by non-physician health professionals, such as dietitians, nurses, occupational therapists, pharmacists and physiotherapists, to adults at high risk of primary or secondary osteoporotic fracture, is integral in the prevention and management of minimal trauma fracture, but may not be sufficiently realised in all European countries. To address this, a commissioned task force has developed the first collaborative EULAR points to consider/recommendations for non-physician health professionals in the prevention and management of osteoporotic fractures, underpinned by a systematic literature review (SLR).

Objectives: To identify and review the scientific literature to inform the development of evidence-based EULAR points to consider/recommendations for non-physician health professionals in the prevention and management of osteoporotic fracture.

Methods: A SLR for each of eight clinical questions that were previously formulated and consensually agreed by the task force members was undertaken by a research fellow (NW), with guidance from the task force convenors and the methodologist. Four electronic databases (Medline, Embase, Cinahl and PubMed) were searched over the period 13th - 31 st October 2017. The search strategies combined MeSH terms and keywords to identify studies related to two key concepts: (i) adults ≥ 50 years of age at high risk of primary or secondary osteoporotic fracture and (ii) interventions delivered by non-physician health professionals to prevent, treat and manage osteoporotic fractures. Exclusion criteria included articles not in English and without online access. Evidence was categorised using the Oxford Centre for Evidence-based Medicine Levels of Evidence. For critical appraisal of systematic reviews, AMSTAR 2 was used. Risk of bias was assessed by the Cochrane Collaboration's tool.

Results: The eight primary searches returned a total of 15 917 citations; duplicates were removed and the remaining 11 195 citations screened for relevance by title, abstract, design and year of publication (recently published reviews and/or RCTs were prioritised). Thirty-two studies were finally selected. Overall confidence in the findings of included systematic reviews ($n=13$) ranged from low to high. Risk of bias also varied across other included studies. Strongest evidence of benefit was found for exercise in the management of osteoporotic fracture [level 1a].

Conclusions: There is a lack of high quality evidence for the role of health professionals in the prevention and management of adults at high risk of primary or secondary osteoporotic fracture. We recommend the instigation of an education and research agenda for non-physician health professionals.

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THU0740-HPR DETERMINATION OF EXERCISE BEHAVIOUR IN PATIENTS WITH JUVENILE IDIOPATHIC ARTHRITIS

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Background: Juvenile idiopathic arthritis (JIA) is one of the most common rheumatic diseases in childhood, affecting at least 1 in 1000 children. Children with JIA experience joint inflammation and swelling, pain and tenderness, morning stiffness, limited mobility. Children with JIA complain pain and have lower functional ability and decreased quality of life compared with their peers. Many studies have reported that patients with JIA have low physical activity levels and also exercise therapy is considered an important component of the treatment of JIA. Nowadays, studies for evaluating exercise behaviours in order to cope with physical inactivity for many chronic diseases are becoming increasingly important.

Objectives: The objective of this study was to determine exercise behaviour in patients with JIA.

Methods: 34 patients with JIA (23 female and 11 male), age range 5–18 years, home exercise program being recommended, participated in this study. The survey that was created with Google Forms was sent via WhatsApp to patients after 1 week-10 days than setting home based exercise program for each patient. In the survey, disease duration, involvement joint(s), Childhood Health Assessment Questionnaire (CHAQ) for functional ability, 11-point Numeric Analogue Scale

(NRS) for satisfaction of exercising, Exercise Stages of Change Scale-Short Form (ESCS), Exercise Self-Efficacy Scale (ESES), and Decisional Balance Scale (DBS) for exercise behaviour were inquired for the patients with JIA.

Results: The mean age and disease duration were 11.38 ± 4.68 and 5.36 ± 4.16 years, respectively. The mean of the number of affected joints was 5 ± 4.41 . According to the five behavioural processes by ESCS, the patients were enrolled 38.2% of them in the stage of maintenance, 26.5% of them in the stage of action, 14.7% of them in the stage of preparation, 14.7% of them in stage of contemplation, 5.9% of them in stage of pre-contemplation. 67.5% of them was satisfaction for exercising (≥ 5 for NRS). When comparison of the patients' CHAQ scores due to satisfaction level with NRS, the mean of CHAQ scores was significantly lower in patients with high satisfaction than patients with low satisfaction ($p=0.014$). The mean of scores ESES and DBS were 17.06 ± 6.13 and 12 ± 4.61 , respectively. All of the patients represented "positive perception of exercise" due to DBS. Only a significant correlation with age of patient and DBS was found ($r=0.375$, $p=0.029$).

Conclusions: This study demonstrated that patients with JIA were in high stages participated in exercising and have high self-efficacy of exercise, decreasing of functional ability may affect the satisfaction level of exercising and as age increases, decisional balance for exercising also increases. Therefore, future researchers should investigate potential facilitators of and barriers to exercise for larger population in patients with JIA by following up long term.

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THU0741-HPR MAPPING THE BEHAVIOUR CHANGE TECHNIQUES USED IN A PRACTICE-BASED FIBROMYALGIA SELF-MANAGEMENT PROGRAMME: A QUALITATIVE STUDY

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Background: Fibromyalgia (FM) is a complex long-term condition affecting up to 5.4% of the UK population. It is associated with chronic widespread pain, fatigue, sleep and cognitive difficulties. FM can cause high levels of functional and work disability; with individuals making frequent use of healthcare resources. There is limited robust evidence for effective pharmacological treatments for FM, and current guidelines all recommend non-pharmacological interventions.

Allied health professionals at the Royal National Hospital for Rheumatic Diseases (RNHRD), Bath developed the Fibromyalgia Self-Management Programme (FSMP); a non-pharmacological, multidisciplinary exercise and education group.

Objectives: Main aims of the FSMP are to provide condition-specific, patient centred, education and exercise advice, to support development of core, self-management skills. The FSMP comprises of 16 hours of group treatment, spread over four or six weekly sessions. Core components include education about FM, sleep, diet and lifestyle advice, hydrotherapy and stretches.

The FSMP was developed clinically, with little opportunity for the clinical team to explore the mechanisms by which it is effective. To inform successful implementation beyond the RNHRD, this evaluation aimed to map the FSMP to the NICE recommended Michie Behaviour Change Taxonomy (BCT) to determine key behaviour change components.

Methods: Non-participatory observations were conducted of the four and six week FSMP. Detailed notes on course content, therapist delivery, and additional content not included in the manual were recorded. Semi-structured interviews were conducted with therapists ($n=4$) and patients ($n=9$). Observations and review of the therapist manual data were deductively coded in NVIVO to the Michie Behaviour Change Taxonomy using Framework Analysis. Interview data were analysed using Theoretical Thematic Analysis.

Results: Review of the course manual and course observations show the FSMP coded onto 12 of the 16 main areas of the Michie Behaviour Change Taxonomy, encompassing 22 behaviour change techniques. Patients' interviews indicated significant behaviour changes as a result of attending the course; including increased activity levels, pacing, better quality sleep, and improved communication with family members. Patients reported positive changes to symptoms as a result of attending the course.

Therapists highlighted four key challenges in delivering the course; fidelity between therapists, patient readiness and acceptance of FM, group management and patient fatigue while attending the programme.

Conclusions: The FSMP utilises a range of behaviour change techniques. Patients who attend the course make changes to their behaviour which enables them to manage their symptoms of FM more effectively.