.

However, for a small number of respondents there was a possible tension between ensuring that the information and support provided is tailored to individual needs, whilst also seeking to achieve consistency.

Quality and consistency

Improving quality and consistency was seen as beneficial to both patients and healthcare professionals. In terms of what equates to quality in this context, ideas included that:

- Clarity, readability and the use of plain English will be key. However, information should not be 'dumbed down'.
- People with lived experience of chronic pain have a vital role to play in drafting and reviewing new materials.

- Keeping public facing information up-to-date will be challenging, including because the evidence base and treatment technologies are continually evolving.

When consistency was referenced, it was often to suggest that it is important and, for example, that patients should receive the necessary information, support and care, irrespective of where they live in Scotland. Consistency in the key messages shared in all of the services where people access healthcare was also seen as important. There was specific reference to in-patient areas, specialist chronic pain services, GP practices and community pharmacies.

While most of the comments relating to consistency were whole system focused, there were also comments about the consistency of information being provided to any single patient by different health care professionals. They included that, if a health care professional considers something has previously been missed or incorrect information given, they must speak up, even if it is an inconsistent message.

Overall approach and coverage

A general observation was that a review of all information resources available would help to ensure that they are addressing the needs of individuals with pain. In terms of the framing of any new or revised information, comments included that:

- It should be grounded in research, evidence based and verified. A specific suggestion was that an editorial policy should be developed.
- Any approach needs to focus on critical health literacy, with patient experiences grounded in a wider context.
- Relative to current levels, the content should be expanded. An example given was that in one area the NHS provides a two-hour information session, while a third sector organisation offers eight two-hour sessions.
- It will be important to be mindful of language used, and to avoid stigmatisation and victim blaming. This issue was highlighted with particular reference to obesity, and it was reported that weight stigma is a significant barrier to participation and access to services for many people. There was a call for those providing information on chronic pain to be mindful of this danger to ensure individuals feel empowered and able to access the services they need.

In terms of the focus and coverage of the information available, respondents identified the following elements as important:

- How pain is created in the body and mind. However, it was also suggested that there should be a limit on how many times a person is told what causes pain and what their attitude towards it should be.
- Risk relating to the transition between acute and chronic pain and/or the risk of pain persistence and/or persistent disability.
- Pathways and access to treatment.

- The pain management options available, along with their limitations and applicability to the long term.
- Issues associated with chronic pain, such as mental health and social issues.
- Resources for people after they have gone through a structured pain management programme in secondary care.
- A Directory of Services, with signposting to available services and support groups.

Respondents also suggested that information about new medicines and pain control techniques should be made available.

Accessibility and delivery

The importance of information being available and accessible to all was stressed, with a number of respondents highlighting particular needs or groups requiring consideration. Comments included that the audience for the information will be diverse, and that attention will need to be paid to:

- Literacy levels, including health literacy.
- How to get information to people who are disadvantaged or difficult to reach, including those who are digitally excluded. An NHS respondent reported that in their area a third sector organisation lends tablets preloaded with Wi-Fi to some of their patients, and that this is an invaluable resource.
- The needs of people for whom English is not their first language.

On the theme of how information should be shared, observations included that online resources, including interactive resources and videos, will be important. Specific proposals were:

- The creation of a single, one-stop-shop style website for all things relating to self-management of chronic pain.
- The upgrading of NHS inform to include comprehensive pain information was also proposed.

Of relevance to this latter proposal was a suggested national review of the barriers to people accessing information using existing national platforms like NHS inform. The importance of considering who will be responsible for keeping any online resources up-to-date was also highlighted.

In addition to the development of a national information resource, it was suggested that a public campaign approach could be considered.

Although many of the comments focused on nationally-developed and delivered resources, it was also noted that some form of local targeting - for example by providing information on local services or through mechanisms such as local newsletters - could be helpful.

Other comments were that information should be made available in:

- Primary care services. It was noted that the majority of people with chronic pain are initially or totally dealt with in primary care services. Therefore it is important that GPs know what services are available to be able to signpost appropriately.
- Community pharmacists. They were described as easily accessible and it was suggested that they could play a bigger role in supporting people to manage their pain. There was specific reference to the Medicines care and review service and to being able to refer to other services, such as exercise schemes.
- Community organisations. It was suggested that health-focused organisations could be promoted as equal partners to local GPs, and could, for example, provide information, activities, and workshops.
- A broad range of locations, including places like supermarkets and libraries, as well as in the more obvious places like GP practices.
- A range of languages.

Aim B: Timely access to care

The consultation paper notes the importance of timely access to high quality care and support wherever people live in Scotland. It acknowledges that there is variation in the way people currently access services for chronic pain across Scotland, especially in community and primary care settings, and suggests that action is needed to reduce the barriers people with chronic pain can face navigating the health system.

Aim B: Timely access to care

Support people to access the care they need, when they need it.

Question 6- Should this aim be a priority

A substantial majority – 97% of those answering the question – thought that Aim B should be a priority. All organisations thought it should be a priority, while one individual did not and two did not know.

Commitment 2

We will support people to access the right care, in the right place, at the right time by working with NHS Boards to improve how they plan and deliver care for people with chronic pain. This includes increased coordination across community-based, GP and hospital services.

Question 7- Should Commitment 2 be included in the Framework

A substantial majority – 95% of those answering the question – thought that Commitment 2 should be included in the Framework. Two individuals did not think so, and two individuals and one organisation did not know.

Commitment 3

We will improve the options people have in accessing chronic pain services, including digital technology where appropriate.

Question 8- Should Commitment 3 be included in the Framework?

A substantial majority – 91% of those answering the question – thought that Commitment 3 should be included in the Framework. All organisations thought it should be included but a number of individuals either thought it should not or did not know whether it should be included.

Question 9. Please explain your response to Questions 6,7 and 8.

A total of 98 respondents answered Question 9.

As at earlier questions, some respondents commented on the challenges that people encounter currently in accessing the care they need, when they need it. Points raised included that most patients have a long and tortuous journey to make before reaching chronic pain services. A 'Representative body' respondent making this point went on to suggest that by the time they have reached chronic pain services, some people would have received treatments that had not helped and would feel frustrated that they are not being heard and even believed. They were among the respondents highlighting that experiences such as these can have a significant impact on mental health and well-being, all of which leads to poor long-term prognosis.

The potential benefits of the right care, at the right time, were also highlighted. It was suggested that success would not only improve the quality of delivered care but also reduce the missed opportunities around disease progression and health promotion. At its simplest, it was suggested that early intervention can improve someone's quality of life.

Other comments referred to the extent of the challenge ahead. For example, it was reported that there are growing numbers of patients with chronic pain on waiting lists and that there are a lack of resources in primary care to deal with chronic pain. It was suggested that most GPs do not have the time or knowledge required to ensure that patients with chronic pain are managed effectively.

Questions about how this part of the Framework will be delivered were sometimes connected to the suggestion that it will depend on adequate resourcing. There was also a question as to how the aim and commitments will be achieved and what measures will be used to hold NHS boards accountable to deliver on these commitments. These themes are returned to at later questions.

Joined up, co-ordinated services

In terms of offering the right care, how services should work together was a central issue for a number of respondents. There was a concern that at present services are not joined up, and that as a consequence, people may be waiting for specialist services which they might not need if community based services could do more to support them.

A general point was that improving co-ordination will be key, including the Framework overall and not just Aim B and Commitments 2 and 3. Some comments were focused on the importance of improving communication and co-ordination between:

- Primary and secondary care.
- Acute and chronic pain treatment in both primary and secondary care.

In terms of how the necessary improvements could be achieved, there were references to the development of referral pathways. A connected point was that shared pathways between primary and secondary care could help ensure that the right professionals are placed at the right places. Other issues raised included that

information sharing will need to be fully addressed to allow integration of services and the provision of safe care.

Other comments focused on how services could or should be developed or redesigned. From a systemic perspective, it was seen as important for primary care clinicians to be able to access support from specialist colleagues.

A number of respondents highlighted the importance of adopting a multidisciplinary team (MDT) approach in primary care. In terms of the range of professions or services, there was particular reference to pharmacists.

The role that non-medical services can play was also referenced, with an associated suggestion that Commitment 2 could be strengthened by acknowledging this potential. There was reference to housing, transport, education, training and employment, social support and social security. The role of local government in delivering many of these services was also noted.

