The RCGP Curriculum: Clinical Modules

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for implementation from 5 August 2015

➢ 3.20 Care of People with Musculoskeletal Problems

Summary

- Each year 20% of the general population consult a GP with a musculoskeletal problem[1]
- Research evidence supports the effectiveness of simple positive approaches for many patients, and general practitioners (GPs) should encourage appropriate self-care[2, 3]
- Common musculoskeletal conditions such as back pain and osteoarthritis are the dominant cause of chronic pain, disability and work loss in the UK
- As a GP, understanding the psychological and social dimensions of chronic pain and disability is fundamental to your management of musculoskeletal conditions
- Taking an effective history and making a simple, focused examination in general practice is likely to be more important than imaging and serology, which on their own may be falsely reassuring
- Early diagnosis and treatment of inflammatory arthritis, such as rheumatoid arthritis, has a major impact on long-term outcome. Urgent referral to specialist care is indicated if there is clinical suspicion of inflammatory arthritis[4]

Knowledge and skills guide

Core Competence: Fitness to practise

This concerns the development of professional values, behaviours and personal resilience and preparation for career-long development and revalidation. It includes having insight into when your own performance, conduct or health might put patients at risk, as well as taking action to protect patients.

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[1] Arthritis Research UK National Primary Care Centre, Keele University. *Musculoskeletal Matters: what do general practitioners see?* Bulletin 1, October 2009, www.keele.ac.uk/media/keeleuniversity/ri/primarycare/bulletins/MusculoskeletalMatters1.pdf
[2] National Institute for Health and Clinical Excellence (NICE). *Osteoarthritis: care and management in adults*, CG 177, February 2014, www.nice.org.uk/guidance/cg177
[3] National Institute for Health and Clinical Excellence (NICE). *Low Back Pain: early management of persistent, non-specific low back pain*, CG 88, May 2009, p5, http://www.nice.org.uk/guidance/cg88
[4] National Institute for Health and Clinical Excellence (NICE). *Rheumatoid Arthritis: the management of rheumatoid arthritis in adults*, CG 79, September 2010, p7, http://guidance.nice.org.uk/CG79/NICEGuidance/pdf/English

This means that as a GP you should:

- Be aware of your own attitudes to patients presenting, for example, with modest back pain and seeking time off work

Core Competence: Maintaining an ethical approach

This addresses the importance of practising ethically, with integrity and a respect for diversity.

Core Competence: Communication and consultation

This is about communication with patients, the use of recognised consultation techniques, establishing patient partnership, managing challenging consultations, third-party consulting and the use of interpreters.

This means that as a GP you should:

- Communicate health information effectively to promote better outcomes, e.g. use positive terms such as 'wear, flare and repair' and avoid unhelpful terms like 'crumbly spine' and 'ruptured disc'
- Explore the perceptions, ideas or beliefs the patient has about the condition and whether these may be acting as barriers to recovery or return to usual activity or work
- Use simple techniques and consistent advice to promote activity in the presence of pain and stiffness, e.g. GPs play an essential role in promoting the message that when it comes to long-term musculoskeletal health patients need to 'use it or lose it' and stay active within their individual capabilities
- Agree treatment goals and facilitate supported self-management, particularly around pain, function and physical activity
- Assess the possibility that musculoskeletal symptoms can be compounded by psychological causes
- Recognise the frustrations that chronic, painful but non-fatal conditions, with few spectacular cures, can have on both patients and the general practitioner

Core Competence: Data gathering and interpretation

This is about interpreting the patient's narrative, clinical record and biographical data. It also concerns the use of investigations and examination findings, plus the adoption of a proficient approach to clinical examination and procedural skills.

