



Learning disability and autism training for health and care staff

A consultation

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Contents

Foreword by Caroline Dinenege	2
Oliver's story	4
1. About this consultation	6
2. The content of training.....	8
3. Staff roles and training	16
4. Delivering training.....	19
5. Involving people with a learning disability and autistic people.....	23
6. Mandating training.....	26
7. Monitoring and evaluating impact.....	30
8. Costs and benefits.....	33
Appendix. The Learning Disabilities Core Skills Education and Training Framework	35

Foreword by Caroline Dinenage

It's a sad truth that, in this role, I have heard many distressing stories about how care and treatment has been experienced by people with learning disabilities and autistic people, in some cases resulting in the worst possible outcomes. Stories I have heard like Oliver McGowan's - recounted by his mum, Paula, below, make me feel both desperately sad and extremely determined. Sad at the dreadful outcome for Oliver and his family; and determined to make care and outcomes better for some of the most vulnerable people in our communities. This means doing what I can to equip NHS and social care staff to understand how to care for all individuals and their families, including by making reasonable adjustments in their care for those with learning disabilities and/or autism. Paula's petition and tireless campaigning for mandatory learning disability and autism training for all health and care staff is a huge inspiration.

I have no doubt that, in nearly all cases, professionals want to do their very best for people and act with their best interests in mind according to established procedures and protocols. But that doesn't stop things going wrong, or mean that we can't do better with appropriate training and knowledge. We should be rightly proud of the very high standards of care that the NHS provides in most cases, and a workforce that has the best interests of the public at heart. Yet we have to equip them with the skills and knowledge to support people with a learning disability and autistic people appropriately.

Mencap's survey for their 'Treat me well' campaign found that almost half of staff responding thought that a lack of training on learning disability might be contributing to avoidable deaths and two thirds would like more training focussed on learning disability. What's more, Mencap's evaluation in 2017 of their Learning Disability Awareness Training for Healthcare Professionals found that after training, 98% of attendees agreed that they were motivated to change their practice.¹

The difference in life expectancy for people with a learning disability and those without is stark - according to the latest data (in 2017-18), females with a learning disability had a life-expectancy 18 years lower than those without (65, compared to 83); males had a life-expectancy 14 years lower (66 compared to 80).² The Learning Disabilities Mortality Review Programme's Second Annual Report, published last May, showed that, in a significant proportion of deaths of people with a learning disability that were reviewed, the individual's health was adversely affected by factors that were avoidable, and the Report recommended that training would help to improve outcomes.³

I am deeply determined to ensure that we learn from what has happened in cases like Oliver's, and do everything we can to improve outcomes and, potentially, save lives. That is why we committed to consulting on proposals to introduce mandatory training in our response to the Report's recommendations and that's why in response to Paula's petition

Learning disability and autism training for health and care staff. A consultation

we have broadened the proposed scope of that training to include autism as well as learning disability awareness. I hope that we get a wide range of responses to this consultation, including those with lived experience of learning disability or autism and their families and friends, to ensure we get this right.



Caroline Dinenage

Minister of State for Care

Oliver's story



Oliver McGowan, by his mother Paula McGowan

Oliver had mild cerebral palsy, partial seizures and a mild learning disability as a result of having meningitis as a baby. He also had high-functioning autism. His disabilities did not hold him back. He played for the South-West and North-West Centre of Excellence FA cerebral palsy England Development football squads; he was a registered athlete with the Power of 10 British Athletics initiative and was ranked 3rd best in the country at running 200 metres. He was a natural leader and became a prefect and member of council at School and college, attaining several GCSE and BTEC qualifications. He went on to attend National Star College in Cheltenham. Oliver loved life and life seemed to love him. He was incredibly popular amongst his peers. On 11 November 2016, aged just 18, Oliver died a horrific premature and, we believe, avoidable death.

Oliver had not been diagnosed with having a mental illness, but had previously been given anti-psychotic medication to control his anxiety when in seizure. This medication caused him to have a significant increase in seizures, and to feel physically and mentally unwell. Consultants had written that Oliver was sensitive to anti-psychotic medications due to his previous reactions.

In October 2016, aged 18, Oliver was admitted to an adult hospital having partial seizures. He was conscious throughout and was very scared and anxious. Accident and emergency staff were presented with Oliver's Hospital Passport detailing how his autism and learning disability affected him, and how to make reasonable adjustments. It also detailed his sensitivities to anti-psychotic medications. This was not read or acted on.

Oliver had said to the ambulance staff he did not want to be given anti-psychotic medicine, giving a clear rationale, stating 'they mess with my brain and make my eyes go funny' (referring to oculogyric crisis). He said this again in the hospital to the doctors treating him.

A few days later, Oliver was given anti-psychotic medication in anticipation should Oliver become anxious when sedation was stopped. We are clear that this was against Oliver's

and our strong wishes. Oliver never woke up: the medication caused him to develop Neuroleptic Malignant Syndrome (NMS). His brain swelled so badly it was bulging out of the base of his skull causing irreversible brain damage. We were told he would be paralysed, blind, with no communication or memory, tube-fed and reliant on a tracheotomy. We were asked to turn Oliver's life-support machines off and he died on Armistice Day, 11 November 2016.

If the doctors and nurses had been trained to understand how to make reasonable adjustments for Oliver as a person with autism and a mild learning disability, I believe they would have known how to adapt the environment to meet his needs. I believe they would have known how to adapt their communication, using humour to settle his anxiety in a crisis, and de-escalate the situation further.

I believe that ignorance of learning disability and autism cost Oliver his life, and we must never allow this to happen again. Mencap's Treat me well campaign report states that one in four doctors and nurses has never had any training on learning disability. This is unacceptable and that is why I have campaigned tirelessly for all NHS staff to receive mandatory training in autism and learning disability, launching a petition for all doctors and nurses to receive appropriate training which would have saved Oliver's life. The text of my petition is below.

'My son Oliver was only 18 when he died in hospital on 11 Nov 2016. I believe his death could have been prevented if his doctors and nurses had received mandatory training. He had autism and a mild learning disability, and they weren't trained to understand how to make reasonable adjustments for him.... The Government must ensure all healthcare professionals get mandatory training to address the huge health inequalities facing people with autism and a learning disability.'⁴

I believe the training should be named after Oliver. His story captures exactly why all NHS staff need autism and learning disability training. Oliver was a teenager people can relate to, and his face gives the training a human identity and challenges subconscious beliefs about what people with additional needs look like. His death serves as a constant reminder of why this change is so urgently needed.