In terms of key aspects on an MDT approach, the following were identified:

- Increased education around the roles of different professionals in improving a patient's quality of life.
- Access to a single shared patient record. This was described as a key enabler to safer and more integrated care.

Although a number of the comments were focused primarily on co-ordination between different parts of the health service, there was also a call for closer collaboration with third sector organisations. It was suggested that there should be a duty placed on those responsible for commissioning chronic pain services to recognise the contribution of charities, including by entering into formal service level agreements with them.

Care and support options

There was a concern, with particular reference to Commitment 2, that it is not clear which mechanisms will be used to ensure that NHS Boards take steps to improve their planning and delivery of services.

Some of the comments addressed the range of services that should be available. There was reference to:

- Specialist pain services.
- Pharmacists having a role to play in both community and specialist settings. Key strengths of the community pharmacy network were said to be the accessibility of its healthcare professionals and their expertise in getting the best out of medicines whilst minimising harm. It was also suggested that a pharmacist should be based in all specialist pain services.

In terms of options to support people in managing their chronic pain, there were calls for better access to supported self-management and non-pharmacological treatment options for people with pain.

There was specific reference to:

- Self-management interventions for complex patients.
- Pharmacist led services, including through pain clinics in GP practices. It was also reported that pharmacists can support self-management via the Medicines Care and Review service.
- Non-pharmacological management such as Cognitive Behavioural Therapy (CBT) and mindfulness. Specifically, Computerised CBT.

It was also noted that the [Modernising Patient Pathways Programme](#) is sponsoring small test of change projects to assess different models of care, including a Scottish Pain Service Model to improve access to specialist pain management expertise in primary care, and that the results are promising.

In addition to references to the right care, there were also references to ensuring that patients are able to access services from someone with the appropriate expertise as quickly as possible. A 'Representative body' respondent suggested that Commitment 2 should make reference to the correct person as that is as important as the correct care, place and time.

Right place

A small number of respondents addressed the location of services, with comments including that while access to services and support close to home is desirable; some specialist services may be more appropriately delivered regionally or nationally.

As in relation to the right care, the potential of community pharmacies was highlighted. They were described as ideally positioned to support patients close to their home. A similar point was that those working in community-based services, such as community nurses, pharmacists, first-contact musculoskeletal practitioners and other health and social care professionals, should have an understanding of the impact of chronic pain management so as to equip them to assess and provide early support in a timely manner.

In terms of variations across the country, it was reported that the [Centre for Sustainable Delivery](#) is facilitating a 'once for Scotland' approach to minimise harmful variation in access to services across Scotland.

Right time

As noted above, a number of respondents commented on the impact that waiting for care or support can have on people's health and wellbeing. Current waiting times for pain management services were described as varied, and it was also reported that waiting times have increased during the pandemic. A number of respondents with lived experience spoke of having to wait for care or support. There was also reference to the inequalities in health care that arise from some being able to self-fund private health care.

Moving forward, it was suggested that timely access should cover all stakeholders, such as community pharmacists and out-of-hours services. It was thought that improving access to information and support, alongside an increase in the use of supported self-management, could help reduce the pressure on specialist services and allow for more timely access for those needing these services.

Other comments were that the Framework should set out realistic time frames for referrals and reviews.

Digital technology

A number of respondents commented on the use and potential of digital technology. Amongst these were a few notes of caution, including that there is already a huge digital divide, and this should not be increased further. It was noted that not all patients have access to the internet but that these patients still need access to the right information and support. Looking to the future, it was noted that issues around digital exclusion will need to be considered.

In terms of the potential uses of digital technology, there was reference to delivery of education programmes, and to some of the online resources that are available.

A number of the comments focused on the potential in relation to appointments and consultations. One view was that the use of digital technology will allow for easier access to appointments, including by eliminating travel time and reducing the need to take time off work and/or make childcare arrangements. It was noted that some people cannot leave their homes to attend appointments. The potential to address barriers to access in remote and rural settings was also noted. Overall, it was hoped that easier access would help improve patient satisfaction and mental health.

However, although digital services - including consultations - were seen as bringing real benefits, a number of respondents also commented that patients should also have the option of face-to-face appointments. It was acknowledged that technical or personal issues will mean that the digital approach is not right for all and there was support for the reference to using digital technology 'where appropriate'.

In terms of the types of approaches that are already being used, or which are being developed, there was reference to:

- Pain Association Scotland's work on digital services during the pandemic.
- One-to-one support provided through Versus Arthritis' Working Well Project and their online Let's Move initiative.

It was also reported that NHS Highland is designing and piloting a national In-healthcare online chronic pain platform. It was reported that the platform is being designed with the potential to be replicated across all Health Board areas. It was hoped that the approach will make access to services and referral processes consistent across the country and will help ensure quality of care in Scotland.

Looking to the future, it was suggested that while the pandemic has paved the way to increased use of digital technology, developing a good evidence base and

careful design will still be critical. There was a note of caution that while digital technologies may well have a place, they can be poorly designed, can lead to health inequalities for those without digital access and that any evaluation tends not to consider possible harm. It was suggested that the controls around digital interventions need to be as rigorous as those around face to face clinical care.

Aim C: Safe, effective treatments

The consultation paper sets out the aim of improving timely and equitable access to a range of evidence-based treatments through a person-centred approach. It notes that there are a range of interventions that can support people with chronic pain to manage their condition and its wider impact on their quality of life.

It also explains that, in developing this Framework, people with chronic pain have highlighted a number of treatment-related issues, including inconsistencies in the availability of certain interventions, delays or changes in how or when treatment is provided, and in some cases a lack of clear explanation about alterations to treatment plans with a lack of communication or involvement.

Aim C: Safe, effective treatments

Ensure people have a choice of effective treatments.

Question 10- Should this aim be a priority?

A substantial majority – 93% of those answering the question – thought that Aim C should be a priority. A small number of individuals did not think so.

Commitment 4

We will support people with chronic pain and healthcare professionals to better understand and agree effective treatment options to manage pain.

Question 11- Should Commitment 4 be included in the Framework?

A substantial majority – 94% of those answering the question – thought that Commitment 4 should be included in the Framework. All organisations thought it should be included but a number of individuals either thought it should not or did not know whether it should be included.

Commitment 5

We will ensure people have more consistent access to effective treatment options wherever they live in Scotland.

Question 12- Should Commitment 5 be included in the Framework?

A substantial majority – 95% of those answering the question – thought that Commitment 5 should be included in the Framework. One individual did not think so, and one individual and a small number of organisations did not know.

Question 13. Please explain your responses to Questions 10,11 and 12.

A total of 100 respondents made a comment at Question 13.

General observations relating to Aim C, and the associated commitments, included that the importance of care being safe and effective is self-evident, but also that Commitments 4 and 5 should be reassuring for patients and clinicians alike.

Another general point was that the references to 'treatment' are not helpful, and that referring to 'pain management' or 'care' would be preferable.

There was also a view that the description of 'effective' should be agreed and set out in the Framework, along with an understanding of the range of treatments being referred to – for example, including whether the Framework covers non-pharmaceutical treatments.

Assessing effective treatments

A number of the respondents addressed what is meant by 'effective'. It was seen as important that treatment provision is based, as far as possible, on best available evidence of effectiveness. However, it was also suggested that, at present we do not have sufficient evidence to demonstrate the efficacy of many treatments. Further views about the current evidence base included that:

- There is very little clinical research that is relevant to real life, clinical settings.
- Where there is evidence, it often related to a small, specific population but results are generalised beyond the findings.
- Much of the research – including into medications, surgical and anaesthetic interventions, rehabilitation approaches and therapy – overstates the benefits and under reports the harms.

Issues relating to research and evidence are covered greater detail under the analysis for Aim D, but points made here included that the following are needed:

- More evidence on the effectiveness of injections and other interventions for chronic pain. With specific reference to injections, it was suggested there is a need for a 'national conversation' about what is a worthwhile intervention.
- Research into possible future drugs and treatments for conditions where pain levels cannot currently be adequately relieved.
- A better understanding of the range of conditions that exist among diverse communities, with investment into how these are treated and managed.
- Longitudinal action research into the effectiveness of current practice, including not only that of the NHS, but also work done by voluntary organisations, fitness clubs, pain management groups etc.