- Assess the importance and meaning of the following presenting features:
    - pain: nature, location, severity, history of trauma
    - variation of symptoms over time
    - symptoms which help distinguish inflammatory from non-inflammatory conditions

- loss of function – weakness, restricted movement, deformity and disability, ability to perform usual work or occupation
- systemic manifestations of rheumatic disease

- Understand that reducing pain and disability rather than achieving a complete cure could be the goal of treatment
- Understand indications and limitations of plain radiography, ultrasound, CT and MR scan
- Understand the limitations of blood tests for diagnosing musculoskeletal conditions where 'negative' tests may not rule out disease and where diagnostic criteria are often not clear-cut. This is particularly the case with inflammatory arthritis (e.g. rheumatoid arthritis) where early referral should be initiated on clinical suspicion rather than based on the results of tests[5]
- Identify 'red flags' that relate to infection (e.g. septic arthritis or osteomyelitis); cancer (e.g. bony metastases and osteogenic sarcoma); fracture (e.g. fragility fracture in osteoporosis); neurological compromise (e.g. cauda equina syndrome); and inflammatory arthritis (e.g. rheumatoid arthritis, ankylosing spondylitis)

Core Competence: Making decisions

This is about having a conscious, structured approach to decision-making; within the consultation and in wider areas of practice.

This means that as a GP you should:

- Be aware of the concept of 'yellow flags' in musculoskeletal disease and the tools that can be used to stratify those at risk of progression to long-term pain and disability[6, 7]
- Use decision-making tools such as iRefer, the Royal College of Radiologists (RCR) imaging referral guidelines (see learning resources)

Core Competence: Clinical management

This concerns the recognition and management of common medical conditions encountered in generalist medical care. It includes safe prescribing and medicines management approaches.

This means that as a GP you should:

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[5] Miller A, Mahtani KR, Waterfield MA, Timms A, Misbah SA, Luqmani RA. Is rheumatoid factor useful in primary care? A retrospective cross-sectional study *Clinical Rheumatol.ogy* 2013 Jul;32(7):1089-93

[6] Kendall N, Burton K, Main C, Watson P. *Tackling Musculoskeletal Problems: a guide for the clinic and workplace – identifying obstacles using the psychosocial flags framework* London: The Stationery Office (TSO), 2009

[7] Hill JC, Dunn KM, Lewis M, Mullis R, Main CJ, Foster NE, *et al*. A primary care back pain screening tool: identifying patient subgroups for initial treatment *Arthritis & Rheumatism* 2008; 59(5):632–41, http://onlinelibrary.wiley.com/doi/10.1002/art.23563/abstract

- Identify and manage acute systemic inflammatory conditions that are appropriately treated in primary care such as gout and polymyalgia rheumatica
- Diagnose common, regional soft-tissue problems that can be managed in primary care (e.g. tennis elbow, trigger finger)
- Diagnose and manage the common, regional pain syndromes such as osteoarthritis, back pain and fibromyalgia
- Understand the issues and debates about use of complementary therapy and opiate analgesia for chronic pain
- Identify those patients at risk of bone disorders, such as osteoporosis, and understand the principles of primary and secondary prevention of fragility fractures
- Consider rare conditions such as connective tissue diseases (e.g. lupus) which may present with non-specific symptoms and affect extra-articular organs such as blood vessels, skin and kidneys
- Identify musculoskeletal conditions in children, the ages at which they commonly present and how pathology is differentiated from variations of normality, e.g. 'bow legs' (varus appearance) is a normal variant and usually resolves by age three
- Be aware of how musculoskeletal problems may be a manifestation of injury not only from trauma but also abuse

Core Competence: Managing medical complexity

This is about aspects of care beyond managing straightforward problems. It includes multi-professional management of co-morbidity and poly-pharmacy, as well as uncertainty and risk. It also covers appropriate referral, planning and organising complex care, promoting recovery and rehabilitation.

This means that as a GP you should:

- Know the problems that can be caused by the treatment of musculoskeletal disorders and explain their primary and secondary prevention (e.g. NSAIDS and gastrointestinal bleeds, cardiovascular disease risk and renal impairment)
- Identify and treat depression to improve clinical outcomes for patients with musculoskeletal conditions
- Be aware of increased cardiovascular risk in patients with inflammatory arthritis, connective tissue diseases and gout
- Be aware of increased fracture risk in patients with rheumatoid arthritis
- Be aware of the burden of treatment for patients with long-term musculoskeletal conditions like osteoarthritis, many of whom will be attending the GP surgery regularly for appointments about other long-term conditions
- Know what resources are available locally and nationally and how to access them, e.g. patient information material from Arthritis Research UK and patient support organisations such as Arthritis Care (see also Web Resources below)

Core Competence: Working with colleagues and in teams

This is about working effectively with other professionals to ensure good patient care. It includes sharing information with colleagues, effective service navigation, use of team skill mix, applying leadership, management and team-working skills in real-life practice, and demonstrating flexibility with regard to career development.