1. About this consultation

- 1.1 This consultation considers how we can ensure staff working in health and social care have the right training to understand the needs of people with a learning disability and/or autism and the skills to provide the most effective care and support. All staff can make a difference to the health and wellbeing outcomes of people with a learning disability and autistic people. The 2nd annual report of the Learning Disabilities Mortality Review Programme (LeDeR) recognised this in its sixth recommendation: that mandatory learning disability training should be provided to all staff, delivered in conjunction with people with learning disabilities and their families. The Government published its response to the report on 12 September 2018. In response to recommendation six, the Department of Health and Social Care committed to consulting on mandatory learning disability training for all relevant staff.

'While in principle employers are required to ensure that their staff have the core skills and knowledge to care for, treat and support people with a learning disability, the LeDeR report and campaigns such as Mencap's Treat me well, demonstrate that in practice this isn't always the case....But persistent inequalities have endured for some of our most vulnerable citizens for too long. For this reason, we will consult on options for delivering mandatory learning disability training for all relevant staff. Consultation will take place with people with lived experience, the wider learning disability sector, NHS and social care providers and the general public to ensure that proposals are practicable and effective and to avoid any training becoming a 'box-ticking exercise'.⁵

- 1.2 Paula McGowan's petition is a further inspiration for the proposals set out in this consultation and for the extension of the scope of mandatory training to include autism and learning disability. There is still a process ongoing to review and learn from the circumstances of Oliver's death which is why this document does not comment on what could have been done differently in that individual case. The Coroner's inquest into Oliver's care found that the anti-psychotic medication in question was properly indicated and prescribed. However, we recognise the weight of opinion that better awareness of autism and learning disability, and of how to reasonably adjust care could have a profound effect, certainly improve experiences and potentially save lives.
- 1.3 There are many similarities between the challenges faced by an autistic person, and a person with a learning disability in accessing health and social care. People with a learning disability and autistic people alike will benefit from staff making reasonable adjustments to working practices. Training needs to be clear on the differences between learning disability and autism and elements of need which are

specific to each. Autism is used in this document to refer to any Autistic Spectrum Condition. Please note that the consultation relates to England only.

1.4 In each section of the consultation there are numbered questions to answer. We would also welcome general comments on any issue which people feel is relevant to improving the training of staff in supporting people with a learning disability or autistic people.

1.5 Responses (including both answers to the numbered questions and more general comments) can be made online

https://www.gov.uk/government/publications?departments%5B%5D=department-of-health-and-social-care&publication_filter_option=consultations

The consultation will run until 12th April.

1.6 All responses are confidential. You can choose to make an anonymous contribution, or you can give your details (or those of the person or group on whose behalf you are responding). We would like to be able to quote people's comments in the Government response to illustrate key points. If you are happy for us to do this, please indicate this on the form. You can remain anonymous and still agree to your comments being quoted.

1.7 An easy read version of this document is available on the GOV.UK website.

1.8 If you do not wish to submit your response online, a Word© form with all the key questions from this document is also available and can be requested from trainingconsultation@dhsc.gov.uk Responses and questions can also be sent to this e-mail address.

1.9 Submissions may also be made by post to:

Dementia and Disabilities Unit,
1N14, Department of Health and Social Care,
Quarry House, Quarry Hill
Leeds
LS2 7UE

1.10 The Department will consider all submissions and, if necessary, consult further with key organisations or groups. A Government response will be published in summer 2019 and published on GOV.UK. An easy read version of the response will also be made available.

2. The content of training

The Learning Disabilities Core Skills Education and Training Framework

- 2.1 The Learning Disabilities Core Skills Education and Training Framework 2016 identifies the different levels of skills and knowledge staff need to support people with a learning disability. We consider that the content of any mandatory training should ensure that staff attain the learning outcomes which they need for their role. The Framework is currently under review, to ensure the categories are particularly relevant to people's specific role rather than to their staff group, but the three-tiered approach will not change.
- 2.2 Staff working in roles who do not interact with service users, such as cleaners, laboratory technicians, maintenance staff and administrative workers, would not need training in learning disability and autism. In relation to children and young people, those requiring training would be those providing health services (or directly supporting the provision of health services), or providing personal care for those unable to provide it for themselves (due to illness or disability), and which is provided in a place where those persons are living at the time the care is provided, as defined in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.⁶ This consultation will not cover staff in educational settings, children's residential care, or foster carers.
- 2.3 The priority should be all staff who have contact to provide care, and they will need different levels of training, based on their role.
- 2.4 The Framework's three Tiers of skills and knowledge are:
- Tier 1 - for roles that require general awareness of learning disabilities. This would include ancillary staff who may occasionally work with those with learning disabilities or autism, such as drivers and porters, and staff with occasional support roles. These staff will largely be non-clinical, but not everyone in a non-clinical role would be in this Tier.
 - Tier 2 - for roles that will have regular contact with people (children, young people and adults) with a learning disability, and whose interaction has a fundamental impact on the quality and type of care they receive. This will include all clinicians, people providing direct support to people with a learning disability (e.g. support workers), and key personnel in roles which facilitate access to care, such as

receptionists who play a pivotal role as gatekeepers to services, and information providers.

- Tier 3 - is the knowledge and skills which the Framework indicates should be held by staff working intensively with people with learning disabilities, either directly providing care and support for people (children, young people and adults) with a learning disability, or in taking a lead role in decision making. These are those in more specialised roles, and we would anticipate that the requirements of Tier 2 would be the minimum level of training for this role, supplemented by professional training and development appropriate for the specialised nature of their role. In most cases, the specialised training needed to distinguish from Tier 2 is provided in pre-registration training (e.g. for example, the extensive training in learning disability received by learning disability nurses).

2.5 One way in which Tier 3 might be distinguished from Tier 2 could be their role as practice leaders and champions, helping to train other staff within an organisation. However, there is no reason why a member of staff in Tier 2 could not train colleagues.

2.6 Note that a job title or qualification would not necessarily be a clear indicator of which Tier of skills and knowledge a member of staff requires: it would depend on the way in which a person supports people with a learning disability.⁷ Any assessment of a person's training needs should be based on an assessment of their role. Appendix A gives further details on the three Tiers of the Framework.

2.7 We expect that training in relation to autism would have significant overlap with training on learning disability: there is common ground in the need for understanding legislation, how to make reasonable adjustments, appropriate methods of communicating, and of supporting people to make decisions, and ensuring an appropriate and supportive environment.

