The Royal College of
Chiropractors

Chiropractic Quality Standard

Low Back Pain and Sciatica

RCC Low Back Pain and Sciatica Quality Standard Development Team

Lead Author

Stuart Smellie FRCC, MRCC (Pain)

Director of Academic Affairs and Quality Standards Lead

Royal College of Chiropractors

Team Members

Matthew Barks FRCC (Pain)

Trustee

Royal College of Chiropractors

Richard Brown FRCC

Secretary General

World Federation of Chiropractic

Annie Newsam FRCC

Senior Lecturer

University of South Wales

About the Royal College of Chiropractors' Quality Standards

This Royal College of Chiropractors (RCC) Quality Standard covers the chiropractic assessment and management of adult patients presenting with low back pain, with or without sciatica. RCC Quality Standards are tools designed to help deliver the best possible outcomes for patients. They are a series of specific, concise quality statements with associated measures that provide aspirational, but achievable, markers of high-quality patient care covering the treatment of different conditions. They also form an important part in the process of improving quality and patient outcomes.

The primary purpose of RCC Quality Standards is to make it clear what quality care is by providing patients, the public, healthcare professionals, commissioners and chiropractors with definitions of high-quality chiropractic care.

By providing a clear description of what a high-quality service looks like, clinicians can improve the quality of care that they provide and demonstrate excellent service provision. RCC Quality Standards encompass statutory requirements, best practice and existing clinical guidelines that are specific to a chiropractic setting, and are a useful standard for the basis of clinical audit and to identify priorities for future improvement.

Chiropractors are encouraged to adopt RCC Quality Standards as practice policy. As a template for best practice, they can be used in a wide range of circumstances, such as a resource to identify areas for professional development, to demonstrate quality of service to stakeholders, or when tendering for NHS contracts. They enable other healthcare professionals to understand the standard of service chiropractors provide and allow commissioners to be confident that the services they are purchasing are of high quality. Importantly, they also help patients to understand what service they should expect.

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Contents

Scope and Context of Quality Standard	6
Quality Measures	7
Additional Resources	7
Quality Statements	8
Assessment and Management Flowchart	9
Identification of Serious Spinal Pathology	10
Additional Risk Screening	10
Non-Physical Factors	10
Diagnostic Imaging	10
Outcome Measures	11
Shared Decision-Making	11
Management Considerations	12
Monitoring and Reassessment	13
Chiropractic Quality Statement 1: Waiting Times	14
Chiropractic Quality Statement 2: History and Examination	15
Chiropractic Quality Statement 3: Non-Physical Factors	16
Chiropractic Quality Statement 4: Diagnostic Imaging	17
Chiropractic Quality Statement 5: Treatment Aims	18
Chiropractic Quality Statement 6: Plan of Care	19
Chiropractic Quality Statement 7: Informed Consent	20
Chiropractic Quality Statement 8: Therapeutic Alliance	21
Chiropractic Quality Statement 9: Package of Care	22
Chiropractic Quality Statement 10: Support to Self-Manage	24
Chiropractic Quality Statement 11: Interprofessional Collaboration	25
Chiropractic Quality Statement 12: Monitoring and Reassessment	26
Chiropractic Quality Statement 13: Discharge and Ongoing Care	27
List of Sources	28

Scope and Context of Quality Standard

This RCC Quality Standard covers the chiropractic assessment and management of adult patients (aged 18 and over) presenting with low back pain, with or without sciatica, but excludes serious spinal pathology. In this context of this Standard, sciatica includes both radicular and referred leg pain.

Low back pain has a massive impact on society, is the greatest cause of disability worldwide and is experienced by most people at some point in their lifetime[1,2,3]. Prevalence of back pain in the UK is approximately 17%, affecting more than 1 in 6 people at any one time. Up to 84% of the general population will experience an episode of low back pain during their lifetime and recurrence rates are high[4,5]. Approximately 50% of all patients presenting to chiropractors report doing so because of low back pain, which makes it the most common condition managed by the profession[6].

In primary care, 90-95% of all low back pain has no indication of a serious cause and is often described as non-specific low back pain[7,8]. For chronic pain, this is analogous with the newer term of chronic primary low back pain[9,10]. Radicular leg pain is relatively common, representing 5-10% of patients presenting with low back pain, and has a lifetime incidence ranging from 13% to 40%[11]. Less than 1% of low back pain is due to specific spinal pathology[8].

Numerous national and international guidelines on the assessment and management of low back pain and sciatica have been published over the last few years[10,12,13,14,15,16,17,18,19,20,21,22,23,24,25] and, given that they draw on the same accumulated evidence base, their conclusions are not dissimilar[4,5,27,28]. However, there are very few guidelines, if any, that address the whole patient journey, and none that are specific to the chiropractic profession and its regulation in the UK. Chiropractic care is usually provided in a setting and environment that is less constrained by time and resource limitation than many other healthcare professions and is able to meet the criteria of a high-quality healthcare service that includes care that is effective, safe, person-centred and timely[29,30].

Due to the complex nature of low back pain that cannot be simply compartmentalised into acute and chronic, this RCC Quality Standard replaces those on “Acute Low Back Pain” (2012) and “Chronic Low Back Pain” (2014). Given the chronic nature of many presentations of low back pain, where appropriate, this standard should be read in conjunction with the following other RCC Quality Standards:

RCC Chiropractic Quality Standard on “Chronic Pain”[31]
RCC Chiropractic Quality Standard “Supportive Self-Management in Chronic Care”[32]

RCC Chiropractic Practice Standards are evidence-based publications designed to help chiropractors meet their obligations in the provision of patient care and/or governance of their services. These Practice Standards are relevant to the assessment and management of patients presenting with low back pain, with or without sciatica, and should be considered in conjunction with this Quality Standard when aspiring to provide high quality care.

There are a wide range of different patient presentations associated with low back pain, with or without sciatica, and the management in each case will require an individual approach. These quality statements are therefore general but nevertheless provide achievable markers of high-quality, cost-effective patient care.

Quality Measures

The quality measures are an important component of RCC Quality Standards and aim to improve the structure, process and outcomes of care. They are designed to assist in measuring compliance with the standards and can be used as a resource for clinical audit. They also specify what each statement means to each stakeholder (provider, commissioners, and patients) and give details of the key evidence used in the development of each statement.

Additional Resources

In addition to the quality statements and accompanying quality measures, supplementary material has been provided that is specifically aimed at supporting chiropractors to embed the quality standard into clinical practice. This includes additional detail and evidence-based explanations that support the statements, as well as an **assessment and management flowchart**. These resources have been developed to be specific to a chiropractic setting and their content may vary from other published guidelines.