This means that as a GP you should:

- Understand the challenge that many musculoskeletal conditions might be better and more confidently managed by other healthcare personnel rather than GPs because they do not fit neatly into the biomedical model of pathological diagnosis and cure, and because most GPs do not gain the necessary treatment skills during their training
- Refer those conditions which may benefit from early referral to an orthopaedic surgeon (e.g. internal derangement of the knee, ruptured achilles tendon, massive rotator cuff tear)
- Apply local shared-care guidelines for safe prescribing and monitoring of disease-modifying anti-rheumatic drugs (DMARDs)

Core Competence: Maintaining performance, learning and teaching

This area is about maintaining performance and effective CPD for oneself and others, self-directed adult learning, leading clinical care and service development, participating in commissioning, quality improvement and research activity.

This means that as a GP you should:

- Describe the key national guidelines that influence healthcare provision for musculoskeletal conditions and the potential problems in applying these guidelines based on local availability of services
- Recognise the difficulty with developing and measuring outcomes in musculoskeletal conditions where diagnoses are often not clear-cut and response to treatment is related to symptoms rather than ‘hard’ outcomes such as improvements in blood tests or other disease markers

Core Competence: Organisational management and leadership

This is about the understanding of organisations and systems, the appropriate use of administration systems, effective record keeping and utilisation of IT for the benefit of patient care. It also includes structured care planning, using new technologies to access and deliver care and developing relevant business and financial management skills.

This means that as a GP you should:

- Examine what systems are in place at your workplace to help prevent practice staff developing common problems such as back pain

- Think about how your workplace facilitates return to work for staff with musculoskeletal problems
- Think about how your workplace facilitates access for people with disabilities

Core Competence: Practising holistically and promoting health

This is about the physical, psychological, socioeconomic and cultural dimensions of health. It includes considering feelings as well as thoughts, encouraging health improvement, preventative medicine, self-management and care planning with patients and carers.

This means that as a GP you should:

- Consider the physical, psychological, social, occupational and financial impact of musculoskeletal conditions on individuals and their carers (e.g. problems with fatigue, altered body image, work, impact on family relationships and sexual issues)
- Be aware of cultural differences in the expression of emotional distress and how this may present as pain and loss of function
- Incorporate a bio-psycho-social approach to assessment and management of chronic musculoskeletal conditions that is tailored to the diagnosis. e.g. addressing the patient's worrying thoughts around experience of pain and providing a consistent message regarding activity and return to work

Core Competence: Community orientation

This is about involvement in the health of the local population. It includes understanding the need to build community engagement and resilience, family and community-based interventions, as well as the global and multi-cultural aspects of delivering evidence-based, sustainable healthcare.

This means that as a GP you should:

- Be aware of the potential effect on the health of patients where services are deficient and frequently have long waiting times
- Understand the huge impact on the community of incapacity for work caused by musculoskeletal conditions, and how you can facilitate a patient returning to work by giving consistent advice and the use of 'fit notes'[8]

[8] Black C. *Working for a Healthier Tomorrow* London: The Stationery Office (TSO), 2008, p 44, www.gov.uk/government/publications/working-for-a-healthier-tomorrow-work-and-health-in-britain

Case discussion

Susan Andrews, a 45-year-old care assistant in a local residential home for older persons, presents in surgery complaining of worsening pain in her lower back during the past four weeks. The pain is confined to her back and does not radiate down her leg. It becomes worse in the course of a day and sometimes wakes her at night. She also has some pain in her neck and right shoulder, and pain, longstanding but occasional, in her left knee when walking.

She dates her back pain to an episode in her workplace where she had to lift a patient off the floor unassisted. She offers the information that staff illness and absence rates in her workplace have been higher than usual in recent months, with change of personnel in the senior management of the home. 'It's not like it used to be – it's more stressed – there are not the people around to help with lifting and moving like before – but I still like the place.'

On questioning, Susan says her appetite and weight have been steady but she now wakes at night, has started to feel a bit low, and she gets more tired than before towards the end of the day. She has had episodes of back pain in the past but it has never lasted this long. She reports no fever, and no significant neurological symptoms or history of malignancy. She lives with her husband, a local council gardener, and her one child is enjoying work as a nurse in a town 20 miles away. She expresses her concern that she might be developing a long-term problem which will make her work difficult.

