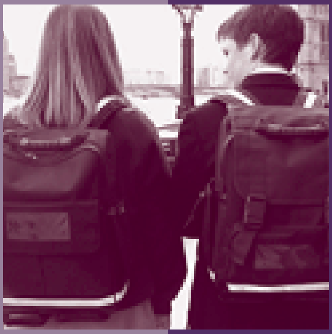
Standards of Care for people with

Back Pain



ARMA
Arthritis and Musculoskeletal Alliance

Contents

The Standards of Care:

ARMA is the umbrella organisation for the UK musculoskeletal community. ARMA is a registered charity No 1108851.
Our member organisations are:

- Arthritis Care
- Arthritis Research Campaign
- BackCare
- British Chiropractic Association
- British Coalition of Heritable Disorders of Connective Tissue
- British Health Professionals in Rheumatology
- British Institute of Musculoskeletal Medicine
- British Orthopaedic Association
- British Scoliosis Society
- British Sjögren's Syndrome Association
- British Society for Paediatric and Adolescent Rheumatology
- British Society for Rheumatology
- British Society of Rehabilitation Medicine
- Chartered Society of Physiotherapy
- Children’s Chronic Arthritis Association
- CHOICES for Families of Children with Arthritis
- Early Rheumatoid Arthritis Network
- Lupus UK
- Manipulation Association of Chartered Physiotherapists (UK)
- Marfan Association (UK)
- National Ankylosing Spondylitis Society
- National Association for the Relief of Paget's Disease
- National Association of Rheumatology Occupational Therapists (NAROT)
- National Osteoporosis Society
- National Rheumatoid Arthritis Society
- Podiatry Rheumatic Care Association
- Primary Care Rheumatology Society
- Psoriatic Arthropathy Alliance
- Raynaud's and Scleroderma Association
- Rheumatoid Arthritis Surgical Society
- Royal College of Nursing Rheumatology Nursing Policy and Practice Group
- Scleroderma Society
- Society for Back Pain Research

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The contents of this document and further resources including contact details for our member organisations, further information about our work and this project, including additional examples of good practice and resources to support implementation are available on the ARMA website at www.arma.uk.net

The Standards of Care project has been managed by ARMA. The project has been funded from a range of sources, including unrestricted educational grants from a number of pharmaceutical companies. A wide range of individuals and organisations have given time, expertise and other support in kind. For details of contributors, please see Acknowledgements on page 14

The background

Back pain: the size of the problem

Back pain is a major health problem, affecting approximately 17.3 million people in the UK – over one-third of the adult population. Over the course of a year, around 3.5 million people experience back pain for the first time, and for 3.1 million people their pain lasts throughout the whole year. It affects men and women equally, and more people experience back pain as they grow older.[1]

What is the impact of back pain?

Persistent back pain (ie pain which has lasted for more than three months or has been present on more than half the days of the previous year), in particular, has a serious impact on people's lives. It frequently reduces people's quality of life and adversely affects their family and social relationships.[2] Back pain can also impact on a person's ability to work, and compromise their earning capacity. Moreover, the longer someone is absent from work with back pain, the poorer their chances are of returning.[3]

The direct healthcare costs of back pain are huge, including £141 million each year for GP consultations and £512 million for hospital care (inpatient, outpatient and emergency). Overall, back pain costs the NHS and community care services more than £1 billion each year – and with £565 million also spent on private services, the direct annual healthcare costs are over £1.6 billion.[4]

Unsurprisingly, back pain has a massive economic impact. It is the second commonest cause of long-term sickness absence for much of the UK[5], and the commonest for people in manual occupations.[6] Up to 180 million working days were lost in 1997/8 due to back pain, including 119 million that were lost due to registered disability caused by back problems.[7] Reports have estimated that the total cost of back pain corresponds to between 1% and 2% of gross national product (GNP).[8]

Types of back pain

There are many different causes of back pain but in most cases the cause is uncertain and the condition is referred to as 'simple' or 'mechanical' back pain. In the remaining cases, it is important to make a specific diagnosis as the underlying pathology may be serious, even life-threatening, or require a specific type of treatment. Examples of serious spinal pathology include tumour and infection, fracture due to trauma or osteoporosis, inflammatory disease as in ankylosing spondylitis, structural deformity such as scoliosis and extensive neurological complications. Between the 'simple' and serious cases are individuals with nerve root pain (also known as sciatica), which is commonly due to a disc prolapse ('slipped disc'). The majority of people with back pain will not require anything more than conservative management, including advice, pain control and exercises.

