

Therapists' experiences of remotely delivering cognitive-behavioural or graded-exercise interventions for fatigue: a qualitative evaluation

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3 **Therapists' experiences of remotely delivering cognitive-behavioural or graded-exercise interventions for**
4 **fatigue: a qualitative evaluation**
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Abstract

Objectives: Fatigue is a challenging feature of all inflammatory rheumatic diseases. LIFT (Lessening the Impact of Fatigue in inflammatory rheumatic diseases: a randomised Trial) included remotely delivered personalised exercise programme (PEP) or cognitive-behavioural approach (CBA) interventions. The aim of this nested qualitative evaluation was to understand rheumatology health professionals (therapists') perspectives of delivering the interventions in the LIFT trial.

Methods: A subgroup of therapists who had delivered the PEP and CBA interventions took part in semi-structured telephone interviews.

Results: Seventeen therapists (13 women, 4 men) who delivered PEP (n=8) or CBA (n=9) interventions participated. Five themes were identified: In 'The benefits of informative, structured training', therapists described how they were able to practice their skills, and the convenience of having the LIFT manual to refer to. When 'Getting into the swing of it', supporting patients gave therapists the confidence to tailor the content of the manual to each patient. Clinical supervision supported therapists to gain feedback and request assistance when required. In 'Delivering the intervention' therapists reported that patients valued the opportunity to address their fatigue and challenge their own beliefs. 'Challenges in delivering the LIFT intervention' therapists struggled to work collaboratively with patients who lacked motivation or stopped engaging. Finally, 'Lift developing clinical skills' therapists gained confidence and professional satisfaction seeing patients' fatigue improve.

Conclusion: Findings support the value of skills training for rheumatology health professionals to deliver a remote fatigue management intervention tested in the LIFT trial. These insights can inform service provision and clinical practice

Key words: fatigue; qualitative; exercise; cognitive-behavioural approaches; rheumatic diseases.

Key messages:

- Skills training for rheumatology health professionals can be used to successfully deliver fatigue management interventions remotely.
- Therapists described increased professional satisfaction and confidence seeing patients' fatigue improve.
- These insights inform strategies for service provision and clinical practice for remotely-delivered support.

Lay summary

What does this mean for patients?

Fatigue can be a challenge in inflammatory rheumatic diseases (IRDs). The LIFT study (Lessening the Impact of Fatigue in inflammatory rheumatic diseases: a randomized Trial) explored interventions to support people with fatigue. These were: a cognitive-behavioural approach (CBA), a personalized exercise programme (PEP), or usual care. People with IRDs were chosen randomly to take part in seven sessions of CBA, seven sessions of PEP or usual care. All sessions (aside from the first PEP session) were delivered over the phone. The aim of this study was to explore therapists' experiences of delivering the intervention. Seventeen therapists (13 women and 4 men) took part; eight had delivered the PEP intervention, and 9 delivered the CBA intervention. Therapists who delivered LIFT told us they enjoyed the chance to practice their skills, and that the LIFT manual gave them the confidence to tailor the intervention to each patient. Clinical supervision was valued. Therapists also shared that LIFT improved their skills and they were happy to see patients' fatigue improve over time. These new results can inform clinical practice, and how services are provided.

Introduction

Fatigue can be an overwhelming and distressing feature of inflammatory rheumatic diseases (IRD). Most of the evidence to date has come from studies in rheumatoid arthritis (RA), which have established that between 42% - 80% of patients experience significant fatigue which they can find difficult to manage(1-3). Similar findings have been reported for other IRDs, including systemic lupus erythematosus (4) and ankylosing spondylitis (5-7).

A qualitative metasynthesis found that patients often experience fatigue as an unpredictable and pervasive symptom with physical, cognitive, emotional and social effects(8). The authors concluded that it is important for health professionals to acknowledge the impact of fatigue on the patients' everyday lives and provide support to develop strategies to cope well, increase physical activity and maintain work(8). This is consistent with a systematic review of non-pharmacological interventions which found evidence to support psychosocial and physical activity interventions(9).