On examination, she looks generally well and is moderately overweight; there is some curvature in the lower spine which disappears when she bends down to touch her toes – she can almost reach her toes but slowly and with some difficulty. She has some difficulty putting her hands behind her head.

You advise Susan about work and physical activity and provide an advice leaflet explaining the simple messages around back pain and how to protect the back when lifting and doing heavy work. You suggest that she tries to lose some weight with the objective of reducing the strain on her back. You recommend simple but regular analgesics, especially at night.

Some elements of Susan's history raise your concerns about a possible poor prognosis for improvement and associated increased risk for time off work.

Reflective questions

To help you understand how the GP curriculum can be applied to this case, ask yourself the following questions:

Core Competence	Reflective Questions
Fitness to practise This concerns the development of professional values, behaviours and personal resilience and preparation for career-long development and revalidation. It includes having insight into when your own performance, conduct or health might put patients at risk, as well as taking action	What is my own attitude towards people who I believe are falsifying or exaggerating their musculoskeletal symptoms?

to protect patients.	
Maintaining an ethical approach This addresses the importance of practising ethically, with integrity and a respect for diversity.	What further information would prompt me to raise concerns about the local residential home?
Communication and consultation This is about communication with patients, the use of recognised consultation techniques, establishing patient partnerships, managing challenging consultations, third-party consulting and the use of interpreters.	How might I negotiate any conflict over time off work? (E.g. if Susan requests 'a sick note for a few weeks until I feel better.')
Data gathering and interpretation This is about interpreting the patient's narrative, clinical record and biographical data. It also concerns the use of investigations and examination findings, plus the adoption of a proficient approach to clinical examination and procedural skills.	What aspects of Susan's case cause me concern? What is the likely prognosis? Would investigations be useful? If so, which ones?
Making decisions This is about having a conscious, structured approach to decision-making; within the consultation and in wider areas of practice.	What are the differential diagnoses for Susan's symptoms? What is the diagnosis likely to be?
Clinical management This concerns the recognition and management of common medical conditions encountered in generalist medical care. It includes safe prescribing and medicines management approaches.	What options do I have in treating this problem? What follow-up arrangements would I make?
Managing medical complexity This is about aspects of care beyond managing straightforward problems. It includes multi-professional management of co-morbidity and poly-pharmacy, as well as uncertainty and risk. It also covers appropriate referral, planning and organising complex care, promoting recovery and rehabilitation.	How might I manage Susan's 'yellow flags'?
Working with colleagues and in teams This is about working effectively with other professionals to ensure good patient care. It includes sharing information with colleagues, effective service navigation, use of team skill mix, applying leadership, management and team-working skills in real-life practice, and demonstrating flexibility with regard to career development.	Who else might be involved in the management of Susan's back pain?
Maintaining performance, learning and teaching This is about maintaining performance and effective CPD for oneself and others. This includes self-directed adult learning,	What barriers might I face in providing the 'best' care for my patients as defined by national guidelines? What tools are available to stratify those at risk of

leading clinical care and service development, participating in commissioning*, quality improvement and research activity.	developing chronic low back pain? What tools are available to measure pain and loss of function caused by musculoskeletal problems?
Organisational management and leadership This is about the understanding of organisations and systems, the appropriate use of administration systems, effective record keeping and utilisation of IT for the benefit of patient care. It also includes structured care planning, using new technologies to access and deliver care and developing relevant business and financial management skills.	What would be the key points of this consultation that should go in the patient's record?
Practising holistically and promoting health This is about the physical, psychological, socioeconomic and cultural dimensions of health. It includes considering feelings as well as thoughts, encouraging health improvement, preventative medicine, self-management and care planning with patients and carers.	What would help Susan to stay at work? What self-care and health promotion advice might I provide to Susan on this occasion? What steps could I take to facilitate continuity of care for Susan? How might Susan's problem impact upon the health of her family?
Community orientation This is about involvement in the health of the local population. It includes understanding the need to build community engagement and resilience, family and community-based interventions, as well as the global and multi-cultural aspects of delivering evidence-based, sustainable healthcare.	What are the advantages of a local back pain service? How might I go about establishing one? What other options might I have in managing musculoskeletal disease in the community? What provision might my practice make for patients and staff with musculoskeletal disorders?