These Standards of Care focus on 'simple' or 'mechanical' back pain.

Why we need Standards of Care

The care of people with back pain involves many different professions and disciplines, and until now there has been no standardised approach. Despite the publication of Clinical Standards

Advisory Group (CSAG) Guidelines in 1994, people's experiences and the quality of the care which they receive vary enormously depending on the approach and configuration of services where they live. Current provision is often poorly co-ordinated and may not fully incorporate evidence-based practice. Worryingly, many people continue to believe that bed rest is the best way to manage an episode of back pain. Indeed, some healthcare providers continue to promulgate the message.

Given the huge costs of back pain to the NHS and to national productivity, it is a major drawback that there is no National Service Framework either for back pain or for other musculoskeletal conditions. This lack of focus is reflected in the fact that back pain does not feature in the Quality and Outcomes Framework of the current General Medical Services (GMS) contract in England.

Yet there is good evidence for the effectiveness of many approaches and treatments. Moreover, despite the lack of priority and resources attached to back pain services, health services in some parts of the UK have identified innovative ways of improving the care that they provide.

These Standards aim to bring together existing evidence and good practice to create a framework for services which really meet the needs of the many people with back pain. Implementation of these Standards should:

- improve quality of life for the millions of people who are affected by back pain each year
- identify for people with back pain the care and treatment which they can expect
- enable the NHS to make more effective use of resources by helping to prevent avoidable disability and by reducing the number of return GP consultations and hospital appointments due to back pain
- promote consistent advice and treatment
- reduce levels of disability due to back pain
- improve productivity and reduce the benefits bill, by supporting people to stay active and remain in work.

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1 Maniadakis A, Gray A (2000).
2 Pain in Europe (2003)
3 Clinical Standards Advisory Group (1994)
4 Maniadakis A, Gray A (2000)
5 Department for Work and Pensions (2002)
6 Chartered Institute of Personnel and Development (2004)
7 Department of Health (2000)
8 Norlund AI, Waddell G (2000)

About these Standards

ARMA's Standards of Care for people with back pain are intended to support people of all ages with back pain to lead independent lives and reach their full health potential through:

- access to information, support and knowledge that optimise musculoskeletal health for everyone and enable self-management
- access to the right services that enable early diagnosis and treatment
- access to ongoing and responsive treatment and support.

The Standards define what services are appropriate under these three themes and suggest ways of providing them effectively, and in a measurable way, in the form of key interventions. A detailed rationale for the Standards draws on available evidence and examples of good practice drawn from ARMA's ongoing call for good practice: a database giving details of these and other examples is available at www.arma.uk.net.

The Standards are not guidelines, or algorithms of care, though they refer to these where available.

The Standards of Care for people with back pain form part of a suite of Standards; other Standards published to date are for inflammatory arthritis and osteoarthritis. Further Standards, for bone disease, soft tissue rheumatism and connective tissue disorders, are planned for 2005.

The Standards acknowledge the fact that those planning and delivering services around the UK face differing demographic, geographic and economic factors, which will affect how the Standards are implemented in each locality. We hope the Standards will act as a tool for all stakeholders - service users, providers, commissioners and policy-makers - to work together to review and improve their local musculoskeletal services.

Key principles – the user-centred approach

The project has been driven by the needs of people living with musculoskeletal conditions. It began with the establishment of a set of key principles for care, developed by a group of people living with musculoskeletal conditions and consulted upon widely. These principles have underpinned the development of each set of condition-specific Standards.

The key principles, which can be found on ARMA's website www.arma.uk.net, affirm that ‘patients’ are individuals who need different types of advice and support at different times; and who need integrated services providing advice and support that cover all aspects of managing and living with the condition – clinical, personal, social and employment/education.