Where the existing evidence does not wholly support treatment effectiveness, it was suggested that the reasons for this should be explored and understood as well as possible. If sufficient research has been conducted, with a treatment found to be ineffective or harmful, it was thought that the Scottish Government should discourage use of that treatment in the NHS. However, it was also reported that the absence of evidence does not necessarily imply absence of benefit. It was suggested that clinicians should apply standards on evidence consistently in order to identify the most appropriate care whether that is surgical, medical or other.

In terms of other aspects that should be considered when assessing effectiveness, there was reference to the cost effectiveness of treatments, including of social

prescribing and non-pharmacological treatments. There was also reference to availability.

It was seen as important to balance evidence-based effectiveness with other considerations, including individual patient choice and the balancing of the risks of harm against chances of benefit. An associated point was that it will be vital that prescribing of pain medicine involves an open and honest discussion with the patient about the risks and benefits of medication options. However, and also connected to issues around patient choice, there was a concern that references to 'safe and effective treatment' will be used as a means to limit the treatments patients can access.

Information about effective treatments

A common theme was that it will be important to share information about which treatment options are effective, and in particular to share messages that self-management is an effective treatment.

Specific suggestions included:

- National public health messaging, or a campaign, to inform and educate the population on chronic pain, including around treatment options and realistic expectations of living with chronic pain. There was specific reference to clear and consistent public health messages about the role and limits of analgesics in the treatment of chronic pain.
- Ensuring that any information, including leaflets, produced provides consistent information on the potential harms of treatment and medication and how to understand if something is helping, not having an impact, or harming.
- The development of a national registry, which could support monitoring and learning about the efficacy and safety of procedures.
- Updating the [SIGN](#) guidelines.
- Ensuring healthcare providers have the appropriate education and support to make sure that patients receive the best and most appropriate care. This issue is covered in further detail in the analysis for Aim D.

Variation in access

As at other questions, some of the comments addressed current variations in the treatment people received. For example, it was suggested that as a patient, your treatment will depend on which Health Board are you live in, and that too often there is variability in access to treatment dependent on proximity to certain services and based on skills and availability of local personnel and funding streams.

It was also reported that the challenge of ensuring consistent access to treatment options has increased over the past few years, as gaps have opened up and backlogs worsened. There was reference to the SIGN guidelines on management of chronic pain having recognised the variation in the availability of safe and effective treatments and the impact of waiting times to access this care particularly during the recent COVID-19 pandemic.

While current variations were often acknowledged, there was also a view that any 'postcode lottery' needs to be avoided. It was considered essential that patients should have equitable access to effective treatment regardless of the Health Board area in which they live.

However, the importance of accounting for specific local differences and needs was also highlighted. The example given was around the importance of taking a localised approach to weight management services, within a nationally consistent framework, to improve both accessibility of, and engagement with, such services.

Achieving consistency

Other comments considered approaches or changes that could help improve consistency in provision.

One theme was around skill sets. There was a call for skills sharing, including in relation to injections, and for investment in training for local healthcare professionals. In the context of training there was particular reference to being able to identify those patients who should be referred on for expert opinion and management at an early stage. Training and skills development is covered in further detail in the analysis for Aim D.

Other comments addressed approaches – including national approaches – that could help promote consistency. They included that:

- Commitment 5 should also include access to effective assessment and treatment, as the latter cannot be properly discussed without the former.
- There needs to be robust national information, either through the SIGN guidelines or an equivalent mechanism, covering non-medical interventions, procedures and follow-up.

There were also comments about new approaches that are being developed or rolled out. They included that:

- The Centre for Sustainable Delivery (CfSD): NHS Golden Jubilee is facilitating a 'once for Scotland' approach, with a view to minimising harmful variation across Scotland.
- A new and expanded MDT has been recruited in the Highland area, which is now offering a new model of pain service. The plan is for a less centralised service, with localised MDT care across various areas of Highland. The approach allows for more collaborative working with primary care, third sector and specialist pain teams in more rural areas and expanded expertise in managing chronic pain consistently, supporting greater equity of care, regardless of postcode.

In terms of specific aspects of care and/or practice that could be looked at, comments included that:

- To empower them to make decisions and become involved in their treatment, all patients should have access to the same information on treatment options.

- MDT meetings with patients and healthcare professionals would be beneficial.
- Regular review of medications is important to preventing harm.
- New methods of providing support and monitoring should be implemented for patients prescribed medicines with a risk of dependence.
- Medication-specific interventions, which can target those on higher-risk therapies proactively, should be developed and resourced.
- There may be some treatments – such as radiofrequency procedures – that could be best provided through a national service.

Treatment options

With reference to effective treatment options, there was support for the Framework identifying the range of options and it was suggested that everyone should be offered a choice of effective treatments. It was highlighted that there is variation across Scotland in consistency and access to consultant level input. There was a view that different patients will respond better to different approaches and that, if a patient has a choice of treatments, and they are involved in decisions, they are more likely to comply with the treatment.

Complementary or alternative therapies: There were references to ensuring that people have a choice of allopathic and non-allopathic treatments, and to non-pharmacological treatment options being available. It was noted that not everyone can afford the alternative therapies that may help people deal with being in chronic pain.

In terms of the Framework, it was suggested that the complementary therapies section needs to be clearer, including possibly through more references to the SIGN guidelines.

Particular conditions or groups: It was suggested that the Framework needs to recognise the role of poor musculoskeletal health in chronic pain, and high-impact chronic pain in particular. A specific suggestion was that Commitment 4 should cover supporting people to improve their musculoskeletal health.

Aim D: Improving quality of life and wellbeing

The fourth aim proposed in the draft Framework covers investment in training, data and research in order to improve care and support for patients who experience chronic pain. Six commitments are set out in support of this aim.

Aim D: Improving quality of life and wellbeing

Invest in training, data and research to improve care and support.

Question 14- Should this aim be a priority?

A substantial majority of respondents – 92% of those who answered the question – thought that Aim D should be a priority, while 4% thought it should not, and 4% said they did not know. All organisational respondents that answered the question took the view that Aim D should be a priority.

Training and support for healthcare professionals

The consultation paper notes that people with lived experience of chronic pain have reported feeling that healthcare professionals do not fully understand or acknowledge the impact of such pain, and that more information about effective management options is needed.

Commitment 6

We will work with NHS Education for Scotland, professional bodies and partners to improve training and education on management of chronic pain.

Question 15. Should Commitment 6 be included in the Framework?

A substantial majority of respondents – 93% of those who answered the question – thought that Commitment 5 should be included in the Framework, while 5% thought it should not, and 2% said they did not know. All organisational respondents took the view that Commitment 6 should be included.

Commitment 7

We will establish and support health and care professional networks to share best practice in pain management at local and national levels.

Question 16. Should Commitment 7 be included in the Framework?

A substantial majority of respondents – 96% of those who answered the question – thought that Commitment 7 should be included in the Framework, while 4% thought it should not. Among organisations, only one Representative Body respondent thought that Commitment 7 should not be included.

Question 17. Please explain your response to Questions 14, 15 and 16.

A total of 92 respondents made a comment at Question 17.

As noted above, there was a high level of support for Aim D being a priority, and for the inclusion of Commitments 6 and 7. General comments included that the approach is both essential and common sense and that it is difficult to see why anyone would oppose these commitments. A national approach to training and sharing of best practice was seen as important to ensure equity of access and consistency of services.

However, it also was argued that: Aim D is ill-defined and lacks detail; 'quality of life' and 'wellbeing' need to be defined; and that placing the training of healthcare professionals under 'improving quality of life' rather than 'improving services' suggests a level of dependency by patients on healthcare professionals. Additional concerns were raised with respect to funding and whether the commitments are achievable in the short to medium term.

Improving training and education on management of chronic pain

Respondents emphasised that healthcare professionals need up-to-date education on chronic pain including with respect to the side effects of medication and the alternatives to drugs. Some respondents expressed a view that not all professionals are sufficiently knowledgeable about chronic pain or do not understand the debilitating effects of living with ongoing pain, and there were calls for better training and support for both specialist and non-specialist staff. Some 'Individual' respondents described their own negative experiences or those of family members when seeking help for chronic pain including feeling their pain was not taken seriously, being told that nothing could be done to alleviate the pain, or being over-medicated. Related impacts on mental health were also reported.