Quality Statements

1. **Waiting Times:** On contacting a chiropractic clinic, patients seeking care for low back pain, with or without sciatica, are offered an appointment within five working days, unless red flags suggesting serious pathology are identified at the initial contact, in which case signposting to urgent or emergency medical care is provided.
2. **History and Examination:** Patients presenting with low back pain, with or without sciatica, are assessed by means of a comprehensive and focused history and physical examination, which will include a neurological assessment and screening for signs and symptoms of underlying pathology, as well as the collection of baseline outcomes data.
3. **Non-Physical Factors:** Psychosocial factors are assessed, and contextual effects considered, in patients presenting with low back pain, with or without sciatica, as well as appropriate use of stratification tools (such as STarT Back), to inform the prognosis and assist in the choice of appropriate treatment regimens.
4. **Diagnostic Imaging:** In the absence of clinical indicators suggesting potential serious underlying pathology, routine diagnostic imaging (including x-rays and MRI) is not required for patients presenting with low back pain, with or without sciatica. If diagnostic imaging is considered appropriate, evidence-based justification and valid consent is required.
5. **Treatment Aims:** The aims of treatment for patients with low back pain, with or without sciatica, are developed on the basis of shared decision-making, but consideration is given to a reduction of symptoms, improvement of function, patient-focused goals and return to normal daily activities (including return to work).
6. **Plan of Care:** A plan of care, which will include the objectives, proposed interventions and treatment dose (number and frequency of appointments), is formulated in partnership with patients presenting with low back pain, with or without sciatica, after their personal expectations, beliefs and preferences have been considered. Co-management with other healthcare practitioners is considered, and a plan of care includes a formal review within six weeks of the commencement of treatment.
7. **Valid Consent:** Prior to commencing care, patients with low back pain, with or without sciatica, are invited to consent to care after they have received an explanation of their condition, different options for care, risks and benefits of treatment, likely outcomes with and without treatment, and after a plan of care has been discussed and agreed. Once provided, ongoing consent will be sought throughout a course of care, including at times where management is reviewed or modified.
8. **Therapeutic Alliance:** Patients presenting with low back pain, with or without sciatica, are provided with patient-centred care through an effective therapeutic alliance to support them in achieving their goals as well as addressing adverse psychosocial and contextual factors.
9. **Package of Care:** Patients with low back pain, with or without sciatica, are treated with an individualised, evidence-based, multimodal package of care, which will include advice and information (including relevant safety-netting advice), as well as a range of management options which may include manual therapies (manipulation, mobilisation and soft tissue techniques), cognitive/behavioural interventions, acupuncture and exercise/rehabilitation.
10. **Support to Self-Manage:** Patients with low back pain, with or without sciatica, are given advice and information to help self-manage their condition and, as far as is possible, are encouraged to exercise, be physically active and to continue normal daily activities.
11. **Interprofessional Collaboration:** When managing patients with low back pain, with or without sciatica, chiropractors are attentive to the expertise and involvement of other health professionals, consider referral and co-management options, and appropriately report their findings and management to the patient's GP.
12. **Monitoring and Reassessment:** The progress of patients with low back pain, with or without sciatica, is continually monitored throughout care, but also kept under review with regular formal reassessments, use of validated outcome tools, and potential referral to another healthcare practitioner, particularly if symptoms deteriorate, or they show no significant signs of improvement within six weeks.
13. **Discharge and Ongoing Care:** Patients with low back pain, with or without sciatica, are discharged from acute care within four weeks of their signs and symptoms being absent. Ongoing supportive self-management, including rehabilitation and prophylactic care, may be offered to patients once their condition has become manageable or resolved.

Low Back Pain and Sciatica

Chiropractic Assessment and Management Flowchart

Red Flags
- Assess for the signs and symptoms of potential serious underlying pathology (including cauda equina syndrome, spinal cord compression, infection, malignancy, and fracture)

1. Assessment
Comprehensive and focused history and physical examination, including neurological assessment, as well as the collection of baseline outcomes data

Non-Physical Factors
- Identification of psychosocial factors adversely effecting presenting symptoms and prognosis
- Appreciation of relevant modifiable contextual factors that may have an effect on outcomes
- Use of stratification tools (eg STarT Back) to inform prognosis and assist management decisions

Specific Risk Screening
- Assess for the presence of co-existing or influencing pathology requiring referral, co-management, or the amendment of management approaches
  - Osteoporosis
  - Axial Spondyloarthritis
  - Hypermobility Spectrum Disorder
  - Vascular Vulnerability

Diagnostic Imaging is not required routinely *(but may be considered in circumstances such as trauma, suspected axial spondyloarthritis, and when positive red flags warrant further investigation)*

Working Diagnosis / Clinical Impression

Possible Serious Underlying Pathology

Non-Specific Low Back Pain with or without **Sciatica**

Relevant Co-Existing or Influencing Pathology (requiring referral, co-management, or additional management considerations)

Interprofessional Collaboration

Emergency Referrals - same day A&E referrals (eg cauda equina syndrome)

Urgent Referrals - to GP within 2 weeks

Referral to GP, or other Healthcare Professional, for opinion, investigations or management (as necessary)

Co-management with another Healthcare Professional (as necessary)

Send GP Report providing information on presentations, diagnosis, management and outcomes

2. Shared Decision-Making
- **Explain** assessment findings, clinical impression, treatment options (including risks, benefits and alternatives) and expected outcomes
- **Listen** to patient aims, expectations, preferences and beliefs
- **Discuss** options for care
- **Agree** treatment aims and a treatment plan

(all the above is necessary to obtain informed consent)

3. Management

An individualised, evidence-based, multimodal package of care, provided within the context of an effective Therapeutic Alliance, may include:
- Manual therapies (manipulative, mobilisation and soft tissue techniques)
- Psychosocial Interventions (eg. cognitive and behaviour approaches)
- Physical activity (tailored exercise and rehabilitation prescription)
- Information, education and lifestyle advice
- Supportive self-management approaches

4. Monitoring and Reassessment
- Progress is continually monitored, with regular formal reviews, including the use of validated outcome measures.
- Patient must be involved in ongoing decisions about their care, including any continuation of care.
- Referral to another healthcare professional should be considered, particularly if symptoms deteriorate, or there are no signs of significant improvement within six weeks.
- Ongoing supportive self-management, including rehabilitation and prophylactic care, may be offered to patients with chronic conditions once their condition has become manageable or resolved.

Identification of Serious Spinal Pathology

A case history and physical examination (including neurological testing) is the cornerstone of clinical decision making for patients presenting with low back pain. Although over 90-95% of presentations to primary care are for non-specific low back pain, and 5-10% for radicular symptoms, an important function of assessment is to identify the less than 1% that is caused by potential serious spinal pathology[8], most notably **cauda equina syndrome, infection, malignancy**, and **fracture**[10,15,27,33,34,35]. Another source of pain to exclude is true and referred visceral pain. This can include conditions, such as abdominal aortic aneurysm, which may require urgent or emergency referral[34,35,36]. The presence of signs and symptoms of, or risk factors for, underlying pathology (red flags) raise the level of suspicion that these may be present, and necessitate additional enquiry, investigation, or referral.

Additional Risk Screening

A comprehensive assessment of patients presenting with low back pain will not only assess the nature of their presenting complaint, but also explore their medical history, identify additional health concerns and highlight possible contraindications to certain types of care. There are also a number of commonly under-diagnosed co-existing conditions, some which are highly prevalent, that are of particular importance in the context of providing manual therapies. These conditions (which include **osteoporosis, axial spondyloarthritis, hypermobility spectrum disorder** and **vascular fragility**) require specific risk assessment screening, so that patients who may be affected can be identified, referred, co-managed, or modifications made to their care plans, as necessary[25,37,38,39,40,41,42].