2.8 There is already an expectation in the statutory guidance for the Autism Act that local authorities and NHS organisations should ensure that those working in health and social care will have not only general autism awareness training but different levels of specialist training for staff in a range of roles, where this is needed to fulfil their responsibilities and for those who wish to develop their knowledge of autism. We are keen to build on this.

Excerpt from Statutory guidance for Local Authorities and NHS organisations to support implementation of the Adult Autism Strategy (2015)

Local Authority, NHS bodies and NHS Foundation Trusts should:

- Ensure autism awareness training is included within general equality and diversity training programmes for all staff working in health and care;
- Ensure that all autism awareness training enables staff to identify potential signs of autism and understand how to make reasonable adjustments in their behaviour, communication and services for people who have a diagnosis of autism or who display these characteristics;
- Ensure that there is a comprehensive range of local autism training that meets National Institute for Health and Care Clinical Excellence (NICE) guidelines for those staff who are likely to have contact with adults with autism;
- Ensure those in posts whose career pathways are highly likely to include working with adults with autism (for example, personal assistants, occupational therapists, residential care workers, frontline health staff including all GPs and psychiatrists) have demonstrable knowledge and skills to:
 - Use appropriate communication skills when supporting a person with autism;
 - Support families and friends and make best use of their expert knowledge of the person;
 - Recognise when a person with autism is experiencing stress and anxiety and support them with this;
 - Recognise sensory needs and differences of a person with autism and support them with this;
 - Support the development of social interaction skills;
 - Provide support with transitions and significant life events;
 - Understand the issues which arise from co-occurrence of mental ill health and autism.
 - Support people with autism to gain and maintain employment (where appropriate);

- Ensure those in posts who have a direct impact on and make decisions about the lives of adults with autism (including, for example, psychiatrists, those conducting needs assessments) also have a demonstrable knowledge and skills in the areas listed above as well as a good understanding of:

- How autism may present across lifespan and levels of ability, and are defined and diagnosed, and the relevant pathways and screening tools;

- The common difficulties faced by individuals on the spectrum and their families/carers, including social and economic hardship;

- Developmental trajectory of autism;

- The impact of autism on personal, social, educational and occupational functioning, and interaction with the social and physical environment;

- Current good practice guidelines (e.g. NICE Quality Standard) and local diagnostic and care pathways;

- Current good practice guidance with respect to an individual with autism's capacity to assess risk;

- Available guidance for good practice in post-diagnostic support and intervention.

2.9 Health Education England is leading development of an Autism Core Competency Education and Training Framework, which is due to be completed in mid-2019. Our expectation is that this will provide a framework complementary to the Learning Disabilities Core Skills Education and Training Framework, setting out different levels of skills and competencies needed specifically to meet the needs of autistic people. We would envisage that this will inform the content of training, and local determination of the appropriate level of training needed by staff in autism awareness.

2.10 Initial discussions with people with a learning disability and autistic people, and with organisations which represent them, identified knowledge and skills in three inter-dependent categories which are fundamental to providing effective support to people with learning disability: understanding learning disability and autism, legislation, and making reasonable adjustments. These are described below.

Understanding learning disability and autism

2.11 Understanding the different types of learning disability and the impact they have on someone's life can help staff determine what adjustments they might need to

make in their practice. For autism, the wide range of needs of people with different profiles of autism can be highlighted.

- 2.12 From the LeDeR reviews carried out to date, we know the challenges which people with a learning disability face in accessing health services can lead to wholly avoidable hospitalisation, life-threatening illness, and premature death resulting from routine conditions. Social care staff may be familiar with how to support a person with a learning disability, but unfamiliar with the presentation of common health conditions. People with a learning disability can experience a range of health conditions such as issues with mobility or sensory impairment, and may face health risks, such as dental problems, obesity and diabetes. It is essential that all staff supporting people with learning disabilities receive specific training in understanding the needs of people with a learning disability. It is also essential that training provides sufficient recognition of the specific needs of children and young people with a learning disability, and the challenges of development and transition to adulthood.
- 2.13 Training must challenge implicit or unconscious attitudes, which might have led staff to fail to spot key symptoms, or to ignore key information given by an individual or their family or carer. 'Diagnostic overshadowing' - where a clinician's perception of a disability influences their clinical judgement, and where symptoms of physical or mental ill health are misdiagnosed - can be avoided through increased awareness of how people with a learning disability may present, and a knowledge of good clinical practice in supporting a person with a learning disability or person who is autistic. Clinicians should ensure that they seek the right information to inform judgement, either from the individual, or their family or carer. Particular attention could be paid to the hidden nature of autism, and the importance of avoiding assumptions based on first impressions, enabling staff to recognise that the right attitudes and behaviour of professionals are key to influencing a positive culture of care.

Legislation and rights

- 2.14 Knowledge of the fundamental rights of people with a learning disability or autism, and how these can be translated into action, would be an essential part of training.
- 2.15 The Equality Act 2010 places a legal duty on services to make reasonable adjustments for people with a disability so that when accessing services, they are not put at a substantial disadvantage compared to people without a disability. All service providers are required to do this on a case-by-case basis and failure to comply could constitute discrimination under the Act. The duty is also anticipatory: providers need to think about what sort of reasonable adjustments can be made and how they are provided before needed, a point especially relevant in a health

setting where adjustments may need to be implemented quickly according to need. Training should focus on the skills to implement these adjustments. Examples include staff meeting the specifications of the Accessible Information Standard,⁸ and staff recognising the value of contributing to a culture of valuing people's views and concerns, embodying the principles of Ask, Listen Do.⁹

- 2.16 The Human Rights Act 1998 incorporates the European Convention on Human Rights, which includes, under article 2, everyone's right to life. The British Institute for Human Rights has developed materials for professionals and people with a learning disability on how rights should be protected, which could be used in training.¹⁰
- 2.17 One of the most important pieces of legislation for people with a learning disability or autistic people is the Mental Capacity Act 2005 (and associated legislation), which is fundamental to the ability of an individual to consent, and has implications for implicit attitudes, advocacy and Do not attempt to resuscitate (DNAR) notices. Any care giver who may need to determine capacity, or act in response to such a decision, would need to be fully aware of the Act and its implications, e.g. registered medical practitioners, clinicians, managers, approved mental health professionals, local authorities and staff.
- 2.18 We would expect that in addition, the training should educate staff in the practical application of:
- The Mental Health Act 1983 and accompanying Code of Practice: the statutory rules for admission as a mental health inpatient, either voluntary or involuntary.
 - The Children and Families Act 2014, and its accompany Code of Practice: the statutory framework for health, education and social care services to work together to support children and young people who have special educational needs and disabilities (SEND).
 - The Autism Act 2009, and how the Government's Adult Autism strategy relates to health and social care, with particular reference to the requirements relating to autism training and what it should cover.

