

## **Full title**

Comparing face-to-face with on-line training for occupational therapists in advising on fitness for work: Protocol for the CREATE study

## **Short title**

Protocol for the CREATE study

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## **ABSTRACT**

### **Introduction**

Occupational therapists (OTs) have a key role in advising on fitness for work, however there is a concern that they lack knowledge and confidence in using the Allied Health

Professions (AHP) Health and Work Report (formerly the AHP Advisory Fitness for Work Report). CREATE compares face-to-face training with on-line training for OTs in completing the AHP Health and Work Report (AHP H&WR).

### **Method**

Mixed methods study.

Phase 1, OTs will co-design an on-line training resource. A standardised face-to-face group-based training session will also be developed based on the same content.

Phase 2, a feasibility study will be conducted. Thirty OTs will either attend face-to-face group training or access the on-line resource. Data on self-reported knowledge and confidence in using the AHP H&WR will be collected at baseline, 1 week and 8 weeks post-training. Feedback on the training will be collected by interview and, for the on-line resource, using an on-line tool.

### **Results**

Quantitative results will be predominantly analysed descriptively. If appropriate, between-group responses will be compared using the Mann Whitney test.

Qualitative findings will be analysed thematically.

**Conclusion** CREATE will have made a significant contribution to the debate around appropriate training methods in advising on fitness for work.

### **Keywords**

Protocol paper

AHP Health and Work Report

Fitness for Work

Training

Reusable Learning Object

On-line training

## **Introduction**

Work is generally good for health (Waddell and Burton, 2006). However, people with health problems do not necessarily receive the advice and support needed to help them stay at work, or enable them to make a successful and sustained return to work (Black, 2008; Black & Frost, 2011). All healthcare professionals have some role in addressing health barriers to work, but occupational therapists are acknowledged by the UK government as one of the key professionals in advising on a patient's fitness for work (Department for Work and Pensions and Department of Health, 2017).

There are currently two standardised methods of communicating the advice given to patients by healthcare professionals about the individual's fitness to work in the UK. One is the Statement of Fitness for Work (or 'fit note') completed by General Practitioners (GPs – primary care/family doctors), and hospital doctors (Department for Work and Pensions, 2008; Department for Work and Pensions, the fit note). The other is the Allied Health Professions' Health and Work Report -formerly the AHP Advisory Fitness for Work Report – (Allied Health Professions Health and Work Report). Both were introduced in 2010.

The fit note was introduced to enable GPs and hospital doctors, to advise patients that they are either not fit, or that they 'may be fit' for work if appropriate workplace modifications can be made, with the aim of reducing unnecessary sickness absence and allowing individuals to do some work as they recover. However, independent and government commissioned research and audit has consistently demonstrated that the fit note has not yet reached its potential. Of serious concern is that fact that only 7% of fit notes have the 'may be fit' option selected, and any advice given is limited (Shiels et al., 2013; Coole et al., 2015; NHS Digital, 2017). The Allied Health Professions Health & Work Report (AHP H&WR, Royal College of Occupational Therapists) was developed by the AHP Federation with specific expertise from the UK professional bodies of physiotherapy, occupational therapy and podiatry, in consultation with the Department

of Health (DH) and Department for Work and Pensions (DWP). Although similar in format to the fit note, the AHP H&WR allows AHPs to provide more detailed information to the individual, their employer and GP on the effects and impact of the patient's reported work related difficulties, and suggest options that would facilitate remaining in or returning to work. It can be used to provide evidence for sick pay purposes, but not to claim ill health benefits, whereas the fit note can be used for both.

To the authors' knowledge, the AHP H&WR is unique to the UK. Internationally, sickness certification is mainly managed by the medical profession, although there are a few of instances where other healthcare professions have a role. For example in Victoria, Australia, physiotherapists, chiropractors and osteopaths can provide subsequent Certificates of Capacity once the first Certificate has been issued by a medical practitioner (Papagoras et al, 2018). Johnston and Beales (2016) report that in Alberta, Canada, a physiotherapist's diagnosis and fitness for work status can be accepted by Workers Compensation Insurers to confirm compensation status without a physician's report. In Scandinavia, Norwegian chiropractors and manual therapists have legislated sickness certification rights, whereas their Danish and Swedish counterparts do not (Stochkendahl et al, 2018).