It was suggested that patients need consistent information and advice with some respondents reporting that patients seeing several health professionals may be offered differing treatments or conflicting advice.

There were calls for training for healthcare students, with education and training about chronic pain and pain management embedded in undergraduate training and pre-registration programmes for all health professionals. It was also thought that there should be training for healthcare professionals in all disciplines, with some respondents suggesting a focus on the training of primary care healthcare professionals.

The importance of anaesthetic specialist involvement in pain services was also highlighted. As well as training for anaesthetists, it was suggested consideration should be given to training pathways for other medical professionals to allow them to take a role in leading services.

Other suggestions with respect to training included opportunities for: GPs; General Practice Clinical Pharmacists and Community Pharmacists; specialist nurses; physiotherapists; and social prescribers. It was noted that professions will have differing training needs and that the content of training will need to be tailored appropriately.

Education of patients in pain management was also highlighted, with a suggestion that providing in depth, accessible information about things people can do help themselves may be empowering. However, it was also argued that opportunities for self-management are limited and do not apply to many patients with multiple medical and psychological co-morbidities as well as pain.

Points on the nature of the training to be provided included that it should:

- Follow a multidisciplinary approach.
- Be experiential, interactive and applied and equally accessible to all healthcare professionals.
- Involve patients in both design and delivery of training or that patient feedback could be used to identify training opportunities.
- Include signposting to third sector organisations who can offer support.

Another issue highlighted for consideration was how education is implemented into practice, for example using supervision models.

There was a difference in views about who could or should provide training, with a 'Third sector' respondent suggesting that the third sector can deliver training and education of healthcare professionals, while a 'Representative Body' respondent argued that investing in internal teaching and training would be more sustainable in the long-term.

Specific suggestions with respect to strengthening the links between primary and secondary care included funded preceptorships for primary care clinicians who are keen to develop and enhance their training in the area of pain management and become a GP with a clinical extended role based in primary care. It was also reported that the Modernising Patient Pathways Programme (MPPP) is sponsoring small test of change projects to assess different models of care including a Scottish Pain Service Model Level 2.5 to improve access to specialist pain management expertise in primary care, and that two projects are testing out Consultant Outreach Pain Management to GP practices.

Sharing best practice at local and national levels

Although there was broad support for Commitment 7, some respondents expressed reservations in relation to the concept of best practice, including views that this has a top-down feel, or that what is considered 'best practice' in the NHS does not take account of scientific research or patient preference and feedback. It was also suggested that innovation should not be stifled by a top-down approach.

Several respondents commented on the value of professional networks in sharing learning including the benefits of both intra- and inter-professional networks, and networks between Health Boards. It was suggested that it may be helpful to consider communication methods within and between networks to contribute to the aims of the Framework and optimise best practice. However, it was also observed that existing networks are typically run by clinicians who lack time and capacity and that a paid administrator role would be helpful.

Examples of existing networks included:

- A Scottish Pain Pharmacists Network.
- A Chronic pain Highland network including not only the local chronic pain team but also primary and secondary care staff, patients with lived experience, and third sector and tertiary care representation.

Partnerships with organisations like the British Pain Society, The Faculty of Pain Medicine and educational institutions were highlighted as ways to help sharing data and research outcomes, and it was suggested that a national database for research and development could be included in the Framework.

It was also suggested that multi-professional pain conferencing and webinars based in Scotland could enhance collaboration and learning, and could include sharing and promoting effective training within and across professions and could also showcase projects such as MPPP projects.

Using Data to Improve Services and Support

The consultation paper outlines work with respect to existing sources of data on chronic pain and exploring data on the wider needs of people with chronic pain. It states the Scottish Government's intention, through the Framework, to continue to work with health and care providers, researchers and people with chronic pain to develop how data is collected and used at all levels in order to inform meaningful and impactful change and improvement for people with chronic pain.

Commitment 8

We will support Health and Social Care Partnerships to improve how pain management support is planned and delivered locally by promoting more consistent use of performance and quality data.

Question 18- Should Commitment 8 be included in the Framework?

A majority of respondents – 85% of those who answered the question – thought that Commitment 8 should be included in the Framework, while 5% thought it should not and 11% did not know. All organisations that answered the question thought that Commitment 8 should be included.

Commitment 9

We will work with Public Health Scotland to increase national reporting and analysis of clinical and patient experience data to improve services for people with chronic pain.

Question 19- Should Commitment 9 be included in the Framework?

A substantial majority of respondents – 91% of those who answered the question – thought that Commitment 9 should be included in the Framework, while 4% thought it should not and 5% did not know. All organisations that answered the question thought that Commitment 9 should be included.

Question 20- Please explain your response to Questions 18 and 19.

A total of 89 respondents made a comment at Question 20.

As noted above, there was a high level of support for inclusion of both Commitments 8 and 9. General comments included that a data driven approach makes sense, and that informative data is essential to target and deliver support. An NHS respondent noted that the absence of clear and accurate data means that, at present, it is not possible to state accurately how available services match national need, to evaluate the effectiveness of services, compare services, or evaluate improvement initiatives.

However, some reservations were expressed, including around the capacity of services to collect data, how that data might be used, and that some existing data is not published. It was also suggested that clinical trials and studies are another important source of data to be used to improve knowledge, treatment and practice.

More consistent use of performance and quality data

With respect to the collection of data, the point raised most frequently was that this must include patient experience feedback. It was suggested that this type of feedback has largely been ignored in the past but that patient experience data should drive clinical governance/audit of services.

It was argued that critical questions must be asked about the impact of treatment on the patient in the context of their daily lives, and not simply on meeting targets. A further point raised was that chronic pain is currently under-reported as some people are left to manage their conditions by themselves, and that the data collected should not be confined to the views and experiences of those who are successfully receiving care. Community pharmacies were suggested as one option for collecting the views of patients with chronic pain.

It was also argued that:

- Data must reflect multi-professional services and not just consultant activity.
- Improved data collection around diagnostic coding, medication dosing and interventional outcomes in both primary and secondary care will be key to optimising the delivery and monitoring of chronic pain.

Setting clear aims and objectives around data collection was thought to be important, including:

- What data would be gathered and why it is required. It was argued that data collection should be informed by clear research questions and ideas on how it would lead to improvement in practice.
- Which organisations would be asked to contribute.
- How data would be analysed, including whether it would be anonymised and who would have access to either raw data or research results.
- Making the agenda a priority for HSCPs to ensure they engage with it.

A focus on nationally agreed parameters for data capture was highlighted as important, both to provide consistent data for assessing performance and quality and to allow benchmarking of performance across Health Boards. However, it was also noted that, at present, data collection differs across Health Boards.

Several NHS respondents commented on the value of the proposed Core Minimum Dataset referenced in the consultation paper with one reporting that its utility has been demonstrated at local level, and recommending that it should contribute to ongoing pain service reporting and analysis across Scotland. It was seen as a positive step in providing data that doesn't only concentrate on a single element such as waiting times and there was a suggestion that agencies with relevant data experience could develop a national picture of care and services.

Respondents also referenced potential sources of data including:

- The 2022 Scottish Health Survey.
- Health Data Research UK's new 'Alleviate' pain data hub, which could provide a valuable resource for large population-based studies relating to chronic pain.
- A National In-healthcare chronic pain platform designed and piloted by NHS Highland. This online patient questionnaire, which collects data on criteria such as mood, pain, function and disability to aid vetting of referral could be replicated across all Health Boards.

With respect to the section headed 'Existing sources of data on chronic pain' it was suggested that, rather than focusing on waiting times, paragraph 85 might explain other chronic pain service data that is collected. It could also include a reference to getting data from Third Sector organisations to give a more rounded picture of people's experiences.

A small number of points were made in relation to the wording of Commitment 8 including that:

- 'Supporting Health and Social Care Partnerships to improve how pain management support is planned and delivered locally' needs to have a more substantial statement behind it.
- What is meant by 'pain management support' is unclear. 'Pain management services' was suggested as an alternative that incorporates self-help, guided help, community and primary care and well as specialist services.