Making reasonable adjustments

- 2.19 Our proposal is that mandatory training should aim to develop the practical skills of the workforce, and ensure reasonable adjustments are made to improve the way people with a learning disability and autistic people, of all ages, are supported. The General Medical Council's (GMC) Good Medical Practice requires of doctors: 'You must consider and respond to the needs of disabled patients and should make

reasonable adjustments to your practice so they can receive care to meet their needs'.¹¹ Reasonable adjustments include:

- **Communication:** understanding the varied abilities of people with a learning disability or autistic people to communicate, and making information accessible to them through use of appropriate, jargon-free language, visual aids such as photo symbols, Books Beyond Words and similar pictorial journeys through what is planned and allowing adequate time for a consultation (e.g. by having a double appointment).
- **Environment:** provision of a supportive environment e.g. without distractions for either staff or service users, to minimise anxiety of people with learning disability or autistic people. Autistic people may be sensitive to aspects of the environment such as ambient noise, crowds, and bright lights.
- **Personalisation:** staff need to value the knowledge and views of someone with a learning disability or an autistic person, and their families and carers, particularly in being supported to make choices. Passports which summarise critical information about an individual's needs must be recognised by all staff as containing valuable information.
- **Good practice:** training should reinforce best practice and encourage professionals to challenge long-standing practices. Examples include the stopping of over-medication with psychotropic medicines (STOMP),¹² reducing the need for restrictive interventions,¹³ and Positive Behaviour Support.

Case study: training in the Mental Capacity Act 2005

Mencap has developed a day-long course for health staff - doctors (including GPs), dentists, and nurses - to support an operational understanding of the Act. This is focused on practice, day-to-day issues so that clinicians understand issues relating to obtaining consent, and how to provide quality healthcare when a patient lacks capacity to consent to care or treatment.

The course considers the legal issues: the five principles of the Mental Capacity Act and how it links to the Equality Act 2010, and how to implement the Act: how to test capacity, best interest decisions, and some of the different elements of care on which the Act might impact, such as medication, resuscitation, less restrictive best interest options for people that lack mental capacity to consent to care or treatment. Similarly, the Social Care Institute for Excellence has a one-day course for senior staff and managers, to allow staff to have a clear understanding of the links between human rights, essential standards of

quality and safety and the Act. The training aims to ensure Mental Capacity Act principles are applied in managing care services, and to reflect and explore how human rights principles inform good practice when supporting people to make decisions.

We propose that the content of mandatory training includes:

- an understanding of what learning disability and autism mean for different individuals;
- the skills to support and care for someone with a learning disability or an autistic person;
- awareness of the statutory framework (e.g. the Human Rights Act 1998, the Mental Capacity Act 2005, the Equality Act 2010, the Children and Families Act 2014) and the rights of people with a learning disability and autistic people, and how these impact on the way support is provided; and
- autism, and highlights the differences between autism and learning disability, as well as how autistic people, and people with a learning disability can both benefit from reasonable adjustments. The Autism Core Competency Education and Training Framework will provide a basis for assessing what skills and knowledge staff in different roles will need, and can inform our implementation plan.

Our questions:

Q1. We have envisaged three main elements to learning disability and autism training: understanding learning disability and autism, legislation and rights, and making reasonable adjustments: do you agree? Should other elements be included?

Q2. Do you agree that awareness of how the Mental Capacity Act impacts on the way in which support is provided needs to be a significant part of training for all staff?

Q3. Are there additional elements which need to be covered by training on awareness of autism and the needs of autistic people?

3. Staff roles and training

- 3.1 The NHS is one of the largest employers in the world. NHS Trusts and Community Health Services in England employ (as of August 2018) 1.2 million staff, including 641,546 professionally qualified staff, from consultants to scientists and nearly four hundred thousand staff supporting clinical care.¹⁴ The number of adult social care jobs in England in 2017 was 1.6 million, with around 830,000 care workers.¹⁵
- 3.2 Anyone working in a role which contributes to the care and support of a person with a learning disability or an autistic person should have training to allow them to best meet their needs. Many staff will work regularly with people with a learning disability - for those aged 18-64, the most common reason for requiring long-term social care support in 2017-18 for example, was learning disability, accounting for 45% of clients.¹⁶
- 3.3 All staff must understand their own role in supporting the delivery of care and support to people with a learning disability and/or autism, and how they can change their practice. This needs to start with a recognition of the value of training. Even staff who regularly support people with a learning disability or autistic people may feel that because they have received some pre-registration training or training in an earlier role, that covers learning disability or autism, further training is unnecessary.
- 3.4 The proposal is to tackle this issue by ensuring that learning disability and autism training which meets a common standard is provided across all professions at the pre-registration stage. We expect that people who have a learning disability and/or autism will be involved in the delivery of the training. For staff already in employment who have not previously received any significant training, it must be made available in employment. The Learning Disabilities Core Skills Education and Training Framework - and, when completed, its counterpart for autism - should be used by all employers and staff in health and social care to make an assessment of the level of skills and knowledge needed to undertake a particular role.
- 3.5 The employer should then ensure that the training needed is undertaken, either as part of induction, or as part of continuing workforce development. A similar assessment would be undertaken periodically (and it could be a self-assessment, to inform continuing professional development, revalidation etc) to audit skills and practice, to determine if any further training was necessary, for refreshing skills and knowledge, or to reflect a change in role. Refresher training at foundation level should be repeated regularly.

- 3.6 Some staff may move to a new employer relatively soon after having completed training. Clearly, to avoid duplicating training already undertaken, it would be reasonable for them to be able to document the training they have undertaken, and use this as evidence for their new employer that they are compliant with any statutory or contractual requirements, through a certificate or training and skills passport. NHS Employers and NHS Improvement have been developing work on streamlining induction training, to ensure portability and avoid duplication which may help to inform also how we ensure portability of training. We propose that learning disability and autism training should be portable between health and care providers and will work with partners to ensure this can happen.
- 3.7 We will work with NHS Improvement to ensure that our proposals for staff training align fully with the recommendations of Baroness Dido Harding's workforce implementation plan for the NHS which is currently in development, and will be published later in 2019.

