Conclusions: Persistence appears to be a driver of cost-effectiveness of SC-TNFi treatment in patients with AS, especially when a societal perspective is taken. Therefore, prescribing the SC-TNFi with the best persistence may be a cost-effective strategy.

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FRI0637 BARRIERS TO REMAIN IN WORK: RESULTS FROM THE NATIONAL RHEUMATOID ARTHRITIS SOCIETY SURVEY (NRAS)

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Background: Problems at work and work loss are still major socio-economic consequences for patients with Rheumatoid Arthritis (RA), employers and the society. Currently, there is a lack of understanding what the main barriers and facilitators are to remain in paid work. For patients and employers identifying these barriers and facilitators will enable them to make the right adjustments at a personal level. For policy makers these factors can determine future policies, aiming to reduce the overall socio-economic burden of RA.

Objectives: i) To understand reasons for work loss in people with RA; and ii) to compare problems at work in employed RA patients and those who had to stop working due to RA.

Methods: An online survey about employment was sent to UK NRAS members and distributed to non-members via social media including questions about problems at work in those employed or problems related to work in those who had to stop working or retire early due to RA. Rates of problems related to work were compared using Chi2 tests.

Results: 891 patients who completed the survey were in paid employment and 189 had stopped working due to RA or retired early due to their RA. Median [IQR] symptom duration was 12.5 [7.5–23.2] years and the majority were women (91%). Main reasons for leaving work included (patients could tick all that applied): unable to carry out duties (73%); time off sick (46%); fatigue (74%); problems with colleagues (12%); need for specific adaptations (11%); unable to travel to work (13%); lack of family support (3%); lack of support from employer (33%); and side effects of medication (24%). The majority of patients left their job >5 years earlier

than they had expected (72%) and 62/172 (36%) mentioned that their employer had not been helpful in assisting them to stay in work. For those in employment, the main challenges to remain in work were: demanding role; RA symptoms; no reasonable adjustments; commuting to work; and lack of understanding. Compared to patients in employment at time of survey, those who had to stop work due to their arthritis, reported having significantly serious problems regarding commuting to work, lack of understanding employers/colleagues, time off due to flare or medical appointments, health and safety and reluctance to make adjustments in their last job (table 1). Lack of family support was not significantly significant.

	not at all serious/ not very serious		neither serious nor non-serious		serious / very serious		P
	Employed	Stopped working due to arthritis	Employed	Stopped working due to arthritis	Employed	Stopped working due to arthritis	
Getting to and from work	326/609 (53%)	58/166 (35%)	136/609 (22%)	36/166 (22%)	147/609 (24%)	72/166 (43%)	<0.001
Lack of understanding from colleagues	300/603 (50%)	38/159 (24%)	129/603 (21%)	42/159 (26%)	174/603 (29%)	79/125 (50%)	<0.001
Health and Safety issues	303/594 (51%)	56/161 (35%)	170/594 (29%)	41/161 (25%)	121/594 (20%)	64/161 (40%)	<0.001
Time of medical appointments	362/624 (58%)	62/167 (37%)	108/624 (17%)	39/167 (23%)	154/624 (25%)	66/167 (40%)	<0.001
Lack of family support	378/617 (61%)	93/147 (63%)	111/617 (18%)	29/147 (20%)	128/617 (21%)	25/147 (17%)	0.577
Time off when having a flare or unwell	245/603 (41%)	29/165 (18%)	107/603 (18%)	17/165 (10%)	251/603 (42%)	119/165 (72%)	<0.001
Employer reluctant to make adjustments	282/538 (52%)	38/151 (25%)	134/538 (25%)	35/151 (23%)	122/538 (23%)	78/151 (52%)	<0.001
Lack of understanding employer	281/573 (49%)	36/156 (23%)	118/573 (21%)	27/156 (17%)	174/573 (30%)	93/156 (60%)	<0.001

Conclusions: Barriers to remain in work with RA are multi-factorial and related to the disease, nature of the work and understanding from employers and colleagues. Increasing understanding about RA amongst employers and colleagues in addition to often simple work adjustments, such as adaptations in the workplace and the opportunity to work more flexible, can prevent problems at work and work loss in the long-term and reduce the socio-economic burden.

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FRI0638 A NOVEL GROUP CLINIC MODEL FOR NEW PATIENTS ENHANCES PATIENT ACTIVATION

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Background: Group clinics are a widely used, key alternative care model in USA (as shared medical appointments and other labels), especially in centres of excellence like the Cleveland Clinic. They are increasingly seen as 'a transformative innovation'¹ and recognised as an effective solution to the universal health-care challenges: increasing demand and limited resource². We have extensive experience of follow up group clinics for inflammatory arthritis patients since 2008 with a co-designed model integrating patient and team views³. Qualitative research showed robust themes associated with successful delivery: Efficiency, Empathy, Education, Engagement and Empowerment. 'Patient activation' describes the knowledge, skills and confidence a person has in managing their own healthcare, but there is no published data in group clinics. A group model has also never been used for seeing new patients in secondary care, so this is an original application of an established care model.

Objectives: To show feasibility for new patients seen in a group setting and assess patient experience, including activation.

Methods: A mixed methods pilot study. New patients awaiting Rheumatology appointments were invited to pilots at one of two hospitals: 1) with experience of group clinics 2) without. Patients agreeing to attend knew this was a new application of an established innovation with an option to stay for a focus group or be interviewed by telephone afterwards. Sessions were videoed for educational purposes and qualitative interviews were conducted under existing research approvals with relevant consents for both. Numerical data included Patient Activation Measure before/after the two-hour clinic, EQ-5D and a standard feedback tool. Qualitative data was analysed using nVivo and compared to previously identified themes.

Results: 19 patients were seen in two two-hour clinics (mean 13 mins/patient vs. 30 mins/patient usual care), including complex patients with multiple diagnoses. 69 patients were phoned, of whom 16 did not answer, 20 declined, 6 failed to attend, 3 declined to see a Rheumatologist at all, 2 were deemed not suitable and 3 already had an appointment. Feedback was very positive: median 10 (IQR 8–10) across all domains, so was consistent with usual clinics and follow up group clinics. Free text positive comments far outweighing the negative. EQ-5D showed a highly impacted group (mean global health index 54 vs. UK age norm 77). Patient Activation Measure showed significant improvement over each two-hour