Increased national reporting and analysis

Comments on reporting of data included that this must be honest and transparent to be useful in holding services and authorities to account and that data can be gathered and reported but must also be shared to drive improvement. It was also noted that in formal reporting of data, pain is often seen as a secondary effect and that data on pain as a key symptom can help understanding of how an individual is affected. While identifying and interrogating relevant data was seen as important for evaluating performance and supporting consistency, it was also argued that the disparity of treatments available across Health Boards will make it difficult to

achieve a national picture. To achieve a unified approach to the use of data, it was suggested there should be explicit guidance for Health Boards that can be modified according to the resources available. A lack of service capacity to analyse and report routine data was identified as a potentially significant barrier, and it was suggested that research coordination roles might be developed to support the Framework and its implementation.

Other points on the uses of data included:

- That inclusion of data about chronic pain in public health data at population level, will make the scale and impact of chronic pain in Scotland more fully visible to policy makers.
- As well as helping in the design and planning of chronic pain services, access to comparative data on implementation of the Framework can assist advocacy organisations to make a case concerning gaps in service provision.
- Data that can easily be used to present key information to GP practices and clusters could be particularly powerful, especially when their performance is compared with other practices or localities.

Promoting Research and Best Practice

Commitment 10

We will develop and agree national standards for pain management services to improve care for people with chronic pain.

Question 21. Should Commitment 10 be included in the Framework?

A majority of respondents – 85% of those who answered the question – thought that Commitment 10 should be included in the Framework, while 5% thought it should not and 10% did not know. Among Individual respondents, 12% said they did not know.

Commitment 11

We will support pain research in Scotland to develop improved care and treatment options for people with chronic pain.

Question 22- Should Commitment 11 be included in the Framework?

A very substantial majority of respondents – 98% of those who answered the question – thought that Commitment 11 should be included in the Framework, while 1% thought it should not and 1% did not know.

Question 23- Please explain your response to Questions 21 and 22.

A total of 90 respondents made a comment at Question 23.

Develop and agree national standards for pain management services

Reasons given for thinking there should be national standards for pain management included that these can drive consistency and quality of care, ensuring everyone can access the same support and care no matter where they

live. It was also suggested that national standards would be of great use to those working on service design and would provide clear indicators of what people with chronic pain should expect in relation to treatment and services. Similar standards for other conditions, such as cancer, were reported to have led to improved clinical outcomes at a national level. An alternative perspective was that no two people are the same, and that setting national standards may negate a person-centred approach.

Respondents also commented on potential cost and resource implications including that, at present, some Health Boards have significantly more funding per capita than others. It was suggested that current workforce and workforce planning and development may limit ability to fully implement national standards. The importance that standards are achievable and are actually delivered was emphasised.

Several respondents commented on guidelines or standards that already exist, referencing:

- The [SIGN guidelines](#) and specifically [Guideline 136](#) which it was suggested could be revised to include guidance for both primary and secondary care.
- The updated [Core Standards](#) document from the Faculty of Pain Medicine. There was a suggestion that Scotland does not need separate standards for pain services in the light of these standards.
- Draft Quality Performance Indicators for Scotland prepared for the Scottish Government by NRS Pain/SPaRC.¹

However, it was also argued that while standards are already in place there is no independent audit to establish whether or not they are met.

Some respondents commented on the importance of collaborative working and on who should be involved in the production of national standards, including a view that standards developed in consultation with all relevant stakeholders are more likely to succeed at the implementation stage. Specifically it was suggested there should be:

- Consultation with frontline workers.
- Co-production with people with lived experience of chronic pain.

Other points raised with respect to national standards included that they should:

- Be informed by evidence.
- See pain management as a human right.
- Put the patient at the centre.
- Reflect a multidisciplinary approach to care.

¹ The Scottish Pain Research Community (SPaRC) has transitioned to NHS Research Scotland Pain (NRS Pain). The main sources of evidence for the Quality Performance Indicators are SIGN 136 and the National Prescribing Strategy.

- Be applicable to all healthcare settings where patients are being treated for chronic pain not just pain management services.
- Be simple and both doctor and patient friendly.
- Support implementation of other relevant standards, policies and programmes for Government.
- Consider the role of socio-economic inequalities in preventing access to adequate and appropriate care for individuals.
- Take account of local demographic variations.

It was also suggested that there is a need to improve communication at the interfaces of primary and secondary care and with chronic pain specialist services, and that improved understanding of pathways and referrals, and the roles for the different services and professionals, would be welcome.

Support development of improved care and treatment options

There was wide support for further research on chronic pain, although also a suggestion that research could be at UK level. It was suggested that research could improve delivery of personalised medicine, with references to person-centred treatments that ensure people get the right treatment at the right time. A further suggestion was that robust research will allow healthcare professionals to bring a consistent message to patients and build confidence in agreeing choices around the most appropriate treatment.

However, there were also requests for clarity and detail with regard to what 'support' actually entails, and how research outcomes will be disseminated across a disparate workforce.

With respect to the type of research that might be carried out there was a suggestion that discussion is needed around priorities and inter-disciplinary collaboration. It was also suggested that both clinical and academic pain research should be included and that incentives for Higher Education Institutions to reach out to pain services may be helpful. It was noted that the research burden tends to fall on clinicians who are time limited, although also that closer integration between academic and applied pain professionals is developing. Supporting clinicians to become Early Career Researchers and having dedicated researchers embedded in a Health Board's pain service were both suggested. Building on the existing expertise of SPaRC and NHS Tayside was also thought essential.

Specific suggestions with respect to areas of research that might be prioritised included:

- Areas of greatest patient benefit or where there is lack of evidence.
- Brief interventions that have the most positive impact on individuals, given the limited time with healthcare professionals that is available.
- Rehabilitation and ways of facilitating practical interdisciplinary working using contemporary methodologies.

Other points on research included that it could or should:

- Be driven by the National Standards and match the scale and impact of chronic pain in Scotland.
- Consider how the complexity of the 'real world' chronic pain population can be better reflected, for example using databases that allow clinical data to be mined for research purposes.
- Be co-ordinated across Scotland with significant sampling across variations in geography, demographics, digital literacy, and socio-economic strata.
- Reflect all stakeholders involved in patient care.
- Encourage people with lived experience of chronic pain to both contribute to research design and to participate in research.
- Include women, both as researchers and as subjects, to ensure that their experiences and perspectives are accounted for.
- Involve a wider range of services in recruitment for trials to support developing a research culture.

Some respondents argued that research should not:

- Have only a psychological focus. It was suggested that much of the current focus is on psychological intervention trials, but that research should consider all aspects of chronic pain.
- Involve animal testing or animal products.

With respect to how research might be shared, it was noted that NRS Pain/SPaRC is well established in Scotland and provides a valuable platform to share learning.

Implementing and delivering the Framework

The consultation paper sets out plans for implementation of the Framework, including an intention that implementation and improvement actions will be undertaken in collaboration with service users and providers. This would build on relationships and systems that enable organisations to co-design care and support through the inclusion of people with lived experience of chronic pain.

Question 24- Please share your views on the barriers to implementing the Framework.

A total of 97 respondents made a comment at Question 24.

Current problems

Some respondents, including several Individual respondents with lived experience of chronic pain, saw elements of the present system, including in relation to the make-up and functioning of the National Advisory Committee for Chronic Pain (NACCP), as presenting barriers to implementing the Framework. Views included that the NACCP is unwilling to publish lived patient experience and that it needs to operate with a much greater degree of transparency. The importance of patient input and of evaluating individual experience to identify problem areas was highlighted as was a view that, to date, pain management has not been prioritised and that service provision currently does not meet demand.

Poor public understanding of chronic pain, or the conflicting understanding of patients and clinicians was also referenced.

Lack of detail and clarity

Comments with respect to the draft Framework included that it is not sufficiently specific, lacks clarity on timing and priorities for implementation, or lacks a strategy to provide the structure under which the framework hangs. It was suggested a strategy for pain management being developed by the Faculty of Pain Medicine along with other stakeholders will provide this.

It was also argued that the Framework should be more precise, measurable and relevant or should distil down to specific outcomes and stakeholders. It was suggested that it is unclear to what extent the Framework will feed into the National Care Service and whether this will change the landscape of the Framework.

A specific suggestion was that the Framework would benefit from clarity on 'effective treatments', as there are few effective treatments but many approaches to supporting people to live alongside persistent pain.