Although cognitive-behavioural based approaches have been widely used within psychology, a growing need for non-psychologically trained healthcare professionals to deliver psychologically-informed care has been recognised (10-12). There are a number of examples within the literature of healthcare professionals being trained in new, psychologically informed skills, such as cognitive behavioural approach (CBA) training, including CBA interventions for low back pain, delivered by trained nurses in primary care (13). Similarly, the RAFT trial (Reducing Arthritis Fatigue- clinical Teams), a seven-session group course for people with RA-related fatigue, was delivered by trained rheumatology healthcare professionals (occupational therapists and nurses) using cognitive-behavioural principles (14). As access to clinical psychology within rheumatology teams is not always

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3 available, and may be difficult for patients to access (14), if healthcare professionals could be trained to deliver
4 an effective CBA intervention, this could potentially offer benefit to patients with IRD-related fatigue.
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8 **Lessening the Impact of Fatigue in inflammatory rheumatic diseases: a randomised Trial (LIFT)** is a multi-centre
9 three-arm randomised trial using a remotely delivered personalised exercise programme (PEP) or cognitive-
10 behavioural approach (CBA) intervention, in addition to usual care (a Versus Arthritis patient information
11 leaflet)(15). Further detail about the LIFT intervention has been published separately(16). The interventions
12 were designed to facilitate cognitive and behaviour change, enhance patients' coping and self-management
13 and reduce the severity and impact of their fatigue. The intervention was delivered by health professionals
14 (termed therapists in this article) who were members of NHS staff at each research site; CBA by a
15 rheumatology nurse or equivalent allied health professional, such as an occupational therapist, and PEP by a
16 specialist physiotherapist, usually with a rheumatology background. Participants with IRD in the intervention
17 arms were randomised to seven one-to-one sessions of either the PEP or CBA interventions delivered by
18 trained therapists over 14 weeks, plus a booster session at 22 weeks. Sessions were delivered via telephone, or
19 by videoconference, depending on patient preference. In the PEP arm only, the first session was delivered
20 face-to-face(15). For the PEP intervention, participants completed detailed physical activity diaries, and set
21 personalised goals relating to what they wanted to achieve from the programme (16). This data was used to
22 plan a personalised progressive exercise programme, in agreement between the therapist and participant(16).
23 In the CBA intervention, participants were given basic information about how cognitive, behavioural,
24 emotional and biological factors can interact to impact fatigue. Participants were encouraged to develop a
25 problem statement that described their own fatigue in terms of these factors, and were encouraged to set
26 goals, complete activity diaries, completed homework activities and participated in review and feedback about
27 the intervention(16). Progress was reviewed in each session, and new goals put in place if required (16).
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40 Therapists delivered the LIFT intervention after separate PEP and CBA training sessions. Initial training for PEP
41 was two days, with additional training for new therapists reduced to 4-5 hours on a single day. Initial training
42 for CBA was three days with additional training for new therapists reduced to two days. In both PEP and CBA
43 training, more efficient and shorter training was used for subsequent sessions. Training was delivered face to
44 face by experienced clinical academics (AW, KL, LP) and featured vignettes of fatigue cases, role play and skills
45 practice(15). During the period that they were delivering the interventions to trial participants, therapists had
46 access to clinical supervision every two weeks or as needed. Clinical supervision was provided by AW, KL, SG or
47 LP via telephone(15). The aim of this study was to evaluate therapists' experiences of intervention training and
48 delivery as part of the LIFT trial.
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55 **Methods**

56 We used qualitative methods and collected data in semi-structured telephone interviews with a subgroup of
57 LIFT therapists who had delivered the PEP and CBA interventions in the LIFT RCT. Qualitative methods are well
58 suited to in-depth exploration of topics(17, 18). The interview schedules for the PEP and CBA arms are outlined
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3 in Supplementary Data S1, available at *Rheumatology Advances in Practice* online, and featured open-ended
4 questions designed by the study team. Questions explored therapists' reasons for taking part in LIFT, prior
5 relevant experience, thoughts on the training and delivery, impact on the therapists' clinical practice, and any
6 suggestions for changing the intervention for future roll out.
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10 **Sample**

11 All therapists who had delivered LIFT intervention sessions at the six participating NHS sites were eligible to
12 take part. LIFT therapists were sent invitations to take part in the nested qualitative evaluation sub study (n=
13 27) after they had completed their delivery as part of the trial. Therapists returned reply slips to the first
14 author (SB) to express an interest in taking part. All therapists provided written informed consent for the
15 qualitative component. To maintain anonymity, participant codes have been used throughout.
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20 **Data collection**

21 Interviews were conducted by CA and SB, research associates with prior experience of conducting telephone
22 interviews but with no involvement in the design or delivery of the LIFT training or interventions. Before the
23 start of each interview, therapists were reminded that the call was being recorded, the procedure for
24 anonymisation and what the aims of the interview were, and they were given the opportunity to ask any
25 questions.
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30 **Data analysis**