Non-Physical Factors

Assessment of modifiable psychosocial risk factors (**yellow flags**) in patients presenting with low back pain can help to identify those who are more likely to have poorer outcomes[4,10,27], as well as those who may benefit from preventative care[43,44]. Use of **stratification tools** (such as STarT Back) can not only help to identify patients with higher risks of chronicity, but may also assist in clinical decision-making, particularly identifying when cognitive and behavioural interventions might be necessary[12,34,45]. Emerging evidence also suggests that wider **contextual factors** have a significant impact on the management of low back pain[46]. Gathering an understanding of patients' beliefs and expectations is therefore important. This extends to recognising and respecting the diverse needs, preferences and values of patients from various cultural and social backgrounds, and being sensitive to different health beliefs and practices, in order to tailor communication and help develop the most effective management plans.

Diagnostic Imaging

Routine imaging of patients who present with low back pain, with or without sciatica, is not indicated unless serious pathology is suspected[12,25,27,47,48]. For patients with uncomplicated, non-specific low back pain, imaging may do more harm than good and is likely to prolong recovery[8]. Imaging might be considered for patients presenting with sciatica if symptoms progress for more than 12 weeks, or if the patient has progressive neurological deficits or worsening pain[8,49]. It is important that if there are individual clinical circumstances in which diagnostic imaging is considered necessary, the most appropriate imaging modality is used, and that evidence-based justification and valid consent is recorded.

Outcome Measures

Use of validated patient reported outcome measures (PROMS) can have a positive effect on patient outcomes[50]. **PROMS** are evidence-based tools used to gather and quantify patients' base-line perceptions and views on their own health, and can be used to guide multi-dimensional management of low back pain, as well as to monitor the effectiveness of care being provided. There is a range of established outcome tools available, many addressing pain and function, as well as others designed to elicit more detailed information relating to specific domains. A number of questionnaires (such as the Bournemouth Questionnaire[51] and MSK-HQ[52,53]) include psychosocial questions in addition to those relating to pain and function.

Shared Decision-Making

A cornerstone of modern person-centred healthcare is to include patients in decision-making related to their health. This is directly related to consent, as patients have a legal right to be involved in decisions about their care[54,55,56,57]. To ensure consent is valid (voluntary, informed and given by someone with capacity), patients must receive detailed information, including an explanation of their presenting complaint, its natural history, options for care (along with the risks and benefits associated with each option) and the expected outcomes. Understanding and appreciating the aims, expectations, preferences and beliefs of patients is crucial before discussing available options (including the option of no treatment), and supporting them to make informed decisions and agreeing a plan of care[58,59,60,61].

Management Considerations

The management of patients with low back pain should be individualised and **person-centred**[10,59]. This requires a biopsychosocial approach, shared decision making and the development of a strong therapeutic alliance[62]. Consequently, the specific management of each patient will vary. However, peer-reviewed evidence provides a clear framework for best practice.

Therapeutic Relationship and Communication

The relationship between patient and clinician is one of the most important elements of care and is integral to the ability to impart clinically important information and advice. Building an effective therapeutic relationship requires adept communication skills. These include engaging in active listening, showing warmth, attention and care, providing encouragement and support, and developing professional rapport[46,63]. Effective communication, a sense of collaboration, and the establishment of shared goals collectively form a **therapeutic alliance** that has been shown to have a beneficial impact on patient outcomes[64,65,66,67,68]. Providing validation (acknowledging the distressing nature and impact of back pain), and reassurance, both play a role in supporting patients to remain active and engage in other self-management activities[7,10]. Considered use of language can enhance contextual effects, but it is important to avoid language that is nocebic or alarmist, which can have a negative effect on outcomes[34,69].

Package of Care

Evidence supports a package of care which is provided alongside appropriate **information, advice and education**[10,27,70]. In a chiropractic setting, and subject to patient preferences, this is likely to include **manual therapies** (including different manipulative, mobilisation and soft tissue techniques) as well as support to increase or restore levels of **physical activity**[22,71,72]. When relevant psychosocial factors are identified, management may also include **psychosocial interventions**, such as cognitive or behavioural techniques, aimed at resolving cognitive barriers to recovery[17,73,74]. Patients with chronic pain should be identified and specific **pain management techniques** considered[31]. The distinct needs of older patients should also be considered (including bone health and osteoporosis, frailty, comorbidities and medication use, mobility, balance and falls risk) and appropriate modifications to care incorporated[10,37]. Other approaches may be utilised, including **acupuncture**, structured **rehabilitation** techniques, and a range of **self-management strategies**[10]. The evidence for acupuncture and specific types of exercise is of low certainty, so should be considered based on shared decision-making, taking into account patient preferences, practicality and other contextual factors[75,76].

Whole Person Health

There are a range of different elements that contribute to low back pain, including pre-existing comorbidities and numerous lifestyle factors (such as body mass index, smoking, drinking and physical activity)[3,77]. Chiropractors have the opportunity to support patients by addressing these, as well as broader **public health** issues. This may include nutritional, exercise and lifestyle advice, as well as signposting to available resources and considering appropriate referrals. This supports the principles of Making Every Contact Count (MECC)[78].

Monitoring and Reassessment

All patients should be monitored and reassessed throughout their care, including with the use of validated outcome measures[70]. This is particularly important for patients with radicular symptoms who should be given relevant safety-netting advice, particularly relating to cauda equina syndrome[79]. Referrals or further investigations should be considered in the event of deteriorating neurology, worsening symptoms, no improvement, or changes in patient tolerance or expectations. Major or deteriorating motor weakness, as well as any degree of sphincter failure, necessitate an emergency referral[12,45].

Interprofessional collaboration and co-management with other healthcare providers is in the best interests of patients[54,80]. As the main point of contact for general healthcare for NHS patients, communicating with a patient's GP and keeping them informed of any care being provided is standard practice within the UK healthcare system, although there may be circumstances when this is not always necessary and patient consent will be required. In addition to making referrals, seeking an opinion, or when co-managing a patient, circumstances in which **GP reports** would be clinically important and in the best interests of patients include when; the patient has consulted (or is likely to consult) their GP or another healthcare professional about their complaint; the patient is taking relevant prescribed medication; any investigations have been carried out; the patient's condition is relevant to their overall medical history and may affect or inform future decisions about their health care.