Financial constraints

Many respondents saw funding as a potential barrier to implementation of the Framework. Some respondents referenced historical underfunding of services and plans to reduce pain management services, which were described as the poor relation in healthcare. It was also argued that underfunding of services can create

incentives to deflect referrals or to discharge patients in order to manage waiting lists. Specific concerns were raised with respect to funding for the NHS Centre for Integrative Care.

It was observed that the draft Framework does not identify how funding will be addressed and a Representative Body respondent noted that they would welcome additional funding to enable local authorities to invest and improve outcomes in chronic pain management. Competing priorities in both health and social care were also acknowledged.

Specific suggestions as to how resources might be allocated included:

- Primary care.
- Online resources to help clinicians offer a better quality of care.
- Sustained funding for third sector organisations.

However, the effectiveness of some past resource allocation was also questioned. One suggestion was that NHS Scotland should stop relying on voluntary sector organisations, instead establishing their own version of successful service models.

Staff and training shortages

Low staffing levels and lack of time were frequently identified as barriers to implementation of the Framework. While it was acknowledged the draft Framework offers support to implement a workforce plan, it was argued the solutions need to be more robust to ensure effective person-centred care can be delivered. Significant difficulties in recruitment of allied health professionals in chronic pain were also reported.

Potential for community pharmacy and practice-based pharmacy teams to support good quality pain management was suggested, although it was reported that the resource is limited and the workload already high. It was also noted that the ability of community pharmacists to undertake chronic pain reviews is likely to be limited by a requirement to refer to a prescriber with recommendations for the patient's management plan.

In terms of staff training, it was suggested that, as well as a lack of training in specialist skills, there is poor understanding of the effects chronic pain has across all healthcare professions and that appropriate training should be provided. Development of formal pain medicine training programmes was proposed. There was also a specific concern with respect to anaesthetists' training in chronic pain.

It was also argued that the Framework focuses on knowledge but makes no reference to communication skills needed to facilitate this. A specific suggestion from an Individual respondent was that clinicians require specific training in assisting patients through a process of acceptance and adaptation, moving away from a 'medical model' to an 'acceptance orientated model'.

However, limitations in training opportunities were also identified in terms of:

- Staff who want to train in pain management.

- Chronic workforce shortages that make teaching and training a challenge.
- Access to training and time for training.

Effects of COVID

Some respondents commented on the potential impact of COVID on implementation of the Framework, including in relation to the effects of the pandemic on staff – their redeployment, fatigue, low morale and lack of training opportunities.

For patients, it was noted that long waiting times have been made worse by the pandemic and there was a suggestion that increased infection risks associated with society opening up post-COVID could mean that specialist services cannot resume. It was also noted that pain is amongst symptoms reported following COVID-19 infection.

Equity of access to services

Variation in opinions and approaches across or between Health Boards was also highlighted as a barrier to implementation, with respondents referencing difficulties in providing consistent care, standardised care, or a choice of effective treatments. Lack of consensus between healthcare professionals and lack of priority in Local Delivery Plans were both suggested as potential issues.

On the latter point it was suggested that there should be consequences for Health Boards and HSCPs that do not apply the Framework in their areas, although also that this might be unfair to Boards with smaller populations and hence less funding.

Respondents also commented on existing inequalities in terms of the services available to patients, including that this can amount to a postcode lottery. The need to ensure fair access for those living in remote rural areas and in deprived communities was argued.

Practical issues identified as limiting a patient's ability to access available services included:

- Location.
- Patient mobility.
- Affordability of travel.
- Access to both the internet and telephone.

Primary care

Specific points were also made about primary care and the role of GPs including a view that not all GPs are willing to refer patients to specialist pain management services, or that GPs may decide to prescribe medication to treat pain without investigating the underlying cause.

With respect to GP appointments it was argued that a typical 10-minute consultation is not long enough to help someone with chronic pain and an NHS

respondent reported findings that longer consultations and/or a series of shorter appointments, together with a wider multi-disciplinary team approach in primary care are effective.

Connecting and co-ordinating services

Given the wide variety of contexts where the Framework will apply, it was argued that planned implementation and governance processes will be important to ensure sharing of best practice and service innovations. It was also observed that in the existing health model, chronic pain works in series with other services but should operate in parallel such that, in some cases, advice and input can be given without transfer of care.

Other challenges identified included:

- Reducing duplication, fragmentation, and waste.
- Removing artificial boundaries between primary care and secondary care.
- Effective multidisciplinary working and joining up services. In particular, existing gaps between chronic pain management and mental health and addiction services were highlighted. With respect to mental health, it was argued that improved collaboration will require investment in mental health services to enable additional pain working, rather than a loss or diversion of their existing resources.

Practical issues such as inability to access patient notes or a risk of data loss during restructuring were also highlighted, with one Representative Body respondent arguing that co-ordination across sectors of care requires a single patient record that all members of the multidisciplinary team can read and write into.

In terms of local co-ordination it was suggested that, in the absence of a local Managed Pain Network, getting key people together to communicate regarding current work/developments and priorities could be difficult on a practical level.

Exploring new ideas and managing change

Respondents also highlighted a number of situations where they thought reluctance to change existing practices or inability to achieve a consensus on treatment could act as a barrier to implementation of the Framework. With respect to healthcare professionals this included suggestions that:

- Clinicians who feel they offer the best service they can with the resources available may be reluctant to change as may those who have developed ways of practice that are not necessarily evidenced based, but have maintained levels of patient satisfaction with the status quo.

As well as varying clinical judgement, it was suggested that barriers to implementation could be created by:

- Healthcare professionals lacking awareness of the Framework and its implications for their own practices.

- A culture of working in isolation rather than in partnership.
- Lack of team working between primary and secondary care and a lack of understanding of the other's role in pain management.
- Lack of recognition that not all people with chronic pain need (or want) to be managed in secondary care.
- Failure to share best practice.

On the last point, it was also suggested national professional networks with a specialist interest in pain will need to ensure they interconnect and share best practice.

With respect to patients, it was argued both that expectations of pain management services may not always be realistic and that there will be no one-size-fits-all solution to chronic pain management. It was also suggested that:

- A public health campaign could highlight the need for change and champion new approaches.
- Some patients may be reluctant to engage, to accept new approaches or to accept a view that the solution to their pain may not always be a medical one. There was a concern that some individuals might disengagement if they feared they would come under pressure to agree to changes to existing drug treatments.
- Partnership working on better solutions should involve patients with chronic pain. Along with openness to new ideas, therapies and treatments there should be an open debate on providing relief of suffering, with legal prescribing of medical cannabis given as an example.
- Specifically with respect to withdrawing opioids, patients may not understand that opioids stop helping and they may feel targeted by people that have never lived with chronic pain, especially if they are not offered alternative support. An alternative perspective was that, if effective, opioids should continue to be available to individual patients.
- On a practical level, there may be difficulties contacting chronic pain sufferers who are not currently receiving support and who may have given up trying to get help.

Research

Points were also raised with respect to the absence of research on and lack of knowledge about chronic pain. Particular issues raised included:

- That chronic pain is not recognised as a chronic disease, not monitored or coded in primary care in the same way as other diseases, and there is less funding and research.
- The difficulty quantifying pain, with a suggestion that better understanding of the physical and psychological causes may be needed before definitive guidelines can be produced.
- The limited evidence base for some interventions.

It was also argued that some specialist procedures do in fact have a good evidence base, and that any national guidelines would need to take account of these.

Question 25- Please share your views on the opportunities for the implementing the Framework.

A total of 83 respondents made a comment at Question 25.

The opportunities referenced most frequently were to improve quality of life for patients and to engage with, listen to and involve patients and carers. There was also a suggestion that the views of patients are currently being disregarded. A Third sector respondent reported that engagement with people with lived-experience of chronic pain has helped to inform drafting of the Framework, highlighting the importance of ongoing, regular updates as part of the roll out.

Some respondents saw the Framework as an opportunity for a change in culture and practice, a chance to do things differently, or to change attitudes and beliefs in relation to chronic pain and its management.

Education and training

Respondents also saw opportunities for improved education and training for healthcare and social care staff, including opportunities for healthcare professionals in other specialities to develop their skills around pain management. For those with such training, job-plan flexibility with their service base to allow sessional working was suggested as a way to stabilise the chronic pain workforce. It was also argued that, as Pain Management is being accredited for General Medical Council credentials, the Framework provides an ideal opportunity to increase the specialist workforce by introducing credentialling in Scotland for pain professionals.