In particular, the Standards recognise that health services play a key role in supporting people to maintain or return to employment or education.

Nevertheless, while these standards focus on health services, it must be recognised that people with back pain and other musculoskeletal conditions have wide-ranging needs. Social care often plays a key role in ensuring people can remain as active and independent as possible. Factors such as access to transport and the built environment may have a major impact on quality of life. More work is needed to understand and meet these needs.

Musculoskeletal conditions affect families and carers as well as individuals. Indeed, many people with these conditions may be carers themselves. The Standards do not make specific recommendations on issues relating to carers: this also needs to be the subject of further work to ensure that carers' needs are understood and addressed.

How the Standards were developed

The Standards of Care for people with back pain were developed by an expert working group, facilitated by ARMA. The group included people with back pain, representatives of user organisations, experienced service providers and experts from many professions, from around the UK. Starting with a review of the needs of people with back pain, the group met 4 times between December 2003 and June 2004 to determine evidence-based Standards to meet those needs, consulting widely and publicly on the drafts. The Acknowledgements on page 14 give details of the working group membership.

Clinical experts have identified the evidence base, including relevant guidelines for the management of back pain. References are shown as footnotes in the Standards. Evidence has not been graded for the purposes of this document. For further details on the evidence base, please refer to the references quoted in the document.

The resulting Standards are therefore based firmly on the experiences and preferences of people with back pain, and on evidence and good practice where this is available.
The working group plans to review these Standards in 2007, or sooner if there are significant developments in care for people with back pain.

Next steps

The publication of these Standards is the beginning of an ongoing programme involving the whole community to improve musculoskeletal services.

We are circulating the Standards widely to people with musculoskeletal conditions, doctors, allied health practitioners, providers and commissioners of health services, voluntary organisations and policy makers. We will publish audit tools to support the Standards' implementation. We are also collecting and sharing examples of good practice, which are accessible to everyone through our online database.

We invite all stakeholders to make a commitment to implementing the Standards. First steps might be to:

- audit existing services
- identify champions for change in musculoskeletal services, and set up a working group to develop your local strategy and priorities
- work in partnership with all stakeholders, including national and local voluntary organisations, to involve service users in designing and developing services.

Above all share your success! Tell us about your initiatives; send us examples of good practice; help to build a national resource for high-quality musculoskeletal services.

standards 1-3

Risk reduction

Standard 1
Information should be widely available on how to reduce the risk of developing back pain.

Self-management

Standard 2
Health services, the voluntary sector and other agencies should provide information, advice and facilities to enable people to manage episodes of back pain in the community, and provide guidance on whether and when to seek medical advice.

Involvement of people with back pain in service development

Standard 3
Healthcare organisations should involve people with back pain in the development of their services for musculoskeletal conditions.

The rationale

- People are not always aware of how to reduce the risk of developing back pain. Information should be widely available which is evidence-based and which emphasises physical fitness, smoking cessation, weight reduction and avoidance of sedentary lifestyles.[9]

- Many people will experience back pain during their lives and for most this will be short-lived. Most individuals should be able to manage their pain without needing medical advice.

- Health promotion campaigns have been shown to be effective in promoting messages about maintaining healthy backs, and in particular the message that ‘hurt’ does not necessarily mean ‘harm’.[10] However campaigns should inform people how to identify warning signs which they should report to appropriate health care professionals.

- Myths persist about the need to limit physical activities during an episode of back pain, for example about the need for bed rest and for absence from work. Health promotion programmes should also therefore educate people to avoid unnecessary bed rest and to maintain normal activities. Healthcare professionals, including pharmacists, play a valuable role in directing individuals to appropriate sources of support and advice.

- These messages are likely to have the greatest impact when they are positively promoted by everyone involved or interested in the problem of back pain, including employers, education and health service providers, leisure services and voluntary organisations.