Chiropractic Quality Statement 1: Waiting Times

Quality Statement	**On contacting a chiropractic clinic, patients seeking care for low back pain, with or without sciatica, are offered an appointment within five working days, unless red flags suggesting serious pathology are identified at the initial contact, in which case signposting to urgent or emergency medical care is provided.**
Quality Measure	**Structure:** Evidence of practice policy listing waiting time targets, and the necessary practitioner availability to reasonably meet those targets, as well as training resources for first contact staff to support the identification of potential serious pathology. **Process 1:** Proportion of patients seeking care for low back pain, with or without sciatica, being offered appointments within five working days. **Numerator 1:** The number of patients in the denominator being offered an appointment within five days. **Denominator 1:** The total number of patients contacting the clinic and seeking care for low back pain, with or without sciatica. **Process 2:** Proportion of first contact staff being provided with training to assist in the identification of potential serious pathology. **Numerator 2:** The number of staff in the denominator provided with training to assist in the identification of potential serious pathology. **Denominator 2:** The total number of first contact staff.
Description of what the quality statement means for each audience	**Chiropractors** should ensure that their clinic has the appropriate capacity to provide appointments within five working days for patients contacting the clinic with low back pain and sciatica, and that first contact staff are provided with training to assist in the identification of potential serious pathology. **Commissioners** should look at the capacity to offer appointments to patients with low back pain and sciatica within five working days, and for evidence that first contact staff are provided with training to assist in the identification of potential medical emergencies. **Patients** with low back pain and sciatica should have an expectation that they will be provided an appointment within five working days or, if concerns are identified, signposted to urgent or emergency medical care.
Source	• A reasonable expectation by both service providers and service users 29. World Health Organization - Quality Health Services: Fact Sheet (July 2020) 30. Chou L et al. Patients' perceived needs of health care providers for low back pain management: a systematic scoping review. Spine J. 2018 Apr;18(4):691-711

Chiropractic Quality Statement 2: History and Examination

Quality Statement	**Patients presenting with low back pain, with or without sciatica, are assessed by means of a comprehensive and focused history and physical examination, which will include a neurological assessment and screening for signs and symptoms of underlying pathology, as well as the collection of baseline outcomes data.**
Quality Measure	**Structure:** Evidence of practice policies relating to the assessment of patients with low back pain, with or without sciatica, including a neurological assessment, screening for underlying pathology and the collection of baseline outcomes data. **Process 1:** Proportion of patients that have a comprehensive history and physical examination recorded in their clinical notes, including a neurological assessment and screening for underlying pathology. **Numerator 1:** The number of patients in the denominator in which a comprehensive history and physical examination, including neurological assessment and screening for underlying pathology, has been recorded in their clinical notes. **Denominator 1:** The total number of patients presenting with low back pain, with or without sciatica. **Process 2:** Proportion of patients for which baseline outcomes data has been recorded. **Numerator 2:** The number of patients in the denominator in which baseline outcomes data has been recorded. **Denominator 2:** The total number of patients presenting with low back pain, with or without sciatica.
Description of what the quality statement means for each audience	**Chiropractors** should ensure that they take a thorough history and carry out a comprehensive examination (including a neurological component), screen for underlying pathology, and collect baseline outcomes data for all patients presenting with low back pain and sciatica. **Commissioners** should ensure that the necessary policies and procedures are in place to carry out and record a thorough assessment of patients presenting with low back pain and sciatica, which should include a neurological examination, screening for underlying pathology and collecting baseline outcomes data. **Patients** with low back pain and sciatica should expect to have a detailed history taken and undergo a thorough examination, including being screened to exclude more serious causes of back pain.
Source	10. World Health Organisation. WHO guideline for non-surgical management of chronic primary low back pain in adults in primary and community care settings (2023). 12. NSW Agency for Clinical Innervation (ACI). Model of care for the management of low back pain - Summary (February 2024) 13. US Department of Veterans Affairs, Department of Defense. VA/DoD clinical practice guideline for diagnosis and treatment of low back pain (Version 3.0 - 2022) 14. Australian Commission on Safety and Quality in Health Care - Low Back Pain Clinical Care Standard 2022. 17. National Institute for Health and Care Excellence. NICE Clinical Guideline 59 - Low back pain and sciatica in over 16s: assessment and management (November 2016, updated December 2020) 33. Finucane LM at al. International Framework for Red Flags for Potential Serious Spinal Pathologies. J Orthop Sports Phys Ther. 2020 Jul;50(7):350-372 34. National Institute for Health and Care Excellence. Clinical Knowledge Summaries: Back pain - low (without radiculopathy) (Last revised September 2023) 35. National Institute for Health and Care Excellence. Clinical Knowledge Summaries: Sciatica (lumbar radiculopathy) (Last revised September 2023) 45. Trauma Programme of Care: NHS England - National Low Back and Radicular Pain Pathway 2017, (Third Edition 3.0, June 2017) 54. The General Chiropractic Council. The Code: Standards of conduct, performance and ethics for chiropractors (June 2016)

Chiropractic Quality Statement 3: Non-Physical Factors

Quality Statement	**Psychosocial factors are assessed, and contextual effects considered, in patients presenting with low back pain, with or without sciatica, as well as appropriate use of stratification tools (such as STarT Back), to inform the prognosis and assist in the choice of appropriate treatment regimens.**
Quality Measure	**Structure:** Evidence of practice policies and procedures relating to the early assessment of psychosocial factors and contextual effects for patients presenting with low back pain, with or without sciatica, including the use of stratification tools. **Process:** Proportion of patients who have had psychosocial factors and contextual effects assessed, and where stratification tools have been used. **Numerator:** The number of patients in the denominator in which an assessment of psychosocial factors and contextual effects has been recorded in their clinical notes, and stratification tools used. **Denominator:** The total number of patients presenting with low back pain, with or without sciatica.
Description of what the quality statement means for each audience	**Chiropractors** should assess for psychosocial factors and contextual effect, and use stratification tools, in patients presenting with low back pain and sciatica. **Commissioners** should seek evidence that patients presenting with low back pain and sciatica are assessed for psychosocial factors and contextual effects, and that stratification tools are used. **Patients** with back pain and sciatica should expect to be asked questions relating to their health beliefs, opinions, and the effects their condition is having on their lifestyle, in order to inform decisions made about their care.
Source	13. US Department of Veterans Affairs, Department of Defense. VA/DoD clinical practice guideline for diagnosis and treatment of low back pain (Version 3.0 - 2022) 14. Australian Commission on Safety and Quality in Health Care - Low Back Pain Clinical Care Standard 2022. 16. Bailly F et al. Clinical guidelines and care pathway for management of low back pain with or without radicular pain. Jt Bone Spine. 2021; 88(6): 105227 17. National Institute for Health and Care Excellence. NICE Clinical Guideline 59 - Low back pain and sciatica in over 16s: assessment and management (November 2016, updated December 2020) 18. North American Spine Society (NASS). Evidence-Based Clinical Guidelines for Multidisciplinary Spinal Care: Diagnosis and Treatment of Low Back Pain (2020) 23. Institute for Clinical Systems Improvement (ICSI). Adult acute and subacute low back pain (16th Edition, March 2018) 34. National Institute for Health and Care Excellence. Clinical Knowledge Summaries: Back pain - low (without radiculopathy) (Last revised September 2023) 35. National Institute for Health and Care Excellence. Clinical Knowledge Summaries: Sciatica (lumbar radiculopathy) (Last revised September 2023) 43. Eklund A et al. The Nordic Maintenance Care Program: Does psychological profile modify the treatment effect of a preventive manual therapy intervention? A secondary analysis of a pragmatic randomized controlled trial. PLoS One. 2019 Oct 10;14(10):e0223349 45. Trauma Programme of Care: NHS England - National Low Back and Radicular Pain Pathway 2017, (Third Edition 3.0, June 2017) 46. Rossettini G et al. Clinical relevance of contextual factors as triggers of placebo and nocebo effects in musculoskeletal pain. BMC Musculoskelet Disord. 2018 Jan 22;19 (1):27 64. Sherriff B et al. Impact of contextual factors on patient outcomes following conservative low back pain treatment: systematic review. Chiropr Man Therap. 2022 Apr 21;30(1):20