A general opportunity suggested was to make pain management a more attractive area in which to work.

Opportunities for better education for patients and carers around pain management were also thought important.

Collaboration

Opportunities for sharing ideas, learning, resources and good practice were all referenced, including a suggestion that social media such as Facebook could be used to connect the Clinical Community. There was also a view that engagement and networking across all levels of pain management can be bolstered if published documents on standards, guidance and pathways are utilised.

Opportunities for improved multidisciplinary team working were highlighted, with a suggestion that shared patient care models that exist for other health conditions could be extended. There were calls for improved connections between primary and secondary care, for better links between health and social care, and for improved links to mental health and addiction services. Potential linkages with Healthcare Improvement Scotland's Medicines and Pharmacy work in areas such

as prison pharmacy, cancer medicines, and Area Drugs and Therapeutics Committees were also suggested.

Developing a method of sharing a patient's record across members of their care team was seen as essential.

Other suggested opportunities for collaboration included:

- Collaborative working between Health Boards.
- Wider collaboration with industry.
- Improved connections between networks.

It was noted that COVID has brought about new ways of working that mean remote meetings are now the norm.

Consistency and quality

Opportunities to provide greater consistency of care and standardise service delivery were suggested, including an opportunity to standardise and rationalise both pharmaceutical and non-pharmaceutical prescribing across NHS Scotland. Although an opportunity to create a national pathway for chronic pain was highlighted, allowing variation of approach between Health Boards was also seen as a missed opportunity to implement a single pathway. Some respondents suggested opportunities to adopt regional approaches or to find models that work locally.

It was also suggested that the Framework will provide Quality Improvement (QI) opportunities, such as including pain elements in QI care bundles. Potential linkages with Healthcare Improvement Scotland's Access QI programme were highlighted, working in partnership with NHS boards to use quality improvement to sustainably and affordably improve waiting times.

Raising awareness

Opportunities to raise awareness on chronic pain management were suggested with ideas including a public health campaign on chronic pain and promotion of the Framework in GP surgeries, pharmacies and community centres.

Working with the Third Sector

A number of respondents commented on potential for third sector working, including that there is an opportunity to recognise the value of the services the sector provides. Improved awareness of the options available to support patients locally, including green prescribing options was suggested.

Working with the pharmacy network

The potential of the community pharmacy network was highlighted, noting its strengths in delivery of person-centred advice and interventions, with teams who are both experts in medicines and trained to support people with their own holistic self-care goals. It was suggested that, if properly resourced to support pharmacy

teams, the Medicines Care and Review service would provide a vehicle for delivery of evidence-based interventions.

Leadership

Recruitment of clinical leads in each region was seen as an important opportunity to drive implementation of the Framework in collaboration with national leads. Creation of a stakeholder group to challenge, critically appraise and guide workstream development was also thought to be essential, with a requirement for such a group to have a degree of independence and a broad membership.

There was also a view that the Framework must ensure chronic pain is a priority for every Health Board and that services must be properly staffed and funded. It was suggested that the Framework should lead to discussion and planning at Health Board level, with changes to existing structure as needed to support optimisation of chronic pain services. An opportunity to drive cost effectiveness, both for people requesting care and staff delivering care without compromising the quality of care was also identified.

Respondents suggested opportunities that could be provided going forward, including the ability to switch plans and adjust to the changing needs of the population, as well as providing tailored management plans to suit the individual. It was also suggested there should be a route map which goes beyond the initial priorities and sets out medium- and long-term milestones, giving confidence that the Framework's vision is a dynamic one.

Other opportunities

A range of other potential opportunities were suggested including:

- Digital approaches including online pain management clinics.
- More research, co-ordinating research or better use of research on chronic pain, and embedding data and research in improving care.
- Use of apps and wearables for real-time monitoring.
- A national website of resources for both staff and patients.
- Investment in local business and creating community health hubs
- Addressing various health inequalities.

Question 26- Are there any groups who will be directly or indirectly impacted by the Vision, Aims and Commitments that have not been identified by the Equality Impact Assessment and/or Fairer Scotland Duty exercises in Annex A.

A total of 47 respondents made a comment at Question 26.

The most frequent comment was that there are no groups, or that the respondent had not identified any groups, that will be impacted and that have not already been

identified in the documents presented in Annex A. Several others did not know or were unsure.

General comments included that the Framework should adopt a cohesive approach to tackling health inequalities, in line with the recommendations of Audit Scotland's report NHS in Scotland 2021. It was suggested this should be reflected in development of a strategy to tackle inequalities, focusing on programmes related to women, ethnicity and social deprivation. A broad point raised was that there may be secondary impacts on other service users if the Framework is not resourced properly.

Equality Impact Assessment

The Equality Act 2010 covers the protected characteristics of: age, disability, gender reassignment, gender including pregnancy and maternity, race, religion and belief, and sexual orientation. With respect to these protected characteristics, respondents highlighted potential issues relating to:

- Older people.
- People with life limiting conditions.
- Women, including because many chronic pain conditions affect women more than men and that women suffering from chronic pain are more likely to be ignored. The Scottish Government's Women's Health Plan was seen as an opportunity to connect with a broader framework tackling inequalities and it was argued the Framework should commit to engaging with the national Women's Health Champion and Health Board leads. Mesh survivors were noted as a particular group of women impacted by chronic pain.
- Women with childcare or other caring responsibilities who may need better support to enable them to attend appointments.
- Women who may experience cultural barriers that prevent them coming forward with concerns about chronic pain.
- Families, since better pain management can improve interactions within the family unit.
- The traveller community.
- People who require translation services.
- Ethnic minority communities, since there is limited research into conditions such as sickle cell anaemia that primarily affect these communities.

It was also argued that the Framework should contain more examples of people who are not white heterosexuals. Suggestions included both that examples relating to the LGBTQ+ community, and people of colour, need to be included, and that health care professionals involved in pain management should not make assumptions about an individual's gender based on their presentation.

Fairer Scotland Duty

The Fairer Scotland Duty places a legal responsibility on particular public bodies to consider how they can reduce inequalities of outcome caused by socio-economic disadvantage, when making strategic decisions. In this respect respondents identified groups that might be impacted as:

- Deprived communities where it was suggested there may be a lack of local health services, or where people may not be able to afford to travel to health appointments.
- Homeless and disengaged people.
- People experiencing digital exclusion or other communication barriers.
- People with drug or alcohol issues including those who may abuse prescribed drugs. People who may have turned to alternative substances were also referenced.
- Those in contact with criminal justice system who need pain management.

Other issues or groups identified

It was suggested that, at present, the Framework does not address those suffering acute pain, in hospital undergoing surgery, or in hospital with flare ups of chronic pain. Cancer patients and people with mental health issues were also highlighted as potentially impacted, as were healthcare professionals including GPs and staff in clinics.

Other suggestions included:

- Rural and island communities where access to services may be difficult.
- Third sector organisations.

Annex 1 - Organisations responding to the consultation

Respondent	Group type
Affa Sair	Third sector
Body & Mind Health Solutions C.I.C.	Other
Centre for Sustainable Delivery Modernising Patient Pathways Programme	NHS
Community Pharmacy Scotland	Representative body
COSLA	Representative body
Directors of Pharmacy, NHS Scotland	NHS
Faculty of Pain Medicine of the Royal College of Anaesthetists	Representative body
Fife Pain Management Service	NHS
Grunenthal Ltd	Other
Healthcare Improvement Scotland	NHS
NHS Ayrshire and Arran Pain Management Service	NHS
NHS Borders	NHS
NHS Forth Valley	NHS
NHS Highland Chronic Pain Service	NHS
NHS Lothian Pharmacy Service	NHS
NHS Scotland Research (NRS) Pain Speciality Group / Scottish Pain Research Community (SPaRC)	NHS
NHSGGC Pain Management Service	NHS
Obesity Action Scotland	Third sector
Pain Association Scotland	Third sector
Pain Concern	Third sector
Royal Pharmaceutical Society	Representative body
Scottish Board of RCOA	Representative body
Scottish National Residential Pain Management Programme	NHS
Scottish Women's Convention	Third sector
The British Pain Society	Representative body
Versus Arthritis	Third sector

Annex 2 – Quantitative results

Question 1. Should this be the overarching vision?					
	Yes	No	Don't Know	Not Answered	Total
Organisations:					
NHS	12				12
Representative body	5	1			6
Third sector	5		1		6
Other	2				2
Total organisations	24	1	1		26
% of organisations answering	92%	4%	4%		
Individuals	82	4	2		88
% of individuals answering	93%	5%	2%		
All respondents	106	5	3		114
% of all respondents	93%	4%	3%	0%	
% of all those answering	93%	4%	3%		

Question 3. Should this aim be a priority?					
	Yes	No	Don't Know	Not Answered	Total
Organisations:					
NHS	12				12
Representative body	6				6
Third sector	6				6
Other	2				2
Total organisations	26	0	0		26
% of organisations answering	100%	0%	0%		
Individuals	83	4	1		88
% of individuals answering	94%	5%	1%		
All respondents	109	4	1		114
% of all respondents	96%	4%	1%	0%	
% of all those answering	96%	4%	1%		

Please note that in some instances percentages do not sum to 100% due to rounding.