- Much of the long-term disability that results from back pain is avoidable. Health promotion

good practice A

Good Practice Example - A

A pain clinic within a hospital trust has developed and implemented, in collaboration with the local district councils, evidence-based active exercise classes at local leisure centres.
The programme employs a back pain co-ordinator to organise healthy back classes. Fitness instructors take the lessons. The programme provides a consistent approach and information on back pain by using The Back Book (TSO) which is given to all attendees. Surveys showed that 70% of attendees self-refer to the class and satisfaction with the classes is high with 93% continuing to exercise at six months.

can play a key role in helping people maintain musculoskeletal health and function, particularly in the workplace and in educational establishments.

- People with back pain should be involved in helping to plan and develop services at both local and national level. Their perspective on service delivery can lead to imaginative solutions and improvements to healthcare services, ensuring that services meet people's real needs.

Putting the Standards into practice: key interventions

i There should be public health strategies to promote healthy backs.

ii Health promotion strategies should educate people about how to self-manage episodes of back pain. The Back Book[11] and other information on exercise and activities should be freely available.

iii Schools, workplaces and other facilities (such as pharmacies and leisure centres) should provide information on how to manage episodes of back pain.

iv **Developmental**: Information should be clear, accessible, and available in a variety of formats. Professionals involved in caring for people with back pain should take into account their language, culture and educational level.

v **Developmental**: There should be a range of facilities available for physical activity and exercise in the community.

vi Employers should have access to information about managing back pain in the work place in order to promote good working practice.

vii Health service providers should involve people with back pain in helping to plan and develop services at both local and national level.

ⓘ For further information and resources, including details of ARMA's member organisations and other examples of good practice and information on implementation, visit www.arma.net.uk

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[9] Burton AK et al (1999)
[10] Buchbinder R (2001)
[11] Roland M, et al (2002)

Standards to improve access to the right services that enable early assessment and management

Early assessment and identification of warning signs

Standard 4

People with back pain should have prompt access to practitioners who are able to identify warning signs of serious disease. Where these warning signs are present, practitioners should refer without delay for specialist assessment.

Pain relief

Standard 5

People with back pain should have access to skilled practitioners who can provide pain control. This should follow the Royal College of General Practitioners' current guidelines for the treatment of back pain.[12]

Standard 6

People with back pain should have access to information and facilities to enable them to make informed choices about management options, including self-management of their pain.

Remaining active

Standard 7

People with back pain should be encouraged and supported to remain in work or education wherever possible, and the professionals involved in their care should avoid 'medicalising' the condition. Vocational rehabilitation should be available to support people in staying in existing employment or finding new employment.

The rationale

- Back pain, particularly when persistent, leads to loss of productivity and diminishes quality of life.[13] It is vital to try to prevent an episode of back pain from developing into a persistent health problem. It is therefore crucial that people whose back pain is not responding to self-management are able to get timely and reliable advice and management to restore them to optimal health as quickly as possible.

- Most back pain can and should be managed 'conservatively' in the community.

- Most active physical interventions are carried out by state-registered therapists, including physiotherapists, chiropractors, osteopaths and musculoskeletal physicians.

- A very small percentage of people will have warning signs which need to be investigated. Health professionals should screen people for these warning signs, or 'red flags', which may indicate serious disease. People in whom serious disease is suspected should be referred without delay to specialist services for investigation and treatment in accordance with national guidelines, such as NICE referral protocols.[14]

Red Flags

The person:
- is younger than 20 or older than 55 when they get back pain for the first time
- has had cancer in the past or at present
- is on steroids
- is a drug user, or has HIV
- is feeling generally unwell
- has lost significant weight
- continues to have great difficulty bending forwards
- has developed a number of problems in their nervous system (e.g. numbness, loss of power, etc)
- has developed an obvious structural deformity of the spine.

The pain:
- is continuing for more than 4-6 weeks
- follows a violent injury, such as a road traffic accident
- is constant and getting worse
- is in the upper part of the spine.

Good Practice Example - B

A hospital trust has established a low back pain triage service managed by the physiotherapy service. The service was planned in consultation with the physiotherapy, rheumatology, orthopaedics and pain services, together with local GP representatives. A referral protocol was agreed, including direct MRI requests by physiotherapists. The physiotherapists assess and either decide on treatment or triage to rheumatology or pain clinics. Introduction of the service has seen a reduction in waiting times for all clinics, almost complete eradication of inappropriate referrals to orthopaedics, and significant reduction of back pain referrals to rheumatology. All patients referred are assessed by the triage team within 4 weeks.

