Background: Although work ability is considered a key element of quality of life for working people, work is underexposed in current treatment in people with rheumatoid arthritis (RA) or axial spondyloarthritis (axSpA). Most people with RA or axSpA attend a physical therapist (PT). Physotherapy can effectively improve physical fitness, which is associated with work ability. Therefore, PTs might play an important role in optimizing work ability of people with RA or axSpA.

Objectives: Developing a personalized, multimodal, PT-led, work-oriented intervention for working people with RA or axSpA who have a reduced work ability, through a co-creation process.

Methods: A systematic co-creation process with all relevant stakeholders was conducted following the Medical Research Council (MRC)-framework for complex interventions (see Figure 1). In step 1, all relevant clinical guidelines and treatment protocols were assessed. Based on the results of this assessment, a draft version of the intervention was developed, consisting of mandatory (i.e., work-oriented intake, patient education, exercise therapy, referral-roadmap of work-related professionals) and optional treatment modalities (i.e., workplace intervention, self-management course). In step 2, focus groups with people with RA/axSpA, PTs and occupational/rheumatology experts were organized and treatments and necessary adaptations to the draft intervention were discussed. In step 3, a pre-test was performed to test the feasibility of the intervention in a primary physotherapy setting, which was evaluated in the group of PTs participating in the pre-test in step 4. Finally, in step 5, a final focus group with researchers in this field was held to discuss the findings from previous steps in this co-creation process and to agree on necessary adaptations in the final intervention.

Results: After developing the draft intervention, we conducted two focus groups with people with RA/axSpA (n=16; 4 with RA, 12 with axSpA), one focus group with PTs (n=12) and one focus group with occupational/rheumatology experts (n=9; 2 rheumatologists, 2 nurse specialists, 1 physiatrist, 1 physician assistant, 1 nurse practitioner, 1 labour expert and 1 occupational therapist). People with RA or axSpA emphasized 3 aspects: i) PTs should have adequate expertise in RA and axSpA, ii) high potential for a role of ‘buddy’ by PTs to support them in work-related problems, and iii) most PTs currently lack adequate expertise on work-related problems. PTs and experts underlined the importance of extensive training of PTs on work-related laws and regulations and adequate (work-related) interprofessional collaboration. After revision of the draft intervention, the intervention was tested for feasibility by three PTs and three working people (2 with RA, 1 with axSpA), who indicated that the intervention was feasible and that the developed intervention facilitated PTs to support people optimizing their work ability. However, adequate training on providing this intervention was recognized to be essential. In a final focus group with researchers (n=6), consensus was reached on minor adjustments to the intervention that were based on findings from previous steps.

Conclusion: Through a systematic co-creation process based on the MRC-framework, we have been able to develop a personalized, multimodal, PT-led, work-oriented intervention for working people with RA or axSpA and a reduced work ability. The (cost-)effectiveness of this intervention is currently being tested in a large trial (Physiotherapy WORKs Study).

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OP0203-PAE

NRA NEW2RA RIGHT START SERVICE FOR PEOPLE RECENTLY DIAGNOSED WITH RA

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Background: The National Rheumatoid Arthritis Society (NRAS) follows best practice, evidence-based standards in all we do. Huge strides have been made in the diagnosis and treatment of Rheumatoid Arthritis (RA), but impact on quality of life can be significant and for many, RA remains hard to come to terms with and depression and apprehension are frequent co-morbidities seen in RA, and this can impede people’s ability to acquire knowledge of their disease together with supported self-management skills and coping strategies.

Objectives: The aim of Right Start (RS) is to improve outcomes of the recently diagnosed with RA through a framework of emotional, educational and peer support and to proceed to high quality supported self-management resources tailored to individual need. RS also enables us to dispel myths and unhelpful health beliefs so that people get the ‘right start’ on their journey with RA to maximise health outcomes. A diagnosis of an incurable disease treated with life-long strong drugs is a life-changing event and without the right support it can be an isolating and emotionally very challenging experience for both the individual and their close family.

We also wanted to give an understanding of the key role that supported self-management and self-help can play in improving quality of life, giving people back some control over their symptoms. Our goal was also to create a quick and easy way for HCPs to refer their patients to Right Start in a consented and GDPR compliant way.

Methods: HCPs are able to refer their patients via the ‘Refer a patient’ button on our website which takes them to a simple form which is filled in and submitted to NRAS with the patient’s consent. NRAS receive the referral and the form is integrated with our Salesforce database, and we contact the patient. RS involves a simple, 4-step process and the individual receives: A call (up to 1hr) with a member of our helpline; 1:1 peer support (phone/Teams/Zoom) from trained volunteers with RA and access to 24/7 online community support; a tailored package of hard copy information with e-links/videos/webinars of interest sent by post; further follow up available from helpline and individual peer support. RS enables health professionals to meet their responsibilities against NICE Quality Standard 33, Statement 3, (patient education and access to self-management resources) on which they are audited through National Early Inflammatory Arthritis Audit (NEIAA). RS is included in the NICE shared learning database of best practice examples. RS also supports the EULAR Recommendations for implementation of self-management strategies in inflammatory arthritis.