31 Audio recordings were transcribed by an approved transcription service, anonymised, and checked for
32 accuracy against the original audio recordings. The transcripts were imported into NVivo 12 (released in
33 2018)(19) and analysed using inductive thematic analysis as outlined by Braun and Clarke, a data-driven
34 approach with no overarching framework applied to the data 'a priori'(20). The underpinning perspective was
35 realist with analysis at the latent level. The first author SB read through all the transcripts and coded text that
36 related to the research questions. Codes were reviewed, revised and organised into overarching themes and
37 subthemes, with some codes raised and upgraded into themes, while less relevant codes were discarded(20).
38 Data saturation was determined when no new themes were identified from therapist interviews(21). Two
39 transcripts were independently reviewed by four co-authors (ED, CA, AW and KL) and the themes and
40 subthemes discussed as a team to reach consensus. Themes and subthemes identified in the thematic analysis
41 can be seen in Table 1.
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50 **Ethics**

51 The study complied with the Declaration of Helsinki, and was approved by the Wales Research Ethics
52 Committee Number 7 (reference: 17/WA/0065). Informed consent was obtained from all participants.
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57 **Results**

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3 A total of 17 therapists (13 women, 4 men) from the PEP (n=8) and CBA (n=9) arms responded and were able
4 to participate in telephone interviews. Interviews were conducted between July 2019 and August 2020.
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6 Therapists who did not respond to invitations to participate were not interviewed, therefore any reasons for
7 non-participation in the interviews were not recorded. The 17 therapists who were interviewed had attended
8 one of four training sessions; 3-day in-person training (n=6), 2-day in-person training (n=5), 4-hour intensive in-
9 person training (n=3), or 4-hour intensive remotely-delivered training (n=3).” This reflects the health
10 professionals joining the LIFT study at different time points. Interviews lasted between 25 and 45 minutes
11 (average 34 minutes).
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20 Table 1 here please.
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22 **The benefits of informative, structured training**

23 Therapists valued the ability to train with other rheumatology health professionals before delivering the
24 intervention. Many identified the benefits of having informative and structured training to guide them in
25 delivery.
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28 *Mixing it up (benefits of training)*

29 Although role play was not everyone’s “favourite thing” [T02 CBA], a variety of methods helped therapists to
30 practice their skills before meeting patients. Therapists approved of the variety in the content and delivery of
31 their training, as it enabled them to stay focused.
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37 *“We weren’t sitting – they were mixing it up, they were taking turns talking, we were doing exercises and being*
38 *included, so they ... kept our attention right throughout the day and good breaks and things. It was ideal. I*
39 *wouldn’t change a thing.” [T07 CBA]*
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43 *“With the exercise cohort, there was a face to face appointment, so we did a bit of role-playing for that and a bit*
44 *of role-playing for the telephone as well.” [T14 PEP]*
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47 *A lot to take in at once*

48 This subtheme captures the challenges that therapists encountered during the training for their role.
49 Training times varied, from two days to four hours. There was a lot to absorb and learn in the longer training
50 sessions “It was...quite a lot of information to take in at one go.” [T12 PEP]. However, those in the shorter training
51 sessions, felt that they would have liked more time to practice their skills before meeting with patients.
52
53 *“[In 3-day training] people had opportunities to do a bit of role playing whereas we kind of tended to gloss*
54 *over that a bit because we only had two days ... if we’d done a bit more role playing, it would have been*
55 *helpful.” [T05 CBA]*
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3 *Nervous, but keen to try*

4 Most therapists felt nervous before delivering the intervention and meeting LIFT participants for the first time,
5 but found that they grew more confident with practice; *“I did feel a bit anxious about that in the beginning, but*
6 *actually the more I practiced at it, the easier it became.”* [T09 CBA]. After training, this therapist described; *“I*
7 *felt quite confident that I knew what I was doing. Certainly, once I went through my first patient from start to*
8 *finish ... it was confidence as you go”* [T12 PEP].
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18 **Getting into the swing of it**