- A small minority of people may need investigations, such as X-rays or other imaging, to help determine whether they need to be referred to specialist services. If so, these should be performed promptly.

- The vast majority of people with back pain do not need investigations, including X-rays,[15] or hospital treatment. It is important to avoid 'medicalising' back pain unnecessarily.

- All people with back pain require information to enable them to make informed choices about the range of management options available, including self-management. All professionals involved in the care of people with back pain should encourage and support them to remain active, to continue at work or in education wherever possible and to maintain other normal activities.

- Good pain control is needed to enable people to maintain or regain function. Under-treated pain is linked to the development of persistent back pain.[16]

- Some people require analgesics to control their pain. These should be appropriate and adequate and may initially include opioids if the pain is severe.[17]

Putting the Standards into practice: key interventions

viii There need to be skilled practitioners in the community who can:
- determine whether people have non-specific back pain, nerve root pain, or suspected serious disease (pathology) that requires specialist opinion and investigation
- refer people directly to specialist services, to be seen within one week or according to clinical urgency, if they identify warning signs of serious disease, or 'red flags'
- offer effective pain management in accordance with national guidelines
- prescribe or recommend appropriate analgesia.

ix Clinical governance teams should ensure that there is access to training on the needs and care of people with back pain for all professionals involved in their care and support.

x There should be timely interventions for back pain that is not resolving in the first four weeks after onset. These should be provided by a competent practitioner, and be available within one week of request. This should be in line with the evidence for effective interventions (see Appendix 1).

xi **Developmental**: In a primary care setting, if X-rays are desirable, they should be performed and reported within one week of request. Other imaging should be performed and reported within one month of request, depending on clinical urgency.

xii Advice should be available on modifying working practices and on adapting workplaces and educational establishments. People should have access to information on the steps that can be taken to support them. Employers should seek advice from various sources, for example from health professionals and government agencies, including the Health and Safety Executive (HSE), Access to Work and Disability Employment Advisors.[18] For children and adolescents attending educational establishments, support and advice should be provided by special needs advisors and through the annual statementing process if this applies to the child/adolescent.

Developmental: Occupational health services, where available, should provide advice to employers.

xiii People who have experienced episodes of back pain, and voluntary organisations concerned with their care, should be involved in and consulted about the development of health care policy and practice, at both local and national level.

ⓘ For further information and resources, including details of ARMA's member organisations and other examples of good practice and information on implementation, visit www.arma.net.uk

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12 Royal College of General Practitioners (1996 and 1999)
13 Maniadakis A, Gray A (2000)
14 National Institute for Clinical Excellence (2001)
15 Royal College of Radiologists (1998)
16 Frank JW, el al (1996)
17 Pain Society (2004)
18 Health and Safety Executive (2004)

Triaging persistent pain

Standard 8

Where a person's back pain is not responding to conservative management, they should be offered effective, evidence-based management in accordance with national guidance. This should ideally be provided through a triage service which has the authority to refer for further specialist assessment or investigation, including surgical opinion if indicated.

Managing persistent pain

Standard 9

People with persistent back pain should be given information on self-management and be offered access to self-management programmes such as the Expert Patient Programme. Information on other management strategies should be provided to enable them to make informed choices. Information should be available about local and national support groups.

Standard 10

People with persistent back pain should have access to a full range of pain and rehabilitation services.

Surgery

Standard 11

For the small minority of people who might benefit from surgery, there should be a convenient and responsive specialist spinal surgery service, including comprehensive post-operative rehabilitation. People should be supported in preparing for and recovering from surgery. This should include a pre-operative assessment and planning for discharge involving relevant healthcare professionals, social workers, family and carers.

Remaining in or returning to work and education

Standard 12

People should be helped to remain in or return to work or education, through effective rehabilitation services working in liaison with employers or educational establishments. **Developmental**: Where it is not possible for people to return to work, they should be referred to the Disability Employment Advisor and given the opportunity to participate in work assessments and retraining and to receive financial and practical support through benefits and other support services. Ideally this should be individualised through personal case management by a competent professional.

