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**January 2016**

**Happy New Year to all our Members**

**ACPA General Meeting and AGM2016-Liverpool**

This year the ACPA Annual Meeting and AGM will be at the Liverpool ACC on the 30th and 31st March 2016. The meeting will run in association with BASK.

Liverpool ACC is in the centre of Liverpool by the River Mersey minutes from the world-famous Liver Building with many hotels nearby.

This year the ACPA theme will be ‘Outside the Box’. So far we have speakers invited to talk on Alkapatanuria, Managing patients with Learning Difficulties and Developing Clinical Reasoning to deal with Complex patients. We also hope to have a speaker presenting on Shoulder complications and a session on case studies of unusual presentations is also planned. It is hoped that ACPA members will be joining the parts of the BASK programme, particularly the Lorden Trickey lecture.

The dinner for BASK and ACPA members will be in Liverpool Town Hall and rumour has it that entertainment will be provided by a Liverpool celebrity.

The AGM will also take place during the ACPA meeting. We welcome nominations for positions on the committee. Being an ACPA committee member is useful in gaining knowledge and providing evidence of working at national level.

So all ACPA members are invited to meet in Liverpool for what we hope will be an interesting and entertaining meeting.

**2016 Dates for your diary**

* **BHS-** 16-18th March 2016- Norwich
* **BASK/ACPA -**30-31st March 2016-Liverpool
* **Image Interpretation** 8-9th Sept2016
* **Surgical skills course** TBC



**Who can take part?**

***Patients, carers, and healthcare professionals***

If you have (or have had), or are caring for someone who has (or has had) early stage osteoarthritis (OA), **or**

work as a health or social care professional with people who have (or have had) early stage OA ***. . . we want to hear from you.***

**Why should I take the survey?**

The **Early OA of Hip and Knee** survey will - for the first time - identify your most pressing unanswered questions about the diagnosis, surgical and non-surgical treatment, and likely outcomes of early OA of hip and/ or knee. This will ensure that future research can be prioritised according to the needs of

patients, carers and health professionals. This exciting initiative will be overseen by The James Lind Alliance, a non-profit making organisation funded by the National Institute for Health Research, ensuring the exercise produces an unbiased result, with equal weighting given to the views of the different participating groups. So whether your interest is personal or professional …your opinions will count.

**How do I take part?**

The survey is available **here** or contact the James Lind Alliance Project Manager at the Oxford Biomedical Research Centre to request a paper version (tel / voicemail 01865 223298, e-mail sandra.regan@ouh.nhs.uk).

***The survey takes about 10 minutes to complete, so please take this opportunity to influence the future of early OA of hip and knee.***

***Funding partners and Wider* partnership -** *The full list is on the website*

**Shared Decision Making (SDM)**

Joanne Yorke, from the RLBUH has recently undertaken a research project on Shared Decision Making In Hip and Knee Osteoarthritis and how theory relates to practice. This is a large piece of work but she has kindly agreed to share a very brief overview with us. This may generate further discussion for when we meet in March, in Liverpool.

**SDM Theory Relating to Hip and Knee OA**

Qualitative studies examining SDM practiced by physiotherapists, involving a range of clinical conditions, conclude that decision making is generally paternalistic as appose to shared (11), and the desire to perform physiotherapeutic treatments may act as a barrier to SDM (12).

Evidence has been published suggesting moderate reliability and validity of the SURE tool (9). This multi-national study included 452 patients from the UK, diagnosed with hip or knee OA. Educational attainment of this study group was above the national average, and SURE questionnaires were completed only after exposure to a condition specific audio-visual decision aid. It could be argued that both these factors aid participants to understand the SURE questions.

AQuA found that other UK NHS settings using the SURE tool have generated high scoring results which do not change in response to SDM training interventions (7).

In 2011 a review of instruments used to measure SDM, identified 20 different measurement instruments (13). More SDM measures have subsequently emerged (14).

Scholl et al conclude that SDM is moving towards assessing both the patient’s and the clinician’s perspective (13). The most widely used instrument to achieve this is currently the Observer OPTION instrument (15). This requires either the presence of an assessor during the consultation, or post consultation assessment of the recorded interaction.

The emphasis of SDM research over the past few years, including a Cochrane review published in 2014 (16), is tending towards use of decisional support aids and tools to enhance SDM.

An American clinical RCT assessing doctor/patient consultations for hip or knee OA, concluded that decision and communication aids provided prior to consultation, resulted in beneficial outcomes in particular speed of decision making and patient satisfaction (17). The decision aids described in this study would be difficult to replicate at RLBUHT, given the cost of the aids described, and the difficulty identifying patients who would benefit from such aids, prior to the single contact within MCAS.

Decision tools designed to integrate into a single consultation, in particular “Option Grids” are available and endorsed by NHS England specifically for the management of Hip and Knee OA (18,19), but are not widely utilised (20). A recent trial, conducted at a UK physiotherapy led triage clinic highly comparable to RLBUHT MCAS clinics, found that Option Grids increased levels of SDM, without increasing the duration of the encounter (21).

Elwyn et al (2013) systematically reviewed the implementation of decision support aids in practice, to conclude that overcoming barriers from professional and organisational factors needs substantial future consideration (22).

Decision making in the management of Hip and Knee OA is influenced by many factors. Patient socioeconomic status has been shown to be significant. (23)

SDM literature makes certain assumptions including the concept that good health care decisions require highly informed patients (4). In reality health care decisions are multi-factorial, and it may not always be appropriate, practical or realistic to fully inform patients about each option (24).

It may be short-sighted to view SDM in terms of management preferences and options discussed at the end of a consultation. Person-centred communication skills from the outset can build relationships using empathetic understanding, and establish a patient’s priorities and preferred level of involvement in their decision making (25)

**References are available on request**

**We look forward to seeing you in March in Liverpool.**