

Blended Learning approaches (online and face-to-face) are Essential for Instructors/Leaders Working with Older People and Stroke Survivors

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Why this statement?

Many training providers are moving to online only teaching and, in response to queries we have received at our office during the COVID-19 national emergency, we provide our rationale for why **LLT will retain blended (online and face to face) learning** for our qualifications (all of which have practical based assessments). **Exercise is not a one size fits all approach** and not all exercise instructors/leaders are the same (do not receive the same training or necessarily hold the same qualifications). This brief statement is designed to support commissioners, funders, exercise services and their workforce to better understand the value and necessity for face-to-face learning time for exercise leaders/instructors preparing to work with older people at risk of falls and stroke survivors.

Historically, qualifications for exercise delivery have involved face to face teaching together with planned hours out of contact with the tutor for additional embedding of learning. In the last 10 years most courses have included an element of online teaching to supplement the shorter face to face teaching hours. This can facilitate people's ability to learn outside of work hours and therefore retain their income (particularly self-employed instructors) and potentially widen access. The retention of face to face teaching for courses which are more practical in content reduces potential reach and class sizes and increases costs for both those delivering and attending compared to online-only courses. Certainly, for courses which are more theoretical in content, learning online has many potential benefits for students and employers. However, there are concerns about learner isolation, lack of peer support and competition¹, exacerbated by the lack of development of in-depth experiential learning, meeting individual learning needs, instant and direct feedback, shared collaborative and co-operative experiences, interpersonal skills and clinical delivery skills, where clinical reasoning underpins competence². There is certainly no evidence to suggest that online learning is more effective than traditional learning methods¹.

LLT are recognised for our commitment to promoting and supporting best practice in programme fidelity and our focus on enhanced practical delivery skills. This is because when it comes to falls prevention and achievement of person-centered goals through specific gains to components of fitness, the 'something is better than nothing' message is not sufficient. Advanced practical skills are required because generic seated exercise and generic exercise programmes delivered by generic 'one size fits all' approaches are not evidenced to reduce falls. Our rationale for LLT retaining face to face content for practically applied skills within our qualifications is underpinned by **five** points of fact:

The benefits of physical activity far outweigh the risks for most people³. But **there are vital considerations for exercise/each component of fitness when it comes to age related changes, frailer older people and people living with long-term conditions** if optimum/cost effective outcomes are to be achieved. These considerations are not just theoretical, so in education settings we need to observe that students can apply/demonstrate principles of safe and effective practice in group situations, whilst transferring skills to one to one interactions also.

Evidence based effective exercise delivery must be **tailored to the individual and requires practical skills and decision making** (including assessment outcomes/levels of challenge and intensity) in order to meet the required level of challenge and intensity required for falls prevention or fitness after stroke. This requirement for decision-making is one of the skill sets of a specialist instructor that differentiates them from generic exercise instructors. **A specialist instructor working with people with long-term conditions, falls prevention, neurological conditions requires a more advanced theoretical understanding AND application of practical skills.**

FaME, Otago, STARTER (exercise after stroke) are all **evidenced based exercise interventions** which inform our Postural Stability Instructor, Otago Exercise Leader (Award), and Exercise and Fitness after Stroke Instructor qualifications. These interventions have been robustly evaluated in unbiased randomised controls trials. No other current REPs L4 Training course is informed by a **single researched intervention requiring fidelity to be achieved**. Effective exercise delivery is achieved by the application of underpinning theory **combined with practical delivery skills** to achieve specific outcomes and ideally in partnership with appropriate referring health professionals (physiotherapists).

Practical skills cannot be effectively imparted, rehearsed and assessed via online platforms and **current prerequisite training does not include the specific delivery or communication skill sets** required to achieve best practice delivery for evidence based programmes to reduce falls and improve fitness in stroke survivors.

Although there is some very low grade evidence for the benefits of online teaching compared to just reading a manual in terms of knowledge acquisition and clinical behaviour, there is **no evidence that practical skills, self-efficacy or satisfaction can be gained from online-only teaching compared with face to face interactive education** in the delivery of clinical interventions amongst health care professionals⁴.

Finally, LLT also have a duty of care to our students and the employers who employ them:

From experience of past and current training of in this area, students that attend our L4 training, with L3 exercise referral as a prerequisite (for REPs members), have minimal practical experience and in many cases **we are required to dedicate time to add 'skilling-up' in fundamental practical delivery skills** including; observation, group management, teaching correction and position, communication, options for tailoring and progressing components of fitness and the critical application of motivational strategies supporting longer term adherence. This can only be seen and acted on face to face.

We know the detrimental effects of too much screen time³ on health and well-being (eye strain, poor posture, lower back pain⁵, stiffness, slows metabolism, increased poor cardiovascular risk markers⁶, depression⁷, anxiety⁸, amongst others) and that people spend too much screen time during their leisure time, therefore **adding large amounts of screen time through education will not be beneficial** to the physical and mental health of our students.

References:

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Other brief statements from LLT:

[LLT Statement on Consistent and Accurate Messaging for Commissioners and Stakeholders in Frailty and Falls Services \(OEP/PSI\)](#)
[LLT Implementation Guidance for Commissioners, Public Health Officers and Leisure Service Managers \(OEP/FaME\)](#)
[LLT Statement - FaME and OTAGO as Dance OR Structured Exercise Formats? \(Dance To Health Programmes\)](#)
[LLT/AGILE/BASES Collaboration Statement – Partnership working for Successful Falls Care Pathways](#)