We propose:

- employers should assess the level of training needed for each member of staff, based on their role, using the three Tiers of the Learning Disability Core Skills Education and Training Framework, and when available the Autism Core Competency Education and Training Framework and have responsibility for ensuring that training is undertaken;
- the Department of Health and Social Care should consider what support employers might need in making this assessment - particularly smaller social care providers;
- training might be undertaken as:
 - part of pre-registration training;
 - induction on recruitment (where a member of staff could not demonstrate that they had undertaken the training e.g. as part of pre-registration training, or at another employer);
 - part of continuing workforce development;
 - apprenticeships (in health or social care).
- provision should be made for documenting training undertaken and standards attained (e.g. through a training and skills passport) to allow portability between different health and care employers.

Our questions:

Q4. Do you agree that the different levels of training should reflect the Learning Disability Core Skills Education and Training Framework (and in due course, the Autism Framework)?

Q5. We propose that individual employers should assess which level of training staff need and ensure that they get it. Do you agree?

Q6. What support might employers need in determining the appropriate level of training for a member of staff - e.g. a more detailed tool for assessment?

Q7. We do not propose that all staff should have face to face training; just those with roles which mean they will be in regular contact with people with a learning disability or autistic people in Tiers 2 and 3. Do you agree?

Q8. Should there be a standard form of documentation, to act as a training passport, portable between employers, indicating when and where training was undertaken, and documenting the specific skills developed?

4. Delivering training

- 4.1 Training of staff could take place at a number of points: for example, as part of academic training prior to registration; during postgraduate speciality-level training; as part of training for an apprenticeship in social care; or in employment (e.g. in induction or continuing workforce or professional development).
- 4.2 For staff undergoing pre-registration training, there are already standards and curricula which inform clinical training, such as the GMC's Generic Professional Capabilities Framework, and the sixty-five speciality-level curricula for doctors which royal colleges develop and which are endorsed by the GMC.¹⁷ These often set competencies in relation to disability and health inequalities but are usually high level.
- 4.3 Working with colleges and regulators, a common curriculum could be agreed which sets out what clinical education and training should cover to meet these standards. It could articulate expectations for both foundation-level and for Tiers 2 and 3. It would provide a clear set of expectations as to how training would meet existing high-level requirements in clinical standards in relation to learning disability and autism.
- 4.4 Ideally, we would aim to ensure that appropriate foundation-level training in learning disability and autism was undertaken as part of foundation level training for all clinical staff. The Academy of Medical Royal Colleges will be revising the foundation curriculum for doctors in 2019.
- 4.5 This would not only inform training prior to employment, but also set the standard for continuing professional development. For example, any clinician working in a Tier 2 role would have to recognise the need for training in learning disability and autism, in line with the common curriculum, as part of the general expectation of regulators that continuing professional development should cover the full scope of an individual's professional practice.
- 4.6 Employers would need to ensure that for staff in employment and new entrants, there was a suitable programme of induction training in learning disability and autism. There are currently a wide range of training materials and models available, e.g. as offered by Mencap and other voluntary sector organisations and those developed by the NHS. We propose that employers should have flexibility as to how they approach ensuring their staff are trained provided it meets standards. Co-production should be an important element. All employers will need to have some capability to train staff either on induction, or in post. This could be developed in-house, or with an appropriate independent or voluntary sector

partner, or purchased from a provider of training. The role of the commissioner here may be crucial in supporting face-to-face training sessions which could be accessed by health and social care providers for whom it would be uneconomical or impractical to establish their own training sessions.

- 4.7 The role of practice leadership will be key to supporting a culture of training and good practice, and to continuously improve the understanding of staff and drive service improvement. Training the trainer is an established model for developing competencies in supporting people with a learning disability, and could provide a sustainable approach for employers to providing on-going induction training.
- 4.8 The common curriculum would inform the e-learning in development by Health Education England which could be used by all staff as foundation training at Tier 1, and it is likely that other e-learning courses which are available would seek to reflect the curriculum in the same way. The UK Core Skills Training Framework (CSTF) sets out 10 statutory and mandatory training topics for all staff working in health and social care settings. The CSTF includes nationally agreed learning outcomes and training delivery standards. We will work with Skills for Care with a view to including mandatory learning disability training in this Framework.
- 4.9 Apprenticeships provide a key mechanism for developing skills and on the job training. Employers pay into the apprenticeship levy which is used to fund apprenticeships. Employers have told us it is vital that they can use this funding and apprenticeships to develop the skills of their staff in better understanding the needs of people with a learning disability or autistic people. We are working to develop specialist learning disability and autism options for health and social care apprenticeships.
- 4.10 Equally, we would expect commercial and other providers of training to ensure their products meet the requirements of mandatory learning disability and autism training.
- 4.11 The Department of Health and Social Care will work with relevant bodies to develop standard core materials to support in-house training by health and social care employers.
- 4.12 A curriculum would set expectations in relation to the content to be covered by any training, and the skills and knowledge to be developed, but there is also the potential to set common standards for how training is to be delivered, covering the duration of training, the proportion of face-to-face time with trainers, as opposed to self-directed learning, and the potential for training champions / trainers who could themselves provide training within the employing organisation.

- 4.13 Use of role plays, 'mystery shoppers', simulations and filmed scenarios are all elements of innovative learning disability training around the country. We need to ensure that our approach has the flexibility to ensure innovation in training and raising staff awareness is encouraged locally. We would value views on what constitutes best practice in training methods and delivery.

Case study: St George's University of London

St. George's Medical School at the University of London has been at the forefront of providing meaningful education in learning disability as part of the curriculum of a medical school since the early 1980s.

The School has pioneered sessions in which students work with actors with a learning disability, and visit people at home, to challenge assumptions, and understand the range of skills needed to support people with learning disability effectively as a clinician. Carers are also involved to provide their perspective.