Results: Since launch at BSR 2019, over 80 UK rheumatology units have referred over 435 patients to this service. Approx. 1/3rd cannot be contacted and after 3 attempts a letter and newly diagnosed pack are sent, inviting contact at future date. Anecdotally people are highly satisfied with this service and a number of units are referring multiple patients where the service is embedded in the patient pathway. To gather empirical data on the impact of the service NRAS has partnered with Manchester University to undertake an Enhanced Right Start pilot in 5 UK rheumatology units involving the use of validated patient reported outcome and experience measures from users recruited, and quantitative/qualitative data from health professionals. The pilot is due to commence recruitment in early Feb, 2022. Throughout, referrals to the standard service continue to grow.

Conclusion: Workforce shortages in all posts within the multi-disciplinary team, and the increase in pandemic related referrals underlines a need for a simple and accessible service which provides a simple, 4-step process and the individual receives: A call (up to 1hr) with a member of our helpline; 1:1 peer support (phone/Teams/Zoom) from trained volunteers with RA and access to 24/7 online community support; a tailored package of hard copy information with e-links/videos/webinars of interest sent by post; further follow up available from helpline and individual peer support. RS enables health professionals to meet their responsibilities against NICE Quality Standard 33, Statement 3, (patient education and access to self-management resources) on which they are audited through National Early Inflammatory Arthritis Audit (NEIAA). RS is included in the NICE shared learning database of best practice examples. RS also supports the EULAR Recommendations for implementation of self-management strategies in inflammatory arthritis.

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OP0204-PARE

FATIGUE IN PATIENTS WITH RHEUMATIC AND MUSCULOSKELETAL DISEASES: A SCORING REVIEW ON ITS DEFINITION, MEASUREMENT INSTRUMENTS, DETERMINANTS, IMPACT AND INTERVENTIONS

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Background: Fatigue is one of the most important symptoms of patients with rheumatic and musculoskeletal diseases (RMDs) and numerous studies on fatigue in patients with RMDs have been published. However, no overview exists.
of all topics relevant to understand and manage fatigue in patients with rheumatoid arthritis (RA), spondyloarthritis (SpA, including psoriatic arthritis (PsA)), osteoarthritis (OA) and fibromyalgia (FM).

**Objectives:** To scope published reviews on aspects of fatigue identified by patients in a preceding initiative as relevant for care and mapped to the following research areas: 1) definitions for fatigue, 2) measurement instruments for fatigue, 3) determinants of fatigue, 4) impact of fatigue, and 5) effect of interventions on fatigue in patients with RMDs of interest.

**Methods:** A methodological framework for scoping reviews was followed. A systematic literature search was performed in five bibliographical databases. Data selection followed by data extraction was done by two independent researchers.

**Results:** The scoping review included 144 reviews (18 CRs, 42 SRs and 84 NRs). RA was addressed most frequently (60/144 (42%)). No agreed upon definition for fatigue in any of the RMDs was found. Across reviews, there was agreement that fatigue is a complex multifactorial and highly subjective symptom, including various subtypes with specific characteristics. Reviews discussed 23 generic and 3 disease-specific self-reported outcome instruments to measure fatigue in RA, SpA and FM, but no reviews on outcome instruments for OA were found. Four of these 23 (17.4%) instruments included validated cut-off values to diagnose or classify excessive fatigue. Numerous factors were associated with fatigue (Figure 1), but the study design (often cross-sectional) hindered studying causality. Across RMDs, pain, physical function, and depressive symptoms were the most frequently studied disease related factors; gender and stress the most frequent contextual factors related to fatigue. The strength of association was small or moderate, but mostly not reported. Work disability was one of the most frequently studied consequences of fatigue in RMDs, followed by impact on pain, physical activity and stress. Strength of these associations was not reported.

Finally, both pharmacological and non-pharmacological interventions, including physical activity-based and psychological interventions, generally had a small positive effect on fatigue in RMDs. No reviews described the effect of pharmacological interventions on fatigue in OA.

All results were relatable for the patient panel and some missing aspects were pointed out. The patient panel advised to develop a research agenda to specifically diagnose and treat excessive fatigue in RMDs, as continuing the current path is likely to increase publications about fatigue, but unlikely to change patients’ lives.

**Conclusion:** This scoping review emphasizes the complexity of fatigue. Only a minority of the reviews had a primary focus in fatigue, whereas to patients this prominent symptom deserves specific attention.

**REFERENCES:**

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**Figure 1.** Determinants of fatigue and the related minimal number of underlying studies within reviews.