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20 Once therapists had embarked upon the LIFT trial, they described how the chance to apply and make use of
21 their training improved their confidence. The therapists spoke of liking the manual as a resource to refer to,
22 alongside support from professional supervision.
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26 *Therapist utilisation of the training manual* Although almost all therapists described being nervous at the start
27 of delivering the interventions to participants, the chance to practice and the support provided by the manual
28 gave them the confidence and flexibility to tailor content to individual patients' needs, and to jump back and
29 forth between sections of the intervention.
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34 *“Sometimes I use them more or less in order sometimes I jump back and forth. No, I've kind of got into the*
35 *swing of it now.”* [T03 CBA]
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38 *“The better you become the slicker you become”* [T08 CBA]
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41 Therapists gave very positive feedback regarding the intervention manual, which many liked to keep close by
42 during sessions, *“I could look at that while I was on the phone ... I actually could look at it quite confidently.”* [T17
43 PEP].
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47 Some therapists suggested a digital copy, both to prevent the paper bound manual from becoming worn with
48 regular use, and to make navigating to key content easier.
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52 *“I did find it difficult to use during sessions because it's big and hard to find things, but they're all where they*
53 *should be and it's well-designed...it's just the nature of that much information and being able to locate it ... If I*
54 *had it open as a PDF I could do a quick search”* [T10 PEP].
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58 *Supervision gives 'input from a different angle'*
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3 The clinical supervision provided to therapists by the LIFT trainers, allowed them to query their own practice,
4 get feedback on their performance, and ask for input and assistance on more difficult interactions.
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8 *“Trying to figure out how to apply it is a difficult thing, and that’s where the supervision was really handy*
9 *because it just comes at a different angle than I’m used to.”* [T03 CBA]

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11 *“That gave me confidence as well ...I knew that somebody was on the end of the phone that could actually answer*
12 *your question.”* [T15 PEP]
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15 16 17 18 19 20 **Delivering the intervention**

21 Therapists had the option to deliver the intervention using telephone or internet-based audio-video calls,
22 according to patient preference. However, only the telephone option was taken up. Although many therapists
23 had not used remote delivery prior to the intervention, they found telephone delivery to be straightforward.
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26 27 *Building rapport*

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29 The first face-to-face session that was part of the PEP delivery enabled therapists to build rapport with
30 participants; *“Because all of the participants I met one to one for their initial appointment so I could visualise*
31 *them and I knew what their capacity and things were”* [T15 PEP]. Similarly, although the face-to-face session
32 was not an element of the CBA arm, therapists still enjoyed the opportunity to build a good relationship with
33 participants; *“Each time you feel like you get to know them a bit more and you recognise their voice ... I remember*
34 *you, it’s nice to speak to you again”* [T04 CBA].
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38 39 *More open communication*

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41 Therapists reported that participants were able to talk about their fatigue and seemed more open in telephone
42 communication; *“[LIFT] worked better because it was over the phone, because there was a level of control that*
43 *people had, so far as they weren’t presenting all of themselves...It was good for them to have ...a barrier that*
44 *they could report and still feel independent.”* [T10 PEP] Participants could challenge their own beliefs about
45 fatigue and the causes of their fatigue; *“[LIFT] gave them a different view on their condition and maybe how they*
46 *can look at things... they looked at things differently and they said they had tools to carry on and manage their*
47 *fatigue.”* [T02 CBA], with LIFT giving them the tools to better manage their fatigue themselves.
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52 53 **Challenges in delivering the LIFT intervention**

54 55 *Patients unable or unwilling*

56 LIFT therapists struggled to engage participants who were unable or unwilling to change their self-
57 management behaviours, in both the PEP and CBA arms:
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3 *“They tell [you] they try, but they don’t really, you can tell that it’s not really going to change. One of them said*
4 *to me, “I know what I have to do, I’m just not really in the right frame of mind to change some habits.” [T01*
5 *CBA]*

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8 *“You wouldn’t necessarily feel like they’d actively changed their everyday life, which for some of them, they*
9 *needed to.” [T16 PEP]*

10 *Patients underestimating the work required*

11 Therapists reported that a minority of participants had not realised *“how much ...work on their side they’ve got*
12 *to do” [T08 CBA]* for them to get the best results from the LIFT interventions and see the greatest benefit.

13 Therapists described these difficulties:

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18 *“The thing that put most people off initially was the first diary and the amount of homework and being organised,*
19 *and how to share that information back” [T12 PEP]*

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23 *“By session three you could see who were the patients that were going to try and apply all this advice and the*
24 *ones that were just really not interested ... Expecting like a magic wand to come out and sort out their fatigue...*
25 *They were not quite prepared to put in the work themselves.” [T01 CBA]*

26 **LIFT helping own practice going forward**

27 *Professional satisfaction*

28 Therapists expressed enthusiasm and professional satisfaction in seeing participants’ fatigue improve and the
29 positive changes made in their lives because of their involvement in the LIFT RCT.