The UK government has recently stated its commitment to start development work to legislate for the extension of fit note certification powers to other healthcare professionals, and to develop a set of competencies for those completing fit notes (DWP and DoH, 2017). It is also exploring the use of the AHP H&WR as an alternative to the fit note. This is a considerable commitment; extending certification would require legislative change and has the potential to impact significantly on occupational therapy practice across the UK. Sickness certification is a huge task; over a 3 month period alone, over 1.3 million certificates were issued by 61.2% of GP practices in England in 2017 (NHS Digital, 2017). This shift has been welcomed by the Royal College of Occupational Therapists and is unquestionably an exciting opportunity to cement the role of

occupational therapy in the work and health arena. However, there are questions regarding the ability of occupational therapists to meet this challenge in the shorter term.

There is a lack of evidence concerning the use of the AHP H&WR in practice; studies have indicated that as yet there is limited awareness or use of the document among occupational therapists and that many therapists lack confidence in communicating with patients and other stakeholders regarding fitness to work (Coole et al., 2013; Coole et al., 2014; McBean & Lebedis, 2017). There have been two studies aimed at training occupational therapists in AHP H&WR use. The first, conducted by the Fife Mental Health Occupational Therapy Service for NHS Fife in 2014 (personal communication) comprised an e-learning module to develop occupational therapy staff understanding of the AHP H&WR and assist in developing their skill in using the form. However, it is unclear how the e-learning tool was designed and the module was completed by a convenience sample of twelve occupational therapists working in a mental health service. Feedback suggested that staff considered the AHP H&WR to be a useful tool but wanted greater knowledge in its use, and how to apply it to their current patient populations. By the end of the study the authors reported that there had been only limited application of the e-learning module to clinical practice. The second study was part of a project conducted by healthWorks for NHS Grampian between 2015 and 2017 (personal communication). The training comprised a 90 minute profession-specific, but not condition-specific, workshop, attended by a total of 206 AHPs (occupational therapists, physiotherapists and podiatrists). However, the impact of the training was unclear due to a limited response rate to post-training questionnaires and, although verbal feedback was reportedly positive, some attendees considered the training covered too much in too little time. One of the largest barriers was the participating therapists not having an appropriate caseload and consequently six months later only two of twelve respondents reported having completed an AHP H&WR. Additionally, in a recent study of group training for UK occupational therapists in delivering vocational rehabilitation to patients with traumatic

brain injury (Radford et al., 2018) one of the greatest learning needs identified by the participants concerned fit notes and AHP H&WR (Holmes et al., 2016). These findings indicate an urgent need to investigate the learning needs of occupational therapists in completing the AHP H&WR, and the fit note, and how these might best be met.

Interactive multimedia Reusable Learning Objects (RLOs), a type of on-line training, may be an inexpensive and accessible means of delivering training to occupational therapists on fit note and AHP H&WR completion. RLOs are small, discrete, self-contained web-based resources consisting of a mixture of multimedia elements such as audio, text, images and video and which engage the learner in interactive learning through the use of activities and assessments (Windle et al., 2011). An example of a healthcare RLO can be seen on the University of Nottingham's Health and E-Learning team's website (University of Nottingham, Health and E-Learning team).

Although there is limited research literature regarding the use of RLOs in occupational therapy they have been widely implemented in healthcare education, including nursing, pharmacy, and physician assistant programmes (Ferguson et al., 2016, Konstantinidis et al., 2017). 'ASPIRE' is a well-used and validated tool within the development of RLO's (Windle et al., 2016). The 'ASPIRE' framework enables a 'community of practice' developmental approach (Wenger, 2007) consisting of experts and learners who together identify learning needs, supported by instructional designers and multi-media developers. An RLO can become an open educational resource under a Creative Commons License enabling the reusability of the resource. Licensing models, such as Creative Commons, allow the owner of the material to distribute RLOs freely for use whilst retaining the ownership. There is therefore huge potential to harness the use of RLOs in this area. Yet although RLOs have much to recommend them in terms of cost and practicality, the current gold standard training for Health Care Professionals (HCPs) is, and has been, face-to face group-based workshops (Beidas et al., 2010). A recent systematic review and meta-analysis (Richmond et al., 2017) has concluded that on-line

methods may be as effective as alternative methods for training HCPs, but that the evidence is of poor quality and more robust research is needed.

The aim of this study is to compare face-to-face group training in AHP H&WR completion with a newly designed purpose-built on-line resource (RLO) by testing the delivery, acceptability and impact of both training packages. We will also explore the feasibility of recruitment.