"The students also consistently report gaining much confidence from their experience of meeting the actors, trainers and real-life patient in the community. Many refer to a new understanding of being able to see the person behind the disability while demonstrating an awareness of the increased complications associated with learning disability."¹⁸

Recently, the school has developed the use of simulations and expert patients, including those with learning disabilities. Students report back on a visit to a patient with learning disability in the community to the expert patient who can provide advice and feedback,

The GMC's review of St George's University of London in 2013 identified this as an area of good practice.¹⁹

We propose:

- the Department of Health and Social Care, working with appropriate partners such as Health Education England and Skills for Care and professional bodies, agree a common curriculum for mandatory learning disability and autism training;
- professional bodies, including the medical and clinical royal colleges, regulators and Postgraduate Deaneries, agree how the curriculum would be reflected in clinical education and training, and expectations for continuing professional development for regulated professions;

- the Department of Health and Social Care will work with people with a learning disability and autistic people to develop materials and identify good practice, to support the common curriculum for learning disability and autism training;
- e-learning will be developed by Health Education England to provide foundation-level training for all staff (and which can be used for training for staff in Tier 1 roles in particular);
- that apprenticeships should reflect the Skills Frameworks;
- encouraging a culture of practice leadership, potentially developing competence in sharing good practice and coaching in specialist staff (e.g. in Tier 3) supporting people with a learning disability or autistic people.

Our questions:

Q9. We propose that a common curriculum for the content of training in learning disability and autism for health and social care staff should be developed which could inform implementation of professional standards. Do you agree?

Q10. What support are employers of health and social staff likely to need to ensure their staff can have mandatory learning disability and autism training?

Q11. What best practice are you aware of in delivering training on learning disability or autism?

Q12. Who should be responsible for ensuring the promotion of best practice in how to support people with a learning disability or autistic people (e.g. through guidance or training for trainers)?

Q13. How quickly after taking up a post should new members of staff who have not previously received training have to complete training?

5. Involving people with learning disability and autistic people

- 5.1 Co-production and co-delivery of training in learning disability is a well-established concept. Mencap's 'Getting It Right – From The Start' project which ended in 2014 saw over seven hundred medical staff from seventy-two GP surgeries attend workshops run by Mencap and delivered by people with a learning disability. Participation of people with a learning disability is also a central feature of Mencap's Learning Disability Awareness Training for Healthcare Professionals. The evaluation in 2017 found that after training, 98% of attendees agreed that they were motivated to change their practice.
- 5.2 People with a learning disability or autistic people are the experts, and often have experience of protecting their rights in action, and navigating a complicated system. They can help professionals understand the challenges they face, and the reasonable adjustments which make a significant difference to accessing care and support, and living healthy and well. It is particularly important for training to include the chance to talk to people with a learning disability and autistic people, as this has been found to be crucial to 'myth-busting', helping to challenge attitudes and unconscious bias.
- 5.3 Clinicians often see an autistic person or someone with a learning disability when the person is unwell, or anxious due to the clinical environment. Knowing how to support someone to mitigate this is a key part of training. Training should provide a safe and relaxed space for a professional to get to know someone with a learning disability or who is autistic, when they are not ill or anxious.
- 5.4 There is clearly a wide range of potential roles for a person with a learning disability or autism in co-producing and delivering training, from running a session with a minimum of support, through co-chairing training, to the person with a learning disability or the autistic person acting as a resource within training, to talk to trainees, and provide answers to questions, and reflect on their experiences.
- 5.5 Working with a local group or groups is likely to allow a more consensual approach to how people with a learning disability or autism should be involved, than when working with only selected individuals. It is essential that in either route, there is clarity about expectations, and how people with lived experience will be supported in training.
- 5.6 It will be essential that where someone with a learning disability or autism is involved in training, there is a clear assessment made, involving the person, of the

support they would like, or need, and the extent to which they need to develop their skills to effectively fulfil the role. Public speaking, responding to questions, participating in role-plays, or telling their personal story, will all be skills which could be tested in learning disability or autism training, and the organisation responsible for the training must be thorough in assuring support is appropriate, and effective, and recognising the importance of access to support.

- 5.7 In delivering Mencap's Learning Disability Awareness Training for Healthcare Professionals, prior to sessions, the lead trainer worked with co-trainers with a learning disability to discuss how to involve them in the session. Co-trainers were not present at all sessions, and usually were involved for a proportion of the time (around 30 minutes for a half day, and an hour for a full day). It is important however to avoid tokenism, or people being asked to just pop into a session and talk about their experiences, as this is likely to limit impact, and be discouraging for people with a learning disability or autistic people.
- 5.8 Arrangements for co-production or co-training should include arrangements for remuneration, either to cover expenses, or as payment for employment. There should not be any expectation on the part of a training organisation that people with a learning disability or autistic people should participate in training on a purely voluntary basis.
- 5.9 It is essential that people with a learning disability or autistic people participating in training are also supported to ensure their own wellbeing. Sometimes, telling a personal story can be distressing. Some of the key issues such as mental health need, involuntary admission, and mortality can be distressing. Involving people with a learning disability and autistic people in helping to design the training would provide an opportunity to ensure co-trainers are fully aware of what will be covered, and any potentially difficult topics.
- 5.10 Appropriate safeguarding policies should be in operation for any vulnerable adults involved in training. Co-trainers with a learning disability and/or autism will need to have a designated individual within the training organisation who is responsible for their welfare and the co-trainers should be aware of how to get help or assistance at any time. Any arrangements for co-production or co-training, should be agreed, documented, and the co-producers made fully aware of them; these would need to be kept under review, and there would be value in having independent, external oversight of these arrangements (e.g. by a local advocacy or similar group).

Case study: Conwy Connect

Students at North Wales develop positive attitudes towards people with learning disability by meeting them and their families as part of their training by Cardiff Medical School.

Working with Conwy Connect, a voluntary organisation for people with a learning disability, regular sessions have been organised at a local cricket club for students to meet with people with learning disabilities and their families in a friendly social space. Through facilitated discussions, doctors can learn from potential future patients about the key things which they need to know about learning disability, and what they can do as part of their clinical practice, to provide the best care.

More information, include several short films can be found on the [GMC's website](#).

We propose:

- the Department of Health and Social Care will work with key partners such as NHS England, people with a learning disability and autistic people, and employers, to develop a framework for involving people with a learning disability and autistic people in training, drawing on the best existing practice;
- the Department of Health and Social Care will work with people with a learning disability and autistic people, and with stakeholders such as Health Education England, and providers of higher education, to identify good practice in how best to involve people with a learning disability and autistic people in clinical training.

Our questions:

Q14. What are the barriers to involving people with a learning disability or autistic people in delivering training as proposed?

Q15. What support or advice might be needed for people on how to best involve people with a learning disability or autistic people in developing training?

Q16. What support might be needed for people with a learning disability or autistic people to ensure they have the right skills to participate in training?

Q17. How should people with a learning disability or autistic people be remunerated for participation in training to health and social care staff?

