The failure to relieve pain after surgery has been demonstrated by many studies in the past and was the subject of a multidisciplinary report in 1990. In December 1997, the Audit Commission published a report entitled 'Anaesthesia Under Examination' which included pain after surgery in its remit. This article will present the Audit Commission's recommendations on acute pain management, discuss the current situation in Lancaster and look to future developments.

Postoperative pain is a result of surgery that can be avoided or reduced. It is rarely an indicator of surgical complications. Pain control is an important quality issue but is of economic significance also; effective analgesia may hasten recovery, reduce postoperative complications and shorten hospital stay. Successful pain management requires a multidisciplinary approach involving surgeons, anaesthetists, ward and specialist pain nurses, physiotherapists and pharmacists to ensure effective, safe treatment with a minimum of side-effects.

Summary of recommendations
1 Purchaser/provider contracts should include standards and specific targets for pain relief.
2 The trust board should state its aims for pain management in its quality strategy and translate these into policies and guidelines for staff to follow.
3 One doctor should be identified as lead specialist to promote good practice.
4 There should be regular audit of pain management targets, especially pain scores, which are reported to the trust board.
5 Evidence-based guidelines on effective therapy should be developed.
6 A co-ordinated approach to pain management should be developed with clear agreement on how anaesthetic, surgical and other staff will work together to ensure patients do not suffer unnecessary pain.
7 The Acute Pain Team should provide written information and guidelines, staff education, leadership and a focus for improved teamwork.
8 A programme of continuing education should be developed for nurses and trainee doctors who are best placed to monitor patient progress. Pain management should be included in the nursing care plan.

The report makes it quite clear that these objectives should involve action from the highest levels including health authorities, chief executive, medical director, other trust board members and GP fund-holders as well as clinicians.

There is one aspect of this report which surprised me somewhat. This is the fact that the Audit Commission described only postoperative pain management and ignored other causes of acute pain such as trauma, pain before surgery, medical (as opposed to surgical) causes of pain such as myocardial infarction, and acute-on-chronic problems such as acute back pain. Acute and chronic pain management have developed along separate pathways and the fact that appropriate management of acute pain will probably modify or prevent the development of chronic pain syndromes has not been emphasised in the past. Over the last five years this attitude has changed, for example the Intractable Pain Society becoming the Pain Society and making a determined effort to involve acute pain specialists in its running. The Royal College of Anaesthetists recently gave subspeciality status to pain management and does not attempt to separate acute and chronic pain. Many of the patients experiencing 'non-postoperative' acute pain will not fall under the direct responsibility of anaesthetists but, inevitably, the Acute Pain Service does play a role in their care. It is disappointing, therefore, that the Audit Commission did not recognise this fact and help to promote it.

The report also documents the emergence of the Acute Pain Team. In 1990 there was none in the North West Region (national figures in parentheses) (3%), by 1994 41% of hospitals had them (42%) and in 1997 52% (57%). Royal Lancaster Infirmary was one of the first hospitals in the North West to use patient-controlled analgesia (PCA), the late Phil Allen having introduced them in about 1988, but it was only in March 1996 that our acute pain service took off with the appointment of Lee Jolly as Nurse Practitioner in acute pain management. This post was funded by Regional money provided to reduce junior doctors’ workloads. Since then Lee has worked very hard to promote acute pain management not only by direct contact with patients but, more importantly, by providing education and training for ward staff. Ward-based learning is complimented by regular two-day lecture sessions which have encouraged considerable interest and enthusiasm for the subject among nurses. Trainee doctors have also found Lee very helpful and frequently seek her advice; caution is needed here, however, to ensure that appropriate lines of responsibility are maintained.

Standards for pain relief
In 1992 the Welsh Office published targets for pain management to reduce the percentage of patients in severe pain after surgery to under 20% by 1997 and to under 5% by 2002. The figures chosen are empirical and the population not specified. It has been assumed that all postoperative patients are included, even the large numbers who undergo minor procedures such as D&C. Nevertheless, these targets are a start and similar standards should be developed for the rest of the UK. The Acute Pain Special Interest Group of the Pain Society in association with the Royal College of Anaesthetists is generating a range of standards which can be used for local audit projects and which may be adopted nationally.

Pain relief targets
Regular audit is essential to ensure that we are delivering a safe, effective, efficient service. The routine monitoring of pain scores using a simple four point scale was introduced with PCA and is now routine for all patients undergoing major surgery as well as day cases. This not only allows monitoring of most patients but also helps to remind staff
of the importance of pain management. In addition to this day-to-day audit, there is constant checking of critical incidents, technical problems and any impact of the service on trainee medical staff which we aim to keep to a minimum. Audits targeting particular areas are also carried out, for example fractured neck of femur prior to theatre and a multidisciplinary audit of pain after mastectomy. We have participated in a pilot study of a national audit database and regularly submit anonymised data to a regional database which allows comparison between our results and other centres.