Chiropractic Quality Statement 4: Diagnostic Imaging

Quality Statement	**In the absence of clinical indicators suggesting potential serious underlying pathology (red flags), routine diagnostic imaging (including x-rays and MRI) is not required for patients presenting with low back pain, with or without sciatica. If diagnostic imaging is considered appropriate, evidence-based justification and valid consent is required.**
Quality Measure	**Structure:** Evidence of practice policies and procedures for the use of diagnostic imaging for patients presenting with low back pain, with or without sciatica, including the recording of evidence-based justification and valid consent. **Process:** Proportion of patients who have undergone diagnostic imaging with evidence-based justification and valid consent having been recorded. **Numerator:** The number of patients in the denominator for which evidence-based justification and valid consent has been recorded. **Denominator:** The total number of patients presenting with low back pain, with or without sciatica, who have undergone diagnostic imaging.
Description of what the quality statement means for each audience	**Chiropractors** should not routinely request diagnostic imaging for patients presenting with low back pain and sciatica when there are no clinical indicators suggesting potential serious underlying pathology, and ensure that there is evidence-based justification and valid consent for any diagnostic imaging that is requested. **Commissioners** should expect to see policies and procedures stating that diagnostic imaging is only requested with evidence-based justification and valid patient consent, and not routinely requested for patients presenting with low back pain and sciatica when there are no clinical indicators suggesting potential serious underlying pathology. **Patients** with low back pain and sciatica should not expect to have x-ray or scans recommended, as these are not usually necessary.
Source	8. Hall AM et al. Do not routinely offer imaging for uncomplicated low back pain. BMJ. 2021 Feb 12;372:n291. 12. NSW Agency for Clinical Innervation (ACI). Model of care for the management of low back pain - Summary (February 2024) 13. US Department of Veterans Affairs, Department of Defense. VA/DoD clinical practice guideline for diagnosis and treatment of low back pain (Version 3.0 - 2022) 14. Australian Commission on Safety and Quality in Health Care - Low Back Pain Clinical Care Standard 2022. 17. National Institute for Health and Care Excellence. NICE Clinical Guideline 59 - Low back pain and sciatica in over 16s: assessment and management (November 2016, updated December 2020) 20. American College of Occupational and Environmental Medicine (ACOEM). Low back disorders guideline (March 2019) 23. Institute for Clinical Systems Improvement (ICSI). Adult acute and subacute low back pain (16th Edition, March 2018) 26. Foster NE et al. Lancet Low Back Pain Series Working Group. Prevention and treatment of low back pain: evidence, challenges, and promising directions. Lancet. 2018 Jun 9;391(10137):2368-2383 34. National Institute for Health and Care Excellence. Clinical Knowledge Summaries: Back pain - low (without radiculopathy) (Last revised September 2023) 35. National Institute for Health and Care Excellence. Clinical Knowledge Summaries: Sciatica (lumbar radiculopathy) (Last revised September 2023) 45. Trauma Programme of Care: NHS England - National Low Back and Radicular Pain Pathway 2017, (Third Edition 3.0, June 2017) 47. The General Chiropractic Council. GCC Registrant Guidance: Diagnostic Imaging (March 2022) 48. The Royal College of Radiologists - iRefer: Making the best use of clinical radiology (version 8, 2017). 49. Jensen RK et al. Diagnosis and treatment of sciatica. BMJ. 2019 Nov 19;367:I6273.

Chiropractic Quality Statement 5: Treatment Aims

Quality Statement	**The aims of treatment for patients with low back pain, with or without sciatica, are developed on the basis of shared decision-making, but consideration is given to a reduction of symptoms, improvement of function, patient-focused goals and return to normal daily activities (including return to work).**
Quality Measure	**Structure:** Evidence of policy statements on the intention of treatment, and the acknowledgement of the personal expectations and preferences of the patient in reaching that decision. **Process:** Proportion of patients whose preferences are incorporated into the aims of treatment, which include reference to the reduction in symptoms, the restoration of function and a return to normal daily activities. **Numerator:** the number of patients in the denominator whose preferences were incorporated into documented aims of treatment, which include reference to reducing symptoms, regaining function and returning to normal daily activities. **Denominator:** The total number of patients presenting with low back pain, with or without sciatica.
Description of what the quality statement means for each audience	**Chiropractors** should aim to establish treatment aims in partnership with patients presenting with low back pain and sciatica, but these should normally address the reduction of symptoms, the restoration of function and enabling a resumption of normal daily activities (including return to work). **Commissioners** should look for evidence that the aim of treatment of patients with low back pain and sciatica are determined in partnership with patients and are addressing the reduction of symptoms, restoration of function, and resumption of normal daily activities (including return to work). **Patients** with low back pain and sciatica should expect to take an active role in determining the aims of treatment, but should anticipate a discussion that considers the reduction of symptoms, the restoration of function and the return to normal daily activities (including return to work).
Source	2. World Health Organization - Low Back Pain: Fact Sheet (June 2023) 12. NSW Agency for Clinical Innervation (ACI). Model of care for the management of low back pain - Summary (February 2024)20. American College of Occupational and Environmental Medicine (ACOEM). Low back disorders guideline (March 2019) 17. National Institute for Health and Care Excellence. NICE Clinical Guideline 59 - Low back pain and sciatica in over 16s: assessment and management (November 2016, updated December 2020) 23. Institute for Clinical Systems Improvement (ICSI). Adult acute and subacute low back pain (16th Edition, March 2018) 54. The General Chiropractic Council. The Code: Standards of conduct, performance and ethics for chiropractors (June 2016) 55. Health Education England, Skills for Health, and Skill for Care. Person-Centred Approaches: Empowering people in their lives and communities to enable an upgrade in prevention, wellbeing health, care and support - A core skills education and training framework. (2017, updated 2020) 61. Hoffmann T et al. Shared decision making and physical therapy: What, when, how, and why? Braz J Phys Ther. 2022 Jan-Feb;26(1):100382. 66. Rogers CJ et al. The use of Patient-Led Goal Setting in the Intervention of Chronic Low Back Pain in Adults: A Narrative Review. Pain Management, 2022;12(5), 653–664 68. Gardner T at al. Combined education and patient-led goal setting intervention reduced chronic low back pain disability and intensity at 12 months: a randomised controlled trial. Br J Sports Med. 2019 Nov;53(22):1424-1431.