6. Mandating training

- 6.1 The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 ('2014 Regulations') are a statutory instrument by which we ensure that staff working in health and social care in regulated activities prescribed by regulation 3 and schedule 1 to those regulations are appropriately qualified.²⁰ The regulations are the potential vehicle to make learning disability and autism training a statutory requirement for people who work in health and social care activities which are regulated by the Care Quality Commission (CQC).
- 6.2 As part of this consultation, we wish to consult on proposals for regulating further to give effect to our policy of requiring all NHS and social care providers who carry out regulated activities to ensure that their staff have relevant levels of training in learning disability and autism: that is, to meet the outcomes of Tier 1, 2 or 3 in the Learning Disability Core Skills Education and Training Framework, depending on their role.
- 6.3 Our proposals are that the effect of any regulation requirement would be that all regulated service providers should:
- i) assess whether or not staff have received the training to give them the learning outcomes for the relevant Tier of the Learning Disabilities Core Skills Education and Training Framework (and the relevant Framework for autism, when developed);
 - ii) consider - if appropriate, in conjunction with the member of staff - how much of their role might be supporting a person with learning disability or an autistic person;
 - iii) satisfy themselves that an employee had received appropriate training prior to registration, or in previous employment, and if they had not, ensure they undertake training, e.g. as induction training, or continuing workforce development (e.g. for Tier 2 staff, through face-to-face sessions in line with the common curriculum) or are working to develop those skills through apprenticeships.
- 6.4 Some staff providing health and care services may be self-employed or lone practitioners (e.g. an independent physiotherapist, providing a service under a personal budget) or partnerships. They would still be subject to the Health and Social Care Act 2008 (Regulated Activities) Regulations for any regulated activity they carry out. If the individual carries out a regulated activity, they must still have the necessary qualifications, skills and experience to deliver the regulated activity.²¹

- 6.5 Similar requirements apply for directors,²² managers or the secretary of a body who is responsible for supervising the management of the carrying out of the regulated activity, 'nominated individual',²³ and also the registered manager (if managing the regulated activity for the service provider).²⁴
- 6.6 We seek views as to whether, and if so what, changes should be made to the 2014 Regulations to better ensure that the people referred to in paragraphs 6.4 and 6.5 obtain training to the level indicated in this consultation. In this context the CQC is required to issue guidance about compliance with the requirements of the 2014 Regulations and take it into account when making any decision under Chapter 2 of the Health and Social Care Act 2008 (e.g. a decision as to whether the nominated individual, director, individual registered service provider or partner has the necessary qualifications skills and experience). So alternatively, it may be sufficient to change the guidance to make clear that the people must have undertaken the requisite level as indicated in this consultation.
- 6.7 The NHS Standard Contract is mandated by NHS England for use by commissioners for all contracts for healthcare services other than primary care.²⁵ Under General Condition 5.2.1, providers are required to comply with regulations 18 and 19 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, and ensure that there are sufficient appropriately registered, qualified and experience medical, nursing and other clinical and non-clinical staff to enable the services in the contract to be provided.
- 6.8 Under General Condition 5.3, a provider must ensure that all staff are registered with and where required have completed their revalidations by the appropriate professional regulatory body (5.3.1), and have the appropriate qualifications, experience, skills and competencies to perform the duties (5.3.2). General Condition 5.4 requires providers to ensure all staff receive 'proper and sufficient induction, continuous professional and personal development, clinical supervision, training and instruction', and 'full and detailed appraisal (in terms of performance and on-going education and training) using where applicable the Knowledge and Skills Framework or a similar equivalent framework' (5.4.1-2).
- 6.9 These conditions could be revisited to place a specific requirement on providers in relation to learning disability and autism training. Employers would have a contractual requirement to ensure themselves that all employees were maintaining skills through workforce development. For social care, there is no standard contract, and a wide range of providers of different sizes. We would seek to work with the provider sector to encourage foundation-level training for staff who might not be covered by the 2014 regulations.

- 6.10 Ensuring that a system of mandatory training is implemented and delivers real benefits for staff and the people they care for, will require the active support of senior leadership. For all organisations which play a role in direct care and support, an executive director or similar board-level member of staff, must have responsibility for ensuring compliance with all requirements for mandatory training. This should include ensuring oversight by Human Resources, medical and nursing directors of staff training and development, and monitoring of staff training, to allow accountability.
- 6.11 Given that mandatory training might be undertaken at several different stages (pre-employment, induction, and employment), and across a wide range of roles, and professional groups, there needs to be a clear timetable for the implementation of mandatory training.
- 6.12 If as proposed above, a core curriculum could be agreed with professional bodies, it could apply from the point of publication, informing pre-registration training and continuing professional development. Induction training for all recruits could be a requirement from a relatively early stage once the curriculum and other requirements were agreed. We think this could be agreed within a year of publication of an implementation plan following this consultation (e.g. from summer 2020).
- 6.13 For staff already in post, a gradual process of training would need to be adopted, to accommodate the numbers of staff, and it will be essential to phase in requirements for training. It might be appropriate to phase in the requirements differently for different staff groups, based on their level of engagement with people with a learning disability and/or autism.

Case study: The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 apply a set of fundamental standards to health and care staff. This include those defining person-centred care, and safe care and treatment, and requirements relating to staffing.

Staffing

18. (1) Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements of this Part.

(2) Persons employed by the service provider in the provision of a regulated activity must—

- (a) receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform,
- (b) be enabled where appropriate to obtain further qualifications appropriate to the work they perform, and
- (c) where such persons are health care professionals, social workers or other professionals registered with a health care or social care regulator, be enabled to provide evidence to the regulator in question demonstrating, where it is possible to do so, that they continue to meet the professional standards which are a condition of their ability to practice or a requirement of their role.

We propose:

- the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 are amended to place duties on employers to ensure staff undertaking regulated activities have learning disability and autism training at the requisite level for their role;
- we will explore with NHS England how the NHS Standard Contract can be used to require providers to ensure staff have learning disability and autism training at the requisite level for their role;
- the Department of Health and Social Care should provide a timeline as part of their implementation plan for ensuring the entire health and social care workforce are trained.

Our questions:

Q18. Do you agree with our proposal to use the Regulated Activities regulations to place further requirements on service providers who carry on regulated activities within the meaning of the Health and Social Care Act 2008 with a view to ensuring that all staff whose role may involve interaction with people who have learning disabilities or autistic people have received appropriate training in learning disability and autism?

Q19. Do you agree that we could use the NHS Standard Contract to place requirements on providers to ensure unregulated staff have received appropriate training in learning disability and autism?