The primary objective will be to measure:

- Acquired knowledge and confidence in fitness for work certification and application to practice.
- Usability of the group and on-line training.
- The extent to which the RLO is accessed, and geographical spread of responders.

The secondary objective will be to measure the rate and ease of recruitment, and retention of participants in the study.

## ***Design***

This is a mixed-methods multi-centre study with two distinct but related phases.

In phase 1, a series of participatory design workshops approach will draw together the theoretical principles of the fit note and AHP H&WR with a practical framework for RLO development. In addition a standardised face-to-face group-based training session will be developed based on the same content as the RLO. Both tools will undergo pilot testing.

In phase 2, a feasibility study will be conducted in which occupational therapists will attend either a face-to-face group training session, or access the RLO to explore the

acceptability and delivery of the intervention, and recruitment and retention of participants (Medical Research Council, 2006).

The RLO will then be released as an open educational resource to qualified occupational therapists and further evaluated through an on-line feedback form. Participants will not be formally recruited.

## **Methods**

Ethical and governance approvals will have been obtained from the Health Research Authority and University of Nottingham Faculty of Medicine and Health Sciences Research Ethics Committee.

An expert panel will be convened to include those with direct experience of training occupational therapists and other healthcare professionals in completing fit notes and AHP H&WRs, and in delivering vocational rehabilitation. This will comprise 6-8 experts from occupational therapy practice and research, occupational medicine and occupational psychology, who will meet as a group with the research team to help identify and agree the training objective of the resources. They will be also be invited to comment on the RLO during its development, using an on-line form. The research team will summarise the feedback and use it to inform the development of the RLO.

## **Data Collection and Outcomes**

### ***i. Phase 1 – development of RLO and Face-to-Face training session***

RLO: A group of 4-6 NHS occupational therapists will be recruited from the Nottinghamshire/Derbyshire/Leicestershire area to form a target RLO 'learner group'. Purposeful sampling will be used to ensure that participants represent a range of healthcare settings and conditions treated. Potential participants will be approached in the following ways:



1. Written invitation to the Trust's lead occupational therapy manager to disseminate information to their staff
2. Professional networks and contacts of the research team
3. The study twitter account

Therapists will be eligible if they:

- Have been practicing at least half-time for a minimum of two years post qualification
- Are currently treating patients who are, or have been in paid employment within the previous six months
- Have not previously completed an AHP H&WR or attended/accessed previous training in its use

The ASPIRE (Aims, Storyboarding, Population, Implementation, Release, and Evaluation) framework will be used for RLO development (Windle et al, 2016). The framework corresponds to distinct steps for RLO participatory creation including content scoping within a team meeting; iterative storyboard sessions with stakeholders; creation of the RLO specifications; iterative review of the specifications and specification adjustment; technical development of the RLO; iterative review of the developed RLO and RLO adjustments; and use and evaluation of the RLO.

Two participatory workshops will be held with the learner group facilitated by HELM (Health E-Learning and Media) team at the University of Nottingham to scope the outline and create the specification of the resource using large wipe-able storyboards.

This iterative process will result in a detailed RLO specification. RLO specification will be developed using an in-house HELM tool, and will go through a quality control process in the form of peer review by an expert panel and representatives from the target learner group, before the technical development of the RLO begins. The specifications are representative of what the final RLO will contain in terms of content and interactive

multimedia. After the development, a second peer review stage takes place, this time focusing more on the representation of the content and the technical aspects of the RLO, rather than the content itself. It will then be released for piloting by the RLO learner group.

Face-to-face training: A second group of 4-6 NHS occupational therapists will be recruited using the same methodology and criteria as before. The content and format of the face-to-face training session will be developed through two participatory workshops held with the learner group facilitated by HELM, based on the ADDIE (Analysis, Design, Development, Implementation, Evaluation) model (Morrison, 2010). ADDIE is a standard procedure and method used by instructional designers and training creators to develop effective and efficient training and is considered to be the most commonly implemented model in this field.

The training session will then be pilot tested with the second learner group. The pilot training will be delivered by a member of the expert panel.

Feedback and evaluation for both learning methods will be collected via individual semi-structured telephone interviews with occupational therapists participating in the RLO learner group and the face-to-face learner group. The learner groups will be instrumental in contributing to the development of the interventions. It will be important to ensure that the interventions are acceptable to the learner groups, and meet their ideas, suggestions and expectations before further testing with a wider group of therapists in Phase 2.