Chiropractic Quality Statement 6: Plan of Care

Quality Statement	**A plan of care, which will include the objectives, proposed interventions and treatment dose (number and frequency of appointments), is formulated in partnership with patients presenting with low back pain, with or without sciatica, after their personal expectations, beliefs and preferences have been considered. Co-management with other healthcare practitioners is considered, and a plan of care includes a formal review within six weeks of the commencement of treatment.**
Quality Measure	**Structure:** Evidence of practice policies and procedures detailing the involvement of patients in formulating care plans that incorporate their personal expectations, beliefs and preferences, and include the objectives of care, proposed interventions and treatment dose, as well as the involvement of other health professionals, and the integration of formal reviews. **Process 1:** Proportion of patients with whose care plans incorporated their personal expectations, beliefs and preferences. **Numerator 1:** the number of patients in the denominator whose documented care plans incorporated their personal expectations, beliefs and preferences. **Denominator 1:** The total number of patients presenting with low back pain, with or without sciatica. **Process 2:** Proportion of patients whose care plan include objectives, proposed interventions and treatment dose, as well as a formal review within six weeks. **Numerator 2:** The number of patients in the denominator whose care plan include objectives, proposed interventions and treatment dose, as well as a formal review within six weeks. **Denominator 2:** The total number of patients presenting with low back pain, with or without sciatica.
Description of what the quality statement means for each audience	**Chiropractors** should have the systems in place to ensure that the personal expectations, beliefs and preferences of patients presenting with low back pain and sciatica are taken into consideration before a plan of care is formulated, in partnership with patients, which include care objectives, proposed interventions and treatment dose, as well as a formal review within six weeks, and the consideration of involving of other health professionals in patients' management. **Commissioners** should expect to see evidence that the personal expectations, beliefs and preferences of patients with low back pain and sciatica are taken into consideration before a plan of care is formulated, in partnership with patients, which will include care objectives, proposed interventions and treatment dose, as well as a formal review within six weeks of the commencement of treatment. **Patients** with low back pain and sciatica should expect to have their personal expectations, beliefs and preferences taken into consideration before taking part in formulating a plan of care, which will include the objectives of care, proposed interventions and treatment dose, as well as the possibility of involving other health professionals. They should expect a formal review within six weeks of starting treatment.
Source	10. World Health Organisation. WHO guideline for non-surgical management of chronic primary low back pain in adults in primary and community care settings (2023). 16. Bailly F et al. Clinical guidelines and care pathway for management of low back pain with or without radicular pain. Jt Bone Spine. 2021; 88(6): 105227 23. Institute for Clinical Systems Improvement (ICSI). Adult acute and subacute low back pain (16th Edition, March 2018) 54. The General Chiropractic Council. The Code: Standards of conduct, performance and ethics for chiropractors (June 2016) 55. Health Education England, Skills for Health, and Skill for Care. Person-Centred Approaches: Empowering people in their lives and communities to enable an upgrade in prevention, wellbeing health, care and support - A core skills education and training framework. (2017, updated 2020)

Chiropractic Quality Statement 7: Valid Consent

Quality Statement	**Prior to commencing care, patients with low back pain, with or without sciatica, are invited to consent to care after they have received an explanation of their condition, different options for care, risks and benefits of treatment, likely outcomes with and without treatment, and after a plan of care has been discussed and agreed. Once provided, ongoing consent will be sought throughout a course of care, including at times where management is reviewed or modified.**
Quality Measure	**Structure:** Evidence of practice policies relating to consent, and the information supplied to patients prior to consent being sought. **Process 1:** Proportion of patients that have consented to treatment following an explanation of their condition, different care options; the risks, benefits and likely outcomes; and a plan of care has been discussed and agreed. **Numerator 1:** The number of patients in the denominator for whom valid consent has been documented, including reference to an explanation of (i) their condition, (ii) different care options, (iii) the risks, benefits, and likely outcomes and (iv) agreement of a plan of care. **Denominator 1:** The total number of patients presenting with low back pain, with or without sciatica. **Process 2:** Proportion of patients for which ongoing consent has been sought, including when management has been reviewed or modified. **Numerator 2:** The number of patients in the denominator whose ongoing consent has been documented, including when management has been reviewed or modified. **Denominator 2:** The total number of patients presenting with low back pain, with or without sciatica, who have undergone a period of care.
Description of what the quality statement means for each audience	**Chiropractors** should ensure that an explanation of their condition, different care options, the risks, benefits and likely outcomes of treatment have been explained to patients, as well as a plan of care agreed, prior to consent to treatment being invited and documented, and that ongoing consent is also sought. **Commissioners** need to ensure that chiropractors have a consent policy in place, in which patients are provided with information about: (i) their condition, (ii) different care options, (iii) the risks, benefits, and likely outcomes of treatment and (iv) a plan of care has been agreed, prior to consent being invited, and that ongoing consent is also sought. **Patients** should expect to be provided with information about: (i) their condition, (ii) different care options, (iii) the risks and benefits of treatment and (iv) the likely outcomes with and without treatment, and to discuss and agreed a care plan, before being invited to consent to receiving treatment. They should expect ongoing consent be sought throughout care.
Source	10. World Health Organisation. WHO guideline for non-surgical management of chronic primary low back pain in adults in primary and community care settings (2023). 14. Australian Commission on Safety and Quality in Health Care - Low Back Pain Clinical Care Standard 2022. 54. The General Chiropractic Council. The Code: Standards of conduct, performance and ethics for chiropractors (June 2016) 56. The General Chiropractic Council. GCC Registrant Guidance: Consent (July 2022) 57. The Royal College of Chiropractors: Health Policy Bulletin. Navigating Consent: A Chiropractor's Guide in Light of the Mongomery Ruling (July 2023)

Chiropractic Quality Statement 8: Therapeutic Alliance

Quality Statement	**Patients presenting with low back pain, with or without sciatica, are provided with person-centred care through an effective therapeutic alliance to support them in achieving their goals as well as addressing adverse psychosocial and contextual factors.**
Quality Measure	**Structure:** Evidence of practice policy that the management of patients is patient-centred, supporting patients to meet their own goals, and structured around an effective therapeutic relationship. **Process:** Proportion of patients with low back pain, with or without sciatica, whose care is patient-centred, addresses the goals of the patient, and is structured around effective therapeutic relationship. **Numerator:** The number of patients in the denominator in which supporting patients to meet their own goals, and an effective therapeutic relationship, can be recognised in the clinical records. **Denominator:** The total number of patients presenting with low back pain, with or without sciatica.
Description of what the quality statement means for each audience	**Chiropractors** should develop an effective therapeutic relationship with patients presenting with low back pain and sciatica in order to provide care that is patient-centred and supporting patients to meet their own goals. **Commissioners** should seek evidence that patients with low back pain and sciatica are provided with patient-centred care that addresses the goals of patients and is based on an effective therapeutic relationship. **Patients** with low back pain and sciatica should expect to be provided with patient-centred care that addresses their own goals, and is provided within a helpful, compassionate and supportive environment.
Source	13. US Department of Veterans Affairs, Department of Defense. VA/DoD clinical practice guideline for diagnosis and treatment of low back pain (Version 3.0 - 2022) 23. Institute for Clinical Systems Improvement (ICSI). Adult acute and subacute low back pain (16th Edition, March 2018) 55. Health Education England, Skills for Health, and Skill for Care. Person-Centred Approaches: Empowering people in their lives and communities to enable an upgrade in prevention, wellbeing health, care and support - A core skills education and training framework. (2017, updated 2020) 63. Ferreira PH et al. The therapeutic alliance between clinicians and patients predicts outcome in chronic low back pain. Phys Ther. 2013 Apr;93(4):470-8 65. Bishop F et al. Direct and mediated effects of treatment context on low back pain outcome: a prospective cohort study. BMJ Open. 2021 May 18;11(5):e044831 67. Pinto RZ et al. Patient-centred communication is associated with positive therapeutic alliance: a systematic review. J Physiother. 2012;58(2):77-87