Supporting those unable to work

Standard 13

Where a person is assessed as unable to work, they should have access to advice about benefits and support services.

The rationale

- The right intervention at the right time is key to preventing an episode of back pain from becoming a persistent health problem. Where an episode of back pain has not settled sufficiently within six weeks for a person to be able to resume work or other normal activities, they should have access to back pain triage and management services.

- These services will often be provided by an extended scope physiotherapist, nurse specialist, or other competent professional. To minimise delay in assessment and management, this professional should be able to refer people directly for investigations, further opinion or other support.

- Self-management programmes are beneficial for people with long-term conditions such as back pain.[19]
- A small percentage of people with back pain may benefit from surgery, especially those with persistent nerve root symptoms.
- People who initially have non-specific back pain that is not responding to explanation and reassurance, pain control and strategies to remain active, may benefit from other types of management, including psychosocial support, cognitive behavioural therapy[20] and other pain management strategies. Treatments should be evidence-based[21] (see Appendix 1).
- The longer a person is off work with back pain, the less likely they are to return.[22] People with back pain should be encouraged to remain at work or in education, or to return as soon as possible, as this has been shown to improve recovery. Whatever the treatment provided, there should be a strong focus on rehabilitation and returning to everyday activities and to work in particular.
- If a person is unable to return to work, they may need advice and support to enable them to access benefits and other services.

Putting the Standards into practice: key interventions

xiv If serious disease (red flags) becomes apparent, immediate referral should be made to appropriate specialist services.

xv There should be prompt access to a triaging service for people with back pain where conservative management has not been successful. Triage arrangements should have been agreed with the relevant stakeholders including:

- provider services (pain, orthopaedic, rheumatology, therapy)
- commissioners of services
- user groups.

xvi A comprehensive chronic pain service should be available to include psychosocial support, counselling, psychology, cognitive behavioural therapy, pain clinics and full Pain Management Programmes (PMPs).

xvii People should have access to self-management and education programmes, including the Expert Patient Programme.

xviii Clear and consistent information should be available about evidence-based treatment options, providers and services, including local and national support

Good Practice Example - C

Several NHS trusts working together have funded a back pain co-ordinator to develop and implement a back rehabilitation programme for low back pain patients. The initiative provides patients with a four-week back rehabilitation programme (of eight sessions) held at a local leisure centre which is run jointly by fitness instructors and physiotherapists. Participants are assessed and complete questionnaires before and after the programme and are also sent a one-year follow-up questionnaire. Assessment showed 81% improvement in function, 47% reduction in disability, 61% reduction in fear of movement. 90% of participants reported that they were very happy with the programme. 70% of participants continued to have reduced disability after one year.

groups. This should be available in a variety of formats, in accessible and understandable terms, and in different languages where appropriate.

xix People with surgically treatable back pain should have prompt access to a specialist surgical spinal service. They should be offered an opinion from a specialist spinal surgeon within three months of referral or sooner if clinically indicated.

xx People who need surgery should be given information to support them in preparing for and recovering from surgery. Pre-operative assessment and discharge planning should involve all professionals involved in their care.

Good Practice Example - D

A rheumatology centre within a hospital trust has established two chronic pain management clinics per week. These are led by nurse consultants and provide a multi-disciplinary pain management programme as an integral part of clinical services within the department. Referrals are from medical clinics following a diagnosis of a chronic pain disorder where medical or surgical intervention is inappropriate. Each patient undergoes an individual assessment to determine a management plan. An audit of the service showed improvement in function and reduced fatigue. All stakeholders, including service users, were involved in the planning and ongoing evaluation of the service.

xxi People should have access to services to support them in returning to work or education. These could include post-operative physical rehabilitation services, vocational rehabilitation and/or occupational health services, Disability Employment Advisors and Employment Medical Advisory Services, who are able to work in liaison with employers and individuals.