How to learn this area of practice

Work-based learning

In primary care

Given the number of patients with musculoskeletal problems that present to their GP, you will have no shortage of clinical exposure during your time in primary care. You will see a wide range of conditions and it is worth keeping a log of the cases – to demonstrate that you are becoming confident in managing the conditions as you become more experienced.

Musculoskeletal problems offer the opportunity for you to develop clinical skills and reflect upon the utility of investigations in managing uncertainty and complexity.

The management of long-term musculoskeletal conditions is often criticised for not being aligned with national guidelines and standards of care. There are few indicators for musculoskeletal

conditions in the Quality and Outcomes Framework (QOF) to incentivise systemised care, but no shortage of national guidelines and standards of care which can be used to improve the outcomes for musculoskeletal patients in alignment with accepted best practice. Take the opportunity to reflect on the care that you deliver patients with musculoskeletal problems with tools such as audit, reviews of referral activity and use of investigations. Guided examples of high impact activity that you can take to improve patient care can be found at www.arthritisresearchuk.org/health-professionals-and-students/impact-toolkit.aspx.

The first contact with a patient is crucial and one of the great things about general practice is time and the opportunity for continuity of care. Following your patients up can provide a very useful insight into the natural course of musculoskeletal problems and give valuable clues in the clinical conundrums we all face.

Listen to the language your patients use to describe how their 'brittle bones', 'crumbly spines', 'grinding', 'worn-out' joints are affecting them; how they feel their bodies have let them down. And see how positive language can influence the perception of their pain and improve both how you feel about what you can do to help and the outcome for the patient[9]. So when a patient states that 'all I need is a new pair of knees, Doc', ask yourself whether you have done what you can to help, using pharmacological and non-pharmacological interventions to help with pain and to improve function as recommended in the NICE guidance.

In secondary care

Few GPs in training will get significant exposure to a core musculoskeletal speciality during their time in secondary care but many of the patients you will see during your training, especially the elderly, will have significant musculoskeletal problems. So take time for a brief, focused examination of a painful joint, and ask about mobility issues, work problems and function around the home, in order to get a feel for the impact that musculoskeletal conditions can have on the individual.

During placements in A&E you will see plenty of common musculoskeletal problems, including acute back pain. Think about whether you would be confident in managing these patients in the GP surgery setting and whether these patients might be more effectively managed in primary care.

Try to spend some time with speciality nurses and pharmacists engaged in shared-care prescribing of disease-modifying anti-rheumatic drugs (DMARDs). Can you think of some of the benefits and potential pitfalls of shared-care prescribing? What issues do the nursing team have? How are problems communicated to all involved? Think how you would, as a GP, ensure a safe service for your patients in the community.

[9] Australian Government National Health and Medical Research Council. *Evidence-based Management of Acute Musculoskeletal Pain: a guide for clinicians* 2004, p 14, www.nhmrc.gov.au/_files_nhmrc/publications/attachments/cp95.pdf

Consider attending an orthopaedic clinic and explore the decision to undertake a joint replacement for osteoarthritis. What factors influenced the decision? Were they the same factors for each patient you saw? Were Patient Decision Aids[10] being used?

Many areas have interface or tier 2 musculoskeletal services in the community or hospital setting. The GPs with a Special Interest (GPwSI) or Extended Scope Physiotherapists who work in these services may be able to help you improve your clinical skills, and the patients are a rich resource of common musculoskeletal problems. Think of the factors that may have influenced the decision to refer patients to these services. What might the advantages and disadvantages be for GPs and patients of such services?

Time spent in a local chronic pain service can give a valuable insight into the multidisciplinary approach to managing patients with chronic musculoskeletal and other pain. Pause to reflect on the barriers that patients face to getting back to normal functional levels and also the factors that may have contributed to the development of chronic problems. Were there missed opportunities that may have presented to address their problems earlier – perhaps preventing progression to a more chronic problem?

Self-directed learning

It's highly unlikely that you will go through the duration of your specialist training and not experience musculoskeletal aches and pains of one sort or other, from the minor through to the more significant. Perhaps you are involved in sport and have noticed some new ache or pain when you are training. How does it make you feel? Are you worried that the pain will get worse? What if you can't do the things you enjoy? What about work? How would you cope if your pain and disability prevented you following your chosen career path?