Interview topics will include whether the training has met the participants' expectations, what they liked or did not like, how the training could be improved.

The research team will also collect feedback through HELM's RLO evaluation toolkit (Wharrad et al., 2008) and learning technologists who have not been included in the

development. Based on the findings, further revision will be made to the RLO and face-to-face training session as required.

***ii. Phase 2 – feasibility study***

A further sample of 30 occupational therapists will be recruited to a feasibility study from NHS Trusts in the East Midlands region representing a diverse range of services i.e. hospital, mental health and community trusts. There is little published guidance on the required sample size for a feasibility study, which can vary from 10 – 300 participants (Billingham et al, 2013). The research team decided that 30 would be the minimum needed to meet the study objectives within the resources of the study.

Purposeful sampling will be used to ensure that participants represent a range of healthcare settings and conditions treated. Therapists will be eligible if they:

- Have been practising at least half-time for a minimum of two years post qualification
- Are currently treating patients who are, or have been in, paid employment within the previous six months
- Have not previously completed an AHP Report or attended previous training in its use

Fifteen occupational therapists will attend one of two face-to-face workshops, each with 6-8 participants, and fifteen other occupational therapists will complete the RLO.

Participants will be allocated on a first-come first-served basis. The two face-to-face training workshops will be delivered by a member of the expert panel.

All participants will complete a study questionnaire approximately one week before commencing training. Pre-training data will be collected on perceived knowledge and understanding of the AHP Report and the fit note, perceived confidence in completing an AHP Report, and demographic data including conditions treated, clinical setting, professional banding, years worked since qualification. Post-training questionnaires will

be completed at one week to measure perceived knowledge and understanding of the AHP Report and the fit note, perceived confidence in completing an AHP Report, and their views on the training they received. Post-training questionnaires will be completed again at eight weeks to measure perceived knowledge and understanding of the AHP Report and the fit note, perceived confidence in completing an AHP Report, and the number of actual AHP H&WRs completed. All participants will then be invited to take part in a telephone interview to share feedback on the training and will be specifically asked about their experiences and recommendations for improving the intervention.

The RLO will then be released as an open educational resource to HCPC registered occupational therapists and further evaluated over a period of three months.

Occupational therapists will be approached through a variety of means including RCOT Specialist Sections, NHS Health & Work Champions, social media, OT News, snowballing etc and invited to complete the RLO and evaluate it through the inclusion of an online feedback form. Respondents will be asked to provide their postcode.

### ***Informed consent***

All participants in Phases 1 and 2 will provide written informed consent.

When the RLO has been released as an open access resource, completion of the RLO and the feedback form will be taken as informed consent.

Participants may be withdrawn from the study either at their own request or at the discretion of the Investigator. Participants will be made aware (via the information sheet and consent form) that should they withdraw, the (anonymised) data collected to date cannot be erased and may still be used in the final analysis. Participants who withdraw will be replaced where possible.

### **Analyses**

## ***Analysis and evaluation***

Qualitative interview data will be analysed thematically (Braun & Clarke, 2006). Both Phase 1 and Phase 2 interviews will be directed by a topic guide. Interviews will be recorded and transcribed by two members of the research team who will both read all transcripts, conduct initial coding of the first 2-3 interviews independently then review and agree the codes before coding the remainder. The researchers will identify and agree themes which are likely to closely match the topic guide, however others may also be identified as a result of the interview process. The transcripts and findings will not be checked back with the interviewees.

Evaluation of the effectiveness of the RLO and face-to-face training in Phase 2 will be undertaken through the following indicators, drawing on the methods used in a previous study by Bath-Hextall et al (2011):

### a) Acquired knowledge and application to practice

Participants' knowledge and understanding of the AHP H&WR and fit note, and confidence in AHP H&WR completion will be measured through self-report pre-and post-training, and rated using Likert scales. Acceptability of the training will be measured through self-report using Likert scales, open text comment, and interview data.

Descriptive statistics and frequency tables will be calculated. Broad comparisons will be made between the two groups to identify any differences relating to acceptability, knowledge and confidence. As qualitative and quantitative data are being collected, the principles of integration of mixed methods research will be followed (O'Cathain, 2015). The narrative approach to integration will be used to describe the findings in a single report. This approach can include 'weaving' the findings together according to theme or concept, reporting qualitative and quantitative results in different sections ('contiguous')

or reporting the results of each step separately ('staged') (Fetters et al, 2013). As this is a multi-staged mixed methods study, the latter is the most likely strategy that will be used.