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33 *“I got a huge amount out of it, and the patients were great I have to say and I really... it was a great... when*
34 *they were getting further and making progress and seeing differences themselves it was a real boost I think, for*
35 *them and for me ... that we were able to manage all this by phone and that they could see a difference in their*
36 *lives.” [T05 CBA]*

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41 *“I felt like had totally changed her life, and sort of socially, personally, professionally, just everything, she was*
42 *like a different person. And that was really lovely, and I felt like I got to the end of it and thought, “I’ve really*
43 *made a difference” and I can see how the results of this would really show huge benefits.” [T16 PEP]*

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48 Implementing the LIFT intervention in daily practice The skills and tools acquired by therapists during LIFT
49 training gave them greater confidence in the advice and support they offered to patients.

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55 *“I don’t think I wasn’t saying the right thing before, I just was not as confident ...we just referred them to the*
56 *occupational therapist, whereas now I can just do the advice myself, and if I do have the time I do explain how*
57 *behaviours and thoughts can affect the way we act and how it’s all connected.” [T01 CBA]*

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3 *"I'm not scared to get them doing more ... [When] fatigue's a big issue you think, "Oh, I don't want them*
4 *overdoing things", whereas now I know that it helps... I'm not as reluctant... it's certainly improved the overall*
5 *management."* [T12 PEP]
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9 *"[LIFT] feels like the missing link to we what we were always doing. It's made a massive difference, we were*
10 *getting quite good results with the fatigue group, but I kind of felt like there was something missing and I feel*
11 *this has absolutely been it...listening, not trying to think of solutions and getting patients to come up with that*
12 *themselves and that's what's made the difference, without a doubt."* [T07 CBA]
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15 16 17 *An intervention that still works with COVID*

18 Many therapists shared ideas about how the interventions could be rolled out clinically. The only limitations to
19 the intervention working remotely, was securing private clinic space to make phone or video calls to
20 participants. To facilitate communication with patients, therapists suggested the option for video
21 consultations, call headsets, and using a data sharing app:
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26 *"Certainly now after Covid, there's a lot more telephone work going on. ... theoretically, I guess, I could have done*
27 *[LIFT] from home."* [T09 CBA]
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31 *"A face to face type video chat might have been a bit more engaging. It was all phone calls, and you needed*
32 *that first face to face, I think, session to get buy-in and build that rapport with your patient to get them to*
33 *engage with the format, so probably something a bit more similar"* [T12 PEP]
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37 *"I do think video link is the way to go if patients are able to do that. Because it's nice to see somebody and also*
38 *the only drawback of the phone was I would have liked to have seen patients' activity diaries."* [T05 CBA].
39