Developmental: People should have access to a case manager with expertise in employment issues, who can help to 'bridge the gap' between people's health and employment needs.[23]

xxii People should have ongoing access to careers advice, employment advice and job retraining which addresses their individual case.

xxiii Children and young people should be supported by all people responsible for their care (including doctors, allied health professionals, teachers, social workers, youth workers and others) in achieving their normal social, educational and physical milestones.

xxiv People should have access to advisory services for benefits and other appropriate support if they are unable to work.

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19 Lorig KR et al. (1999)
20 Van Tulder MW et al (2000)
21 Waddell G, et al (1999); Van Tulder MW et al (2000 and 2004); Carroll D et al (2004)
22 Clinical Standards Advisory Group (1994)
23 British Society of Rehabilitation Medicine (2003)

Glossary

Allied Health Practitioner (AHP)
a member of the care team who is not a medical doctor. For example a nurse, physiotherapist, occupational therapist, podiatrist, dietician, pharmacist.

Nurses are registered with the Nursing & Midwifery Council.

Health professionals are registered with the HPC (Health Professions Council) who regulate arts therapists, orthoptists, biomedical scientists, prosthetists, orthotists, chiropodists/podiatrists, paramedics, clinical scientists, physiotherapists, dietitians, radiographers, occupational therapists, speech and language therapists.

Pharmacists are registered and regulated by the Royal Pharmaceutical Society

analgesia
pain relief

conservative management
management to reduce the impact of illness without using invasive or high-risk measures

episode
a period of time during which someone experiences back pain

extended scope physiotherapist
a physiotherapist with additional skills and clinical responsibilities

Expert Patient Programme
is the name given to an initiative to help people with long-term conditions maintain their health and improve their quality of life; a key element of this initiative is lay-led self-management training whose primary aim is to facilitate the development of self-management skills rather than to provide medical information.

interventions
a general term covering treatments, advice, education and other care that a practitioner may give

medicalising
identifying or categorising a condition or behaviour as being a disorder requiring medical treatment or intervention

multi-disciplinary team
a healthcare team that includes professionals from different disciplines working together to provide a comprehensive service for people with back pain; the team may include GP, consultant rheumatologist, consultant orthopaedic surgeon, consultants in other disciplines, doctors in training (both hospital and GPs), nurse specialist, physiotherapist, occupational therapist, dietician, podiatrist, orthotist, psychologist, pharmacist and social worker

opioids
a group of medications that can be prescribed for strong pain control

persistent pain
pain that has lasted for more than three months or has been present in episodes on more than half the days of the previous year; sometimes alternatively referred to as chronic pain

psychosocial support
professional care which addresses a person's psychological and social health needs; this may include support to reduce a person's distress, fear or ability to cope, support for social and family relationships, and support/advice about employment or benefits

red flags
a group of symptoms or signs (clinical indicators), any one or more of which may suggest a possibility of serious disease

triage
the categorisation of a person's back pain into one of the following: non-specific back pain, nerve root pain or serious pathology; also the process to decide the preferred treatment option and/or referral pathways

Appendix 1: Evidence-based interventions

The following evidence-based[26] interventions should be available for people with low back pain in the absence of serious disease or neurological complications (red flags).

In the first four weeks from onset:
- adequate information and reassurance
- advice to avoid bed rest
- advice to stay active
- adequate pain control.

For people whose back pain is not resolving by four weeks from onset, add:
- access to physical reconditioning exercises
- access to spinal manipulation.

For people whose pain is becoming persistent (six to 12 weeks from onset) or have been off work for four weeks, add:
- multi-disciplinary biopsychosocial intervention including:
- educational programme
- exercise programme for functional restoration
- cognitive interventions
- work based intervention
- involvement of Disability Employment Advisor.

for people whose pain has become persistent (more than 12 weeks without improvement):
- specialist pain service
- biopsychosocial assessment
- group cognitive behavioural therapy sessions
- vocational intervention
- special investigations if indicated

Appendix 2: Developing the Standards

The working group met four times between December 2003 and June 2004 and consulted widely and publicly on these Standards during May and June 2004.

Acknowledgements

The Standards of Care project has been managed by the Arthritis and Musculoskeletal Alliance (ARMA). A wide range of individuals and organisations, including ARMA member organisations, have generously given time, expertise and other support in kind.

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[26] Waddell G et al (1999)

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