If appropriate, between-group responses will be compared using the Mann-Whitney test with the significance level set at  $p < 0.05$ . To be effective, the RLO would have the same or better outcome evaluation than the face-to-face training.

b) Usability

Participants' ratings of the attributes (educational value, learning support, flexibility and control, usability and media attributes) of the RLO will be measured in Phases 2a and 2b through self-report using Likert scales through an integrated on-line evaluation form.

The RLO would require a minimum of 70% on average user satisfaction to demonstrate fitness for rapid adoption.

c) RLO-use data analysis

To inform breadth and depth of uptake of the RLO in phase 2b we will also collect data on:

- Number of tracked site/page visits
- Average time per visit per webpage for content pages
- Number of return users
- Access area

Data will be analysed descriptively

***Sample size and justification***

The sample size for both phases has been determined by the research team and relevant literature as being of sufficient size to develop and test the training tools (Morse, 2000; Sim and Lewis, 2011)

***Study management and service user involvement***

The Chief Investigator will have overall responsibility for the study and shall oversee all study management. A study steering group, comprising the co-investigators, two service user representatives, a GP, an employment sector representative and a physiotherapy representative, will oversee the study.

## **Discussion**

The study will make significant contributions to the debate around appropriate training methods in advising on fitness for work. It will also have important implications for the future completion of AHP H&WRs by occupational therapists, including the impact on staff roles and responsibilities, student curricula, professional competencies and supervision, departmental resources, and professional standing and recognition both nationally and internationally.

The anticipated outcome of this research will be to produce a robust on-line learning resource and face-to-face workshop format for occupational therapists in completing AHP H&WRs. It will also raise awareness of the AHP H&WR at a time when the government is urging health professionals to actively support their patients in remaining in, and returning to work.

Our research proposal will also lay the foundations for future research to further evaluate the effectiveness and cost-effectiveness of the on-line resource when compared with face-to-face training, and the feasibility of these methods in training other healthcare professionals such as physiotherapists.

Since the CREATE study was conceptualised, at least two further research studies are now evaluating the use of the AHP H&WR by occupational therapists. These have received Challenge Funding from the Department for Work and Pensions and the Department for Health and Social Care. The occupational therapists are based in GP surgeries and are using the AHP H&WR in their provision of vocational rehabilitation and

case management to support people in their return to work (OT News, 2019). The findings from these studies will further advance the evidence base for the AHP H&WR.

### ***Study limitations***

This study is not designed to demonstrate the impact of training on the quality or effectiveness of AHP H&WR completion. Also, it is a feasibility study without randomisation, and the participants may have a preference for a particular method of training which may influence the findings. We are at an initial stage of researching a complex intervention and our primary aim was to establish if we could recruit sufficient participants to deliver and compare the intervention. If this is attainable, it would be appropriate to further test the interventions using a larger, randomised sample.

Furthermore, they are likely to be those with an interest in advising patients on fitness for work and may be biased in their attitudes to the training. There is also a possibility that occupational therapists will not have the opportunity to complete an AHP H&WR during the timeframe of the study. Further research might consider asking participants to report how many patients with work problems the participants treated in the study period, to enable the authors to identify the percentage of patients with a completed AHP H&WR, and to explore why AHP H&WRs were not completed for all, in order to provide a more accurate picture of uptake. However, a valid and reliable method of recording this data would be required.

Finally, the UK government's plans for the future completion of fit notes and AHP H&WRs have not yet been formally established and may change.

### ***Study status***

This is an ongoing study. The first participant was recruited on 4<sup>th</sup> December 2018. At the time of preparing this manuscript, Phase 2 is underway. The study is due to finish in November 2019.



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## **Research ethics**

Ethical approval was gained from the Health Research Authority (19/HRA/0377), 2018 and the University of Nottingham Faculty of Medicine and Health Sciences Research Ethics Committee (128-1810), 2018.

## **Declaration of Conflicting Interests**

The authors declared no potential conflicts of interest with respect to the research, authorship and/or publication of this article

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## **Contributorship**

Carol Coole, Stathis Konstantinidis, Kate Radford, Louise Thomson, Sayeed Khan and Avril Drummond contributed to the concept and design of the work. Carol Coole wrote the first draft of the manuscript which was revised and approved by all other authors.

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