40 41 **Discussion**

42 While rheumatology teams are increasingly aware that fatigue can be a challenging symptom for patients to
43 manage, they have very few treatment options available to help (22). These results have highlighted the
44 benefits of health professionals receiving structured training and learning skills to support patients with
45 fatigue. Although seen as awkward by some therapists, the use of role play during training allowed them the
46 chance to practice their skills before undertaking sessions with patients. Role play encourages participation
47 and the adoption of an identity, based on simulated scenarios, for educational purposes(23). In modern
48 medical education, role play is typically used to develop communication and critical thinking skills in clinical
49 practice(24) and to enable health professionals to experience the imagined perspectives of the clinician and
50 the patient(23). In the present study, some patients showed a lack of engagement with the intervention.
51 Although financial and time constraints on therapists time could potentially limit what can be offered to
52 patients, there is potential for future therapist training to focus on engaging participants who were less willing
53 to take part in in the intervention. The benefits of skills training for rheumatology nurses, occupational
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3 therapists and physiotherapists to support patients with fatigue have been highlighted in self-management
4 interventions for multiple sclerosis (MS)(25) and RA(26). Healthcare professionals who undertook an intensive
5 self-management programme for patients with RA, described how techniques such as motivational
6 interviewing had seemed difficult initially, but had become easier with practice and had increased their
7 professional confidence in supporting patients(27).
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12 A further benefit of the LIFT RCT was the clinical supervision that therapists could access. Supervision has been
13 cited as a helpful element of other interventions, including delivery of a group fatigue intervention for RA
14 patients by clinical teams(26). Although the supervision in this study was provided by experienced
15 professionals to their less experienced colleagues, peer support may offer a more realistic and achievable
16 model within NHS care that is worth pursuing in further studies. This may be particularly relevant in busy
17 rheumatology departments(28), for example, a rapid review of clinical supervision in the NHS found that peer
18 supervision was perceived as a positive form of support. Helpful elements included supervisors' self-disclosure
19 regarding their own experiences, helping to normalise the supervisees' experiences and encouraging them to
20 share their viewpoints (28, 29). For these benefits to influence patient care, it is vital that supervision be given
21 regularly, with protected time for staff to take part in supervised practice (28).
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31 Few LIFT therapists had previous experiences of delivering care over the telephone, but they were able to
32 work effectively with remote delivery. Although some concerns have been raised regarding the potential
33 disadvantages of telephone delivery, such as the inability to see facial expressions (30), and some patients
34 have voiced scepticism(31), a recent systematic review comparing remotely delivered and face-to-face CBT
35 interventions found no significant effect on patient-therapist interactions (32). Remotely-delivered exercise
36 interventions using videoconferencing were found to result in significantly greater 12-week weight loss,
37 compared to in-person or usual care arms,(33) or a control group (34). Telephone delivery offered several
38 advantages to both participants and therapists. Although this study was designed and delivered prior to the
39 COVID-19 pandemic, therapists commented that most patient-facing rheumatology services had changed to
40 remotely delivered consultations since March 2020.
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47 While the PEP and CBA interventions were perceived positively by therapists, they had several ideas for
48 improvements before rolling them out to more NHS sites. These included the more widespread use of video
49 consultations to facilitate communication, particularly when explaining exercises in the PEP intervention or
50 sharing pictorial information, such as activity diaries in the CBA intervention. Ideas for making data sharing
51 between therapists and patients more streamlined were proposed, such as using a secure data-sharing app. In
52 addition, future research could also explore the more cost-effective and practical means of delivering the
53 intervention across a wider range of NHS sites, and at lower cost. Future economic evaluation and analysis
54 would be beneficial, to evaluate whether the LIFT intervention offers cost savings compared to usual care.
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Strengths and limitations

A strength of this research is that therapists were contacted after they had finished delivering the interventions, giving them the opportunity to reflect on the whole process. Therapists in this study were based at six hospital sites across the UK and seemed very open to communicating about their experiences. This enabled exploration of a variety of viewpoints from therapists working in a range of clinical settings, serving different communities and with different local infrastructures that might impact their experiences. A limitation is the small sample size of participants (n=17) recruited to the qualitative evaluation sub study. In addition, interviews with therapists after training, and prior to delivery of LIFT, may have given more detail about their thoughts prior to starting the intervention.

Conclusions

These findings support the value of skills training for rheumatology health professionals to deliver PEP and CBA fatigue management interventions remotely. Therapists described many positives of the LIFT interventions, including professional satisfaction at seeing patients' fatigue improve, increased confidence in supporting patients with fatigue, and the challenges and benefits of learning new skills. Valuable therapist-proposed ideas for positive changes to the LIFT interventions, to improve efficiency of delivery and information sharing have been proposed, which can be considered for wider roll out of the interventions in the future. Further research could also consider the most cost effective and practical way to deliver the intervention across a wider range of study sites. These insights can inform service provision and clinical practice for remotely delivered support of rheumatology patients with fatigue.

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A list of LIFT study team members can be found in Supplementary Data S2, available at *Rheumatology Advances in Practice* online.

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Table 1: Themes and subthemes identified in the thematic analysis.

Theme	Subthemes
1. The benefits of informative, structured training	<i>Mixing it up (benefits of training)</i>
	<i>A lot to take in at once</i>
	<i>Nervous, but keen to try</i>
2. Getting into the swing of it	<i>Therapist utilisation of the training manual</i>
	<i>Supervision gives 'input from a different angle'</i>
3: Delivering the intervention	<i>Building rapport</i>
	<i>More open communication</i>
4. Challenges in delivering the LIFT intervention	<i>Patients unable or unwilling to engage</i>
	<i>Patients underestimating the work required</i>
5. LIFT developing clinical skills	<i>Professional satisfaction</i>
	<i>Implementing the LIFT intervention in daily practice</i>
	<i>An intervention that still works with COVID</i>

LIFT: Lessening the Impact of Fatigue in inflammatory rheumatic diseases: a randomised Trial.

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*From biochemical assays, the clinical relevance of which is uncertain. JAK, Janus kinase; RA, rheumatoid arthritis; TYK, tyrosine kinase.

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