Evidence-based guidelines on effective analgesia (the in phrase!) All techniques have the potential to manage pain successfully if they are used appropriately. Equally, the best techniques are, at best, a waste of time, effort and money if not applied with care. Analgesic techniques must be applied to the individual patient's needs, be assessed for efficacy and safety and be modified if they do not achieve appropriate goals, rather than jumping on the evidence-based medicine bandwagon and expecting it to work!

Information, guidelines, education and teamworking Nursing practice is based on competency and this necessitates policies. The acute pain team endeavours to develop these to permit nursing staff to manage pain successfully. The introduction of guidelines for medical staff is a more contentious issue, trying to encourage good practice whilst maintaining clinical freedom. All new trainees are invited to a lecture on acute pain management and are encouraged to seek advice for specific problems. There is no doubt that in the last few years the awareness of pain and its management has grown and that a team approach is becoming more widely accepted.

Action from the top Many of the recommendations in the report involve action by the chief executive, medical director and director of quality but little comment is made about funding an acute pain service. Where should this funding come from? Ultimately the purchasers of our services must pay but should this cost be included in the overall charge for a procedure or should we, like Cardiff, add an extra £10 for every surgical procedure to cover acute pain management (which, I am told, their purchasers willingly pay)? Neither of these options covers the cost of providing care for those patients with 'non-postoperative' pain. At present there is no budget in Lancaster for acute pain management. There is no funding for staffing, the nurse practitioner's salary is covered by ring-fenced money from Morecambe Bay Health Authority, equipment is largely purchased using charitable donations, disposables are 'lost' in the theatre budget and Pharmacy supplies the drugs, while any financial benefits such as reduced morbidity and shorter hospital stays are a bonus for the surgical budget. I believe the time has come for the trust to agree a specific budget for acute pain management which can be negotiated with the purchasers on the grounds of invisible savings but also, more importantly, on the grounds of quality. New developments can then be introduced by producing a business plan such as the one for the ward-based epidural service on Ward 33, following agreement between the trust board and purchasers. This system has worked very well in Blackpool where the quality and financial aspects of pain management were given some priority; I hope the Audit Commission report will provide the stimulus for a similar system in Lancaster.

THE FUTURE

The short to mid-term future will present a number of challenges for the acute pain service such as:

The Morecambe Bay Trust The amalgamation of the three acute trusts around Morecambe Bay will bring together three different systems for managing acute pain which require rapid integration. At present Westmorland General Hospital has no nurse with designated responsibility for pain management and no resident anaesthetic staff. Patient-controlled analgesia is used but other continuous techniques such as local anaesthetic infusions are avoided. Furness General Patient-controlled analgesia is used but other continuous techniques such as local anaesthetic infusions are avoided. Furness General does not have a designated medical or nurse specialist and, like WGH, largely restricts techniques to PCA.

Lancaster ward-based epidural service A pilot project has been running on Ward 33 at the RLI since May 1997 and has succeeded in providing good pain relief for most patients with minimal side-effects. The continuation of this service beyond April 1998 and the proposed extension of it to Ward 34 is now dependent on funding from the new trust.

Postoperative Care Service (POCS)/postop ward The monitoring of oxygenation, and fluid and electrolyte balance, and the management of analgesia, nausea and vomiting are fundamentals of care after surgery. A POCS is a logical development. At present patients must be admitted to the ICU/HDU or return to the general ward. I believe that better care, including analgesia, could be delivered if all major surgery patients returned to a single postop ward irrespective of surgical specialty. This would concentrate expensive items such as syringe and PCA pumps on a single site, it would provide intensive experience for medical (anaesthetic and surgical) and nursing staff which would be carried to other wards when they rotate, staffing levels would reflect the high activity levels and the best possible care would be delivered to patients at the most critical point after (or before) surgery. It would, however, demand a fundamental change to current surgical practice which could reduce its appeal. Ward 37 is ideally placed for this role with its proximity to theatres and ICU and presents a great opportunity for a radical change to the way in which we deliver postoperative care.

Future funding and development Acute pain management is an important quality issue, the financial benefits of which may not be so apparent. A number of acute pain nurses are finding their continuing funding threatened by management who believe that an acute pain service, once established, no longer needs a nurse specialist. Our own experience tells us this is fallacious. I am confident that the funding for our Acute Pain nurse is secure and is supported by the Audit Commission report. In 1997 the Clinical Standards Advisory Group (CSAG) commissioned a national study into services for managing all kinds of pain. The report has now been submitted to the CSAG committee and will then be passed to the Secretary of State for Health. If he approves the report's findings and recommendations then there will be further strong support for developing the acute pain team.

Developing an acute pain service for Lancaster has been hard work and there is much still to do be done, but we are well on the way to achieving safe, effective analgesia for the great majority of our patients.

REFERENCE


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