Reflecting on such issues provides a valuable insight into how your patients may be feeling when they come to see you. Asking about such worries forms part of the thorough assessment of a patient. If you do not address these concerns, you are less likely to help that person and may miss acting on cues that could prevent the patient from developing a chronic problem.

Learning with other healthcare professionals

It is worth spending time with allied health professionals including physiotherapists, occupational therapists and podiatrists to see how their methods of assessment differ from yours. In particular, time with physiotherapists learning clinical skills and improving your 'handling skills' will be well spent and will also help your understanding of what patients should expect when they are referred to physiotherapists.

You may be surprised by the number of patients who have paid to see a 'complementary' therapist before coming to see you. Osteopaths, chiropractors, acupuncturists and massage therapists may

[10] Patient Decision Aids are designed to help patients make difficult decisions about their treatments and medical tests. They are used when there is no clinical evidence to suggest that one treatment is better than another and patients need help in deciding which option will be best for them. Research shows that PDAs are effective in helping patients make informed choices about their healthcare and increase patients' awareness of the expected risks, benefits and likely outcomes. See also http://sdm.rightcare.nhs.uk/pda/

play a role for some patients. Find out what these practitioners do and whether they have registered governing bodies. Would you recommend them to patients?

Other members of the practice team, including nurses and healthcare assistants, spend the most time with patients with chronic diseases. They have valuable insights into how patients are getting along. Find out if their assessment includes asking patients about pain and level of function and which validated tools can be used to measure this.

Carers, both professional and informal, may be the best-placed individuals to inform how a person is coping at home and in the community. You often get a very limited view of the stoical patient within the confines of the surgery.

All GPs have a role in advising patients about fitness for work. How this advice is communicated has a significant effect on the future of that individual's working life. Discussion with occupational health physicians involved in Department of Work and Pensions work-capability assessments can help you understand how decisions regarding work fitness are made and how you as a GP can facilitate patients to stay in work, for example by delivering a consistent message around back pain.

Formal learning

There are many e-learning resources available and the RCGP online learning environment has a module on musculoskeletal care (www.elearning.rcgp.org.uk/msk). This module consists of seven lessons and focuses on a primary care approach to assessment of patients with a musculoskeletal problem. It covers diagnosis, investigations and treatment. Specific conditions frequently encountered by GPs are described in more detail, including back pain, gout, inflammatory arthritis, polymyalgia rheumatica and osteoarthritis. The final session looks at musculoskeletal problems which can be exclusively managed within primary care and features useful exercises for patients.

Look out for core musculoskeletal skills courses, aimed at GPs, which offer the opportunity to develop your consultation and examination skills, as well as keeping you up to date with the latest evidence and opinion on best practice.

You may also consider attending courses offering joint injection training. But remember that, while injection skills can be very helpful, you should not run before you can walk – the core skill for GPs is competent assessment of patients with musculoskeletal problems and, as a general rule, if you don't know the diagnosis you shouldn't be injecting the patient. A fundamental skill is knowing what not to inject as well as what to inject.

Useful learning resources

Web resources

Arthritis Research UK

Arthritis Research UK is the charity that is leading the fight against arthritis. This website is a resource for patients and professionals on all musculoskeletal conditions.

In the primary care area you will find all the resources for GPs and the primary care team in one place, including publications, the Core Skills in Musculoskeletal Care programme, GP trainee prizes

and training bursaries for GPs. www.arthritisresearchuk.org/health-professionals-and-students/information-for-gps.aspx

Resources available from Arthritis Research UK include:

Hands On* and *Synovium

Each issue of *Hands On* contains practical advice about managing musculoskeletal problems within primary care. *Hands On* also aims to inform GPs about current relevant topics within rheumatology and musculoskeletal medicine. *Synovium* presents a digested overview of current hot topics and research in musculoskeletal conditions. www.arthritisresearchuk.org/health-professionals-and-students/reports.aspx

Clinical Assessment of the Musculoskeletal System: a guide for medical students and healthcare professionals