Chiropractic Quality Statement 9: Package of Care

Quality Statement	**Patients with low back pain, with or without sciatica, are treated with an individualised, evidence-based, multimodal package of care, which will include advice and information (including relevant safety-netting advice), as well as a range of management options which may include manual therapies (manipulation, mobilisation and soft tissue techniques), cognitive/behavioural interventions, acupuncture and exercise/rehabilitation.**
Quality Measure	**Structure:** Evidence of practice policy on the provision of an evidence-based multimodal package of care for the treatment of low back pain, with or without sciatica, which will include advice and information, and the consideration of manual therapies, cognitive behavioural interventions, acupuncture and exercise/rehabilitation. **Process:** Proportion of patients who are treated with an evidence-based multimodal package of care, which includes advice and information, and components of: manual therapies, cognitive behavioural interventions, acupuncture and exercise/rehabilitation. **Numerator:** the number of patients in the denominator with evidence of having been treated with an evidence-based multimodal package of care, including advice and information, and components of; manual therapies, cognitive behavioural interventions, acupuncture and exercise/rehabilitation. **Denominator:** The total number of patients presenting with low back pain, with or without sciatica.
Description of what the quality statement means for each audience	**Chiropractors** should provide an evidence-based multimodal package of care for the treatment of low back pain and sciatica, that will include advice and information, as well individualised provision of: manual therapies, cognitive behavioural interventions, acupuncture and exercise/rehabilitation. **Commissioners** should seek evidence that patients presenting with low back pain and sciatica are treated with an evidence-based multimodal package of care, including advice and information, as well other management options, including; manual therapies, cognitive behavioural interventions, acupuncture and exercise/rehabilitation. **Patients** with low back pain and sciatica should expect to be treated with a number of different techniques, which will include advice and information, as well as options including; manual therapies, acupuncture, exercise, and addressing the psychological and social implications associated with low back pain.
Sources	10. World Health Organisation. WHO guideline for non-surgical management of chronic primary low back pain in adults in primary and community care settings (2023). 12. NSW Agency for Clinical Innervation (ACI). Model of care for the management of low back pain - Summary (February 2024) 13. US Department of Veterans Affairs, Department of Defense. VA/DoD clinical practice guideline for diagnosis and treatment of low back pain (Version 3.0 - 2022) 14. Australian Commission on Safety and Quality in Health Care - Low Back Pain Clinical Care Standard 2022. 15. George et al. Interventions for the Management of Acute and Chronic Low Back Pain: Revision 2021 - Clinical Practice Guidelines Linked to the International Classification of Functioning, Disability and Health From the Academy of Orthopaedic Physical Therapy of the American Physical Therapy Association. JOSPT 2021; 51(11): CPG1-CPG60

Chiropractic Quality Statement 9: Package of Care

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74. Richmond H et al. The Effectiveness of Cognitive Behavioural Treatment for Non-Specific Low Back Pain: A Systematic Review and Meta-Analysis. PLoS ONE 2015 10 (8): e0134192.
75. Verville L et al. Systematic review to inform the World Health Organization (WHO) Clinical Practice Guideline: benefits and harms of structured exercise programs for chronic primary low back pain in adults. J Occup Rehabil. 2023; 33: 636-650.

Chiropractic Quality Statement 10: Support to Self-Manage

Quality Statement	**Patients with low back pain, with or without sciatica, are given advice and information to help self-manage their condition and, so far as is possible, are encouraged to exercise, be physically active and to continue normal daily activities.**
Quality Measure	**Structure:** Evidence of practice policy for patients with low back pain, with or without sciatica, with regard to the provision of ongoing supportive self-management, including the encouragement to exercise, be physically active and continue normal daily activities. **Process 1:** Proportion of patients who are provided with information and advice to self-manage their condition, including to exercise, be physically active and continue normal daily activities. **Numerator 1:** The number of patients in the denominator who have a record of being provided with information and advice to self-manage their condition, including to exercise, be physically active and continue normal daily activities. **Denominator 1:** The total number of patients presenting with low back pain, with or without sciatica.
Description of what the quality statement means for each audience	**Chiropractors** should ensure that patients with low back pain and sciatica are provided with advice and information to help self-manage their condition, including encouragement to exercise, be physically active and to continue normal daily activities. **Commissioners** should seek evidence that patients with low back pain and sciatica are supported to self-manage their condition, including encouragement to exercise, be physically active and to continue normal daily activities. **Patients** with low back pain and sciatica should expect to be provided with advice and information to help them self-manage their condition, including encouragement to exercise, be physically active and to continue normal daily activities.
Source	10. World Health Organisation. WHO guideline for non-surgical management of chronic primary low back pain in adults in primary and community care settings (2023). 13. US Department of Veterans Affairs, Department of Defense. VA/DoD clinical practice guideline for diagnosis and treatment of low back pain (Version 3.0 - 2022) 14. Australian Commission on Safety and Quality in Health Care - Low Back Pain Clinical Care Standard 2022. 16. Bailly F et al. Clinical guidelines and care pathway for management of low back pain with or without radicular pain. Jt Bone Spine. 2021; 88(6): 105227 17. National Institute for Health and Care Excellence. NICE Clinical Guideline 59 - Low back pain and sciatica in over 16s: assessment and management (November 2016, updated December 2020) 20. American College of Occupational and Environmental Medicine (ACOEM). Low back disorders guideline (March 2019) 22. Bussieres AE et al. Spinal manipulative therapy and other conservative treatments for low back pain: a guideline from the Canadian chiropractic guideline initiative. J Manipulative Physiol Ther. 2018 May;41(4):265-293 34. National Institute for Health and Care Excellence. Clinical Knowledge Summaries: Back pain - low (without radiculopathy) (Last revised September 2023) 35. National Institute for Health and Care Excellence. Clinical Knowledge Summaries: Sciatica (lumbar radiculopathy) (Last revised September 2023) 45. Trauma Programme of Care: NHS England - National Low Back and Radicular Pain Pathway 2017, (Third Edition 3.0, June 2017)

Chiropractic Quality Statement 11: Interprofessional Collaboration

Quality Statement	**When managing patients with low back pain, with or without sciatica, chiropractors are attentive to the expertise and involvement of other health professionals, consider referral and co-management options, and appropriately report their findings and management to the patient's GP.**
Quality Measure	**Structure:** Evidence of practice policy relating to the recognition of the role of other healthcare professionals in the management of patients and keeping them appropriately informed of assessment and care. **Process:** Proportion of patients who, when it is their best interest, have had a detailed report written to their GP. **Numerator:** The number of patients in the denominator who have had a detailed report written to their GP. **Denominator:** The total number of patients presenting with low back pain, with or without sciatica, who it is in their best interest to have a detailed report written to their GP (this includes when a patient is referred, an opinion is sought, or there is co-managing of the patient; when the patient has consulted (or is likely to consult) their GP or another healthcare professional about their complaint; when the patient is taking relevant prescribed medication; when any investigations have been carried out; or when the patient's condition is relevant to their overall medical history and may affect or inform future decisions about their health care).
Description of what the quality statement means for each audience	**Chiropractors** should be mindful of the role of other healthcare professionals in the assessment and management of patients with low back pain and sciatica and, when appropriate, write detailed reports on their findings and management, as well as making appropriate referrals. **Commissioners** should seek evidence of chiropractors providing multidisciplinary care by informing and collaborating with other healthcare professional for the benefit of patients with low back pain and sciatica, as well as appropriately writing reports and referring patients as appropriate. **Patients** with low back pain and sciatica should expect their chiropractor to be aware of the role of other healthcare professionals, seek their permission to write to their GP when appropriate, and to refer them if they feel that it is in their best interests.
Source	16. Bailly F et al. Clinical guidelines and care pathway for management of low back pain with or without radicular pain. Jt Bone Spine. 2021; 88(6): 105227 54. The General Chiropractic Council. The Code: Standards of conduct, performance and ethics for chiropractors (June 2016) 80. World Health Organisation. Framework for Action on Interprofessional Education & Collaborative Practice (2010). WHO/HNH/HPN/10.3