Question 4. Should Commitment 1 be included in the Framework?					
	Yes	No	Don't Know	Not Answered	Total
Organisations:					
NHS	12				12
Representative body	6				6
Third sector	6				6
Other	2				2
Total organisations	26	0	0		26
% of organisations answering	100%	0%	0%		
Individuals	76	8	3	1	88
% of individuals answering	88%	9%	3%		
All respondents	102	8	3	1	114
% of all respondents	89%	7%	3%	1%	
% of all those answering	90%	7%	3%		

Question 6. Should this aim be a priority?					
	Yes	No	Don't Know	Not Answered	Total
Organisations:					
NHS	12				12
Representative body	6				6
Third sector	5			1	5
Other	2				2
Total organisations	25	0	0	1	26
% of organisations answering	100%	0%	0%		
Individuals	84	1	2	1	88
% of individuals answering	97%	1%	2%		
All respondents	109	1	2	2	114
% of all respondents	96%	1%	2%	2%	
% of all those answering	97%	1%	2%		

Question 7. Should Commitment 2 be included in the Framework?					
	Yes	No	Don't Know	Not Answered	Total
Organisations:					
NHS	12				12
Representative body	6				6
Third sector	4		1	1	5
Other	2				2
Total organisations	24	0	1	1	26
% of organisations answering	96%	0%	4%		
Individuals	82	2	2	2	88
% of individuals answering	95%	2%	2%		
All respondents	106	2	3	3	114
% of all respondents	93%	2%	3%	3%	
% of all those answering	95%	2%	3%		

Question 8. Should Commitment 3 be included in the Framework?					
	Yes	No	Don't Know	Not Answered	Total
Organisations:					
NHS	11			1	11
Representative body	6				6
Third sector	5			1	5
Other	2				2
Total organisations	24	0	0	2	26
% of organisations answering	100%	0%	0%		
Individuals	76	8	3	1	88
% of individuals answering	87%	9%	3%		
All respondents	100	8	3	3	114
% of all respondents	88%	7%	3%	3%	
% of all those answering	90%	7%	3%		

Question 10. Should this aim be a priority?					
	Yes	No	Don't Know	Not Answered	Total
Organisations:					
NHS	12				12
Representative body	6				6
Third sector	5			1	5
Other	2				2
Total organisations	25	0	0	1	26
% of organisations answering	100%	0%	0%		
Individuals	79	4	4	1	88
% of individuals answering	91%	5%	5%		
All respondents	104	4	4	2	114
% of all respondents	91%	4%	4%	2%	
% of all those answering	93%	4%	4%		

Question 11. Should Commitment 4 be included in the Framework?					
	Yes	No	Don't Know	Not Answered	Total
Organisations:					
NHS	12				12
Representative body	6				6
Third sector	5			1	5
Other	2				2
Total organisations	25	0	0	1	26
% of organisations answering	100%	0%	0%		
Individuals	80	3	4	1	88
% of individuals answering	92%	3%	5%		
All respondents	105	3	4	2	114
% of all respondents	92%	3%	4%	2%	
% of all those answering	94%	3%	4%		

Question 12. Should Commitment 5 be included in the Framework?					
	Yes	No	Don't Know	Not Answered	Total
Organisations:					
NHS	12				12
Representative body	6				6
Third sector	5		1		6
Other	2				2
Total organisations	25	0	1	0	26
% of organisations answering	96%	0%	4%		
Individuals	82	1	4	1	88
% of individuals answering	94%	1%	5%		
All respondents	107	1	5	1	114
% of all respondents	94%	1%	4%	1%	
% of all those answering	95%	1%	4%		

Question 14. Should this aim be a priority?					
	Yes	No	Don't Know	Not Answered	Total
Organisations:					
NHS	12				12
Representative body	6				6
Third sector	5			1	5
Other	2				2
Total organisations	25	0	0	1	26
% of organisations answering	100%	0%	0%		
Individuals	78	5	4	1	88
% of individuals answering	90%	6%	5%		
All respondents	103	5	4	2	114
% of all respondents	90%	4%	4%	2%	
% of all those answering	92%	4%	4%		

Question 15. Should Commitment 6 be included in the Framework?					
	Yes	No	Don't Know	Not Answered	Total
Organisations:					
NHS	12				12
Representative body	6				6
Third sector	6				6
Other	2				2
Total organisations	26	0	0	0	26
% of organisations answering	100%	0%	0%		
Individuals	79	6	2	1	88
% of individuals answering	91%	7%	2%		
All respondents	105	6	2	1	114
% of all respondents	92%	5%	2%	1%	
% of all those answering	93%	5%	2%		

Question 16. Should Commitment 7 be included in the Framework?					
	Yes	No	Don't Know	Not Answered	Total
Organisations:					
NHS	12				12
Representative body	5	1			6
Third sector	5			1	5
Other	2				2
Total organisations	24	1	0	1	26
% of organisations answering	96%	4%	0%		
Individuals	83	4		1	88
% of individuals answering	95%	5%	0%		
All respondents	107	5	0	2	114
% of all respondents	94%	4%	0%	2%	
% of all those answering	96%	4%	0%		

Question 18. Should Commitment 8 be included in the Framework?					
	Yes	No	Don't Know	Not Answered	Total
Organisations:					
NHS	12				12
Representative body	6				6
Third sector	5			1	5
Other	2				2
Total organisations	25	0	0	1	26
% of organisations answering	100%	0%	0%		
Individuals	69	5	12	2	88
% of individuals answering	80%	6%	14%		
All respondents	94	5	12	3	114
% of all respondents	82%	4%	11%	3%	
% of all those answering	85%	5%	11%		

Question 19. Should Commitment 9 be included in the Framework?					
	Yes	No	Don't Know	Not Answered	Total
Organisations:					
NHS	12				12
Representative body	6				6
Third sector	5			1	5
Other	2				2
Total organisations	25	0	0	1	26
% of organisations answering	100%	0%	0%		
Individuals	77	4	6	1	88
% of individuals answering	89%	5%	7%		
All respondents	102	4	6	2	114
% of all respondents	89%	4%	5%	2%	
% of all those answering	91%	4%	5%		

Question 21. Should Commitment 10 be included in the Framework?					
	Yes	No	Don't Know	Not Answered	Total
Organisations:					
NHS	11		1		12
Representative body	6				6
Third sector	5			1	5
Other	2				2
Total organisations	24	0	1	1	26
% of organisations answering	96%	0%	4%		
Individuals	70	6	10	2	88
% of individuals answering	81%	7%	12%		
All respondents	94	6	11	3	114
% of all respondents	82%	5%	10%	3%	
% of all those answering	85%	5%	10%		

Question 22. Should Commitment 11 be included in the Framework?					
	Yes	No	Don't Know	Not Answered	Total
Organisations:					
NHS	12				12
Representative body	6				6
Third sector	5			1	5
Other	2				2
Total organisations	25	0	0	1	26
% of organisations answering	100%	0%	0%		
Individuals	84	1	1	2	88
% of individuals answering	98%	1%	1%		
All respondents	109	1	1	3	114
% of all respondents	96%	1%	1%	3%	
% of all those answering	98%	1%	1%		



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