This handbook covers 50 core competencies in musculoskeletal examination. The guide is accompanied by video clips demonstrating the widely used GALS (gait, arms, legs, spine) screening examination and a detailed regional examination of the musculoskeletal system (REMS). www.arthritisresearchuk.org/health-professionals-and-students/student-handbook.aspx

www.arthritisresearchuk.org/health-professionals-and-students/video-resources/rems.aspx

Paediatric gait, arms, legs, spine (pGALS) assessment

Short videos and supporting text that demonstrate a simple, quick and effective way to screen the musculoskeletal system in school-aged children. www.arthritisresearchuk.org/health-professionals-and-students/video-resources/pgals.aspx

www.arthritisresearchuk.org/~/media/Files/Education/Hands-On/HO15-June-2008.ashx

Expert Patients Programme

The Expert Patients Programme (EPP) is a self-management programme for people who are living with a chronic (long-term) condition. The aim is to support people who have a chronic condition by increasing their confidence, improving their quality of life and helping them manage their condition more effectively. www.nhs.uk/Conditions/Expert-patients-programme-/Pages/Introduction.aspx

FRAX

The FRAX® tool has been developed by the World Health Organisation to evaluate the fracture risk of patients. It is based on individual patient models that integrate the risks associated with clinical risk factors, including rheumatoid arthritis, as well as bone mineral density (BMD) at the femoral neck. www.shef.ac.uk/FRAX

QRISK

QRISK®2-2013 is a cardiovascular disease risk calculator adjusted for rheumatoid arthritis and SLE http://qrisk.org

QFracture

QFracture®-2012 is an osteoporotic fracture risk calculator adjusted for rheumatoid arthritis and SLE. www.qfracture.org

Royal College of General Practitioners

The RCGP and Arthritis Research UK have jointly produced the Core Skills in Musculoskeletal Care programme with free e-learning lessons, clinical and consultation skills workshops and an impact toolkit to help GPs demonstrate improved patient care from their learning. More details on the course can be found on: www.elearning.rcgp.org.uk/msk

The *e*-GP Rheumatology and Musculoskeletal Problems course includes back pain, joint pains, arthritis, connective tissue disease, osteoporosis and various problems in children. The *e*-GP course also includes sessions on a variety of musculoskeletal physical examinations. www.e-GP.org

Work and employment resources

Healthy Working UK brings together a range of resources to support GPs in helping patients stay at or return to work. It includes a Fit Note guide, e-learning, decision aids and an advice line for general and patient related health and work issues. www.healthyworkinguk.co.uk

There are a number of patient and professional organisations' websites which you will also find useful, including:

Arthritis Care www.arthritiscare.org.uk

Arthritis and Musculoskeletal Alliance http://arma.uk.net

BackCare

National charity for back health. www.backcare.org.uk

British Association of Occupational Therapists/College of Occupational Therapists www.cot.co.uk

British Chiropractic Association www.chiropractic-uk.co.uk

British Institute of Musculoskeletal Medicine www.bimm.org.uk

The British Orthopaedic Association www.boa.ac.uk

The British Pain Society www.britishpainsociety.org/

The British Society for Rheumatology www.rheumatology.org.uk/

British Sjögren's Syndrome Association www.bssa.uk.net

The Chartered Society of Physiotherapists www.csp.org.uk

Children's Chronic Arthritis Association (CCAA) www.ccaa.org.uk

London College of Osteopathic Medicine www.lcom.org.uk

Lupus UK www.lupusuk.org.uk

National Ankylosing Spondylitis Society www.nass.co.uk

National Osteoporosis Society www.nos.org.uk

Osteoporosis resources for primary care www.osteoporosis-resources.org.uk

National Rheumatoid Arthritis Society www.nras.org.uk

Paget's Association www.paget.org.uk

Pain Community Centre www.paincommunitycentre.org

The Society of Podiatrists and Chiropodists www.scpod.org/about-us

Polymyalgia Rheumatica and Giant Cell Arteritis (PMR-GCA) Scotland www.pmrandgca.org.uk

Primary Care Rheumatology Society www.pcrsociety.org

The Psoriasis Association www.psoriasis-association.org.uk

RSI Action (National repetitive strain injury charity) www.rsiaction.org.uk

Scleroderma Society http://sclerodermauk.org

Society of Musculoskeletal Medicine www.sommcourses.org/about-somm