Chiropractic Quality Statement 12: Monitoring and Reassessment

Quality Statement	**The progress of patients with low back pain, with or without sciatica, is continually monitored throughout care, but also kept under review with regular formal reassessments, use of validated outcome tools, and potential referral to another healthcare practitioner, particularly if symptoms deteriorate, or they show no significant signs of improvement within six weeks.**
Quality Measure	**Structure:** Evidence of practice policy with regard to the regular assessment of patients, the use of outcome measures and the consideration of referral for those who do not show significant signs of improvement. **Process 1:** Proportion of patients who are reassessed on a regularly basis, including the use of outcome measures. **Numerator 1:** The number of patients in the denominator who have had regular formal reassessments, including the use of outcome measures. **Denominator 1:** The total number of patients presenting with low back pain, with or without sciatica. **Process 2:** Proportion of patients presenting with low back pain, with or without sciatica, that are referred to another healthcare professional if their condition shows no significant signs of improvement within six weeks. **Numerator 2:** The number of patients in the denominator who have been referred to another healthcare professional. **Denominator 2:** The total number of patients presenting with low back pain, with or without sciatica, who have shown no significant signs of improvement within six weeks.
Description of what the quality statement means for each audience	**Chiropractors** should regularly assess patients with low back pain and sciatica using validated outcome measures, and consider a referral if they show no significant signs of improvement within six weeks. **Commissioners** should expect to see policies on reassessments and referrals stating that patients with low back pain and sciatica will be regularly assessed (including with the use of outcome tools), and referrals considered if they show no significant signs of improvement within six weeks. **Patients** with low back pain and sciatica should expect to be regularly assessed, and a referral considered if they show no signs of improvement within six weeks.
Source	10. World Health Organisation. WHO guideline for non-surgical management of chronic primary low back pain in adults in primary and community care settings (2023). 12. NSW Agency for Clinical Innervation (ACI). Model of care for the management of low back pain - Summary (February 2024) 14. Australian Commission on Safety and Quality in Health Care - Low Back Pain Clinical Care Standard 2022. 20. American College of Occupational and Environmental Medicine (ACOEM). Low back disorders guideline (March 2019) 22. Bussieres AE et al. Spinal manipulative therapy and other conservative treatments for low back pain: a guideline from the Canadian chiropractic guideline initiative. J Manipulative Physiol Ther. 2018 May;41(4):265-293 25. Institute of Health Economics (IHE), Toward Optimized Practice Program - Alberta, Canada. Guidelines for the Evidence-Informed Primary Care Management of Low Back Pain (3rd Edition, 2015 – revised 2017) 34. National Institute for Health and Care Excellence. Clinical Knowledge Summaries: Back pain - low (without radiculopathy) (Last revised September 2023) 35. National Institute for Health and Care Excellence. Clinical Knowledge Summaries: Sciatica (lumbar radiculopathy) (Last revised September 2023) 45. Trauma Programme of Care: NHS England - National Low Back and Radicular Pain Pathway 2017, (Third Edition 3.0, June 2017) 49. Jensen RK et al. Diagnosis and treatment of sciatica. BMJ. 2019 Nov 19;367:I6273. 54. The General Chiropractic Council. The Code: Standards of conduct, performance and ethics for chiropractors (June 2016)

Chiropractic Quality Statement 13: Discharge and Ongoing care

Quality Statement	**Patients with low back pain, with or without sciatica, are discharged from acute care within four weeks of their signs and symptoms being absent. Ongoing supportive self-management, including rehabilitation and prophylactic care, may be offered to patients once their condition has become manageable or resolved.**
Quality Measure	**Structure:** Evidence of practice policies regarding the discharge of patients from acute care and the provision of ongoing supportive self-management, including rehabilitation and prophylactic care, once their condition has become manageable or resolved. **Process 1:** Proportion of patients that, once their signs and symptoms have been absent for four weeks, have been discharged from acute care. **Numerator 1:** The number of patients in the denominator who have been discharged from acute care. **Denominator 1:** The total number of patients presenting with low back pain, with or without sciatic, whose signs and symptoms have been absent for four weeks. **Process 2:** Proportion of patients that, once their condition has become manageable or resolved, are offered ongoing supportive self-management, including rehabilitation and prophylactic care. **Numerator 2:** The number of patients in the denominator who have been offered ongoing supportive self-management, including rehabilitation and prophylactic care. **Denominator 2:** The total number of patients presenting with low back pain, with or without sciatic, whose condition has become manageable or resolved.
Description of what the quality statement means for each audience	**Chiropractors** should ensure that patients with low back pain and sciatica are discharged from acute care within four weeks of their signs and symptoms being absent, and/or should be offered ongoing supportive self-management, including rehabilitation and prophylactic care if their condition becomes manageable or resolves. **Commissioners** should seek evidence of practice policies regarding the discharge of patients from acute care, and that patients with low back pain and sciatica are offered ongoing supportive self-management, including rehabilitation and prophylactic care if their condition becomes manageable or resolves. **Patients** with low back pain and sciatica should expect, once their condition has become manageable or resolved, to be offered ongoing support to help them to manage their condition, including rehabilitation and preventative care.
Source	16. Bailly F et al. Clinical guidelines and care pathway for management of low back pain with or without radicular pain. Jt Bone Spine. 2021; 88(6): 105227 21. Shirado O et al. Formulation of Japanese Orthopaedic Association (JOA) clinical practice guideline for the management of low back pain - the revised 2019 edition. J Orthop Sci. 2022 Jan;27(1):3-30 26. Foster NE et al. Lancet Low Back Pain Series Working Group. Prevention and treatment of low back pain: evidence, challenges, and promising directions. Lancet. 2018 Jun 9;391(10137):2368-2383 44. Eklund A et al. The Nordic maintenance care program: maintenance care reduces the number of days with pain in acute episodes and increases the length of pain free periods for dysfunctional patients with recurrent and persistent low back pain - a secondary analysis of a pragmatic randomized controlled trial. Chiropr Man Therap. 2020 Apr 21;28(1):19. http://doi.org/10.1186/s12998-020-00309-6

Chiropractic Quality Standard

Low Back Pain and Sciatica

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Chiropractors

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The Royal College of Chiropractors
Chiltern House
45 Station Road
Henley on Thames
RG9 1AT

01491 340022
E: admin@rcc-uk.org
W: www.rcc-uk.org