Q20. What do you think we should do to ensure that self-employed staff / lone practitioners/ partners undertake training to an appropriate level?

7. Monitoring and evaluating impact

- 7.1 The CQC is the independent regulator of health and social care in England; Ofsted undertakes a similar role for children's social care. As part of its inspections, the CQC follows a series of Key Lines of Enquiry (KLOEs), to answer its five key questions: is the service safe, effective, caring, responsive and well led? In assessing if care is effective, the CQC considers 'how does the service make sure that staff have the skills, knowledge and experience to deliver effective care, support and treatment?', and 'do staff have appropriate training to meet their learning needs that covers the scope of their work, and is there protected time for this training?'²⁶ The CQC (and in similar fashion, Ofsted), could utilise these KLOEs to ensure that providers are ensuring staff have had mandatory training in learning disability and autism.
- 7.2 As an example, the Care Certificate has been the minimum expectation in terms of the induction, training and assessment of new care workers, and individuals giving support to clinical roles in the NHS where there is any direct contact with patients, since March 2015. Whilst the Care Certificate is not written into law, the fact that the CQC inspect a regulated providers compliance with delivering the Care Certificate or equivalent induction standards as part of the Effective "Key Line of Enquiry" has resulted in wide usage of this approach.
- 7.3 There is not currently a way to quantify levels of mandatory training uptake for health staff and care staff, but a number of potential data systems which could be used for this, such as the Electronic Staff Record, which enables Trusts to record employee details including training completion and the National Minimum Dataset for Social Care Staff (NMD-SC) which collects data on Care Certificates, levels of social care qualification, and topic-specific training.²⁷ We propose exploring with NHS Digital and other stakeholders how we can best use existing datasets to get a better understanding of levels of training in learning disability and autism.
- 7.4 The aim of introducing mandatory training is to deliver improved outcomes for people with a learning disability and autistic people, in terms of their health and wellbeing, and their experience of care. This is something which could be assessed both locally, and through research on a national scale.
- 7.5 We would also want to encourage local health and care providers to be monitoring the outcomes for service users. There may also be a need to develop a bespoke independent evaluation of the impact of mandatory learning disability and autism training; this would ideally need to capture the views of service users and families,

as to how their experience of care had changed, as well as finding quantitative measures of improvement.

Case study: National Learning Disability Standards

The NHS Improvement Learning Disability Standards characterise high quality services for people with a learning disability, autism or both, with accompanying improvement measures capturing the actions that trusts are expected to take to make sure they meet the standards, and deliver the best outcomes for people with learning disability and autistic people.

Improvement standard three states:

'All trusts must have the skills and capacity to meet the needs of people with learning disabilities, autism or both, by providing safe and sustainable staffing, with effective leadership at all levels.'

It includes the following improvement measure.

'Staff must be trained and then routinely updated in how to deliver care to people with learning disabilities, autism or both, who use their services, in a way that takes account of their rights, unique needs and health vulnerabilities; adjustments to how services are delivered are tailored to each person's individual needs.'

We can work with NHS Improvement to consider how the standards, and their accompanying metrics, can provide quality assurance that mandatory learning disability and autism training is happening, and having a beneficial impact in standards of care in Trusts.

In particular, we would want to see how the training dovetails with appropriate system change to support better care for people with learning disability and autism, such as implementation of the Accessible Information Standard and flagging of, and response to, reasonable adjustments.

We propose:

- the Department of Health and Social Care and the Department for Education explore with CQC and Ofsted how they can monitor learning disability and autism training in their inspections;

- NHS Improvement Learning Disability Standards are used as vehicle for ensuring Trusts are implementing mandatory learning disability and autism training;
- the Department of Health and Social Care work with NHS Digital and other stakeholders in identifying appropriate datasets to monitor uptake of learning disability and autism training;
- the Department of Health and Social Care commission a formal evaluation into the impact of mandatory learning disability and autism training once the new arrangements are fully embedded.

Our questions:

Q21. We envisage that CQC and Ofsted inspections can provide a robust means of ensuring mandatory learning disability and autism training is happening? Do you agree?

Q22. How might people with a learning disability or autistic people be involved in assessing or monitoring mandatory learning disability and autism training?

8. Costs and benefits

- 8.1 A cost and impact assessment will be undertaken as part of the consultation, drawing on the responses we receive and reflecting the likely implementation proposals.
- 8.2 The benefits of mandatory training to people with a learning disability and autistic people are self-evident yet unquantified. Non-monetised benefits include greater awareness by staff of the needs of people with learning disabilities and/or autism, leading to a more positive experience of health and care services and improved health and wellbeing outcomes.
- 8.3 The costs of ensuring Tier 1 training are considered to be relatively limited: the development of e-learning is included within existing Departmental budgets; we would anticipate several hours would be needed for completion. The quantified cost of this time would be considerable but if those several hours are regarded as part of required continued workforce development, this would not constitute an additional burden on the NHS and social care.
- 8.4 For Tier 2 training, with an assumption of 2 days @ 300 per day for trainer, and £150 for people with lived experience, for 20 people, the cost per person would be limited; the demands of people's time would be significantly greater than Tier 1, but we believe still able to be accommodated within continued workforce development, or induction training.
- 8.5 As previously proposed, we would not anticipate that staff whose roles were recognised as being in Tier 3 would require training additional to that for Tier 2.
- 8.6 The likely costs and benefits of mandatory training will depend critically on the current level of provision of training. Informally, we are aware of many good examples of training packages at different levels delivered in Trusts and by health and care providers around the country. Further evidence on the level of provision will help us to assess the formal costs and benefits of these proposals.

Our questions:

Q23. What do you think are the likely costs of implementing mandatory training for health and care staff in learning disability and autism?

Q24. What evidence is available on the economic benefits of mandatory training?

Q25. What evidence can you provide on the current provision of learning disability and autism training around the country?

Appendix. The Learning Disabilities Core Skills Education and Training Framework

Tier 1 - knowledge for roles that require general awareness of learning disabilities.

This level of knowledge and skills is relevant to the entire health and social care workforce including ancillary staff, who may occasionally interact with those affected by a learning disability. For example, this may include those working in education, policing, custodial care, housing or indeed a manager or leader in any organisation.

This is matched to social care workforce group 1 i.e. all social care staff including those not providing direct care and support, such as catering, maintenance or administration staff.

Tier 1 is a foundation of knowledge in learning disability, and training to this level could feature in any induction training in the health and social care sectors, and provide a basis for more advanced practice.

Health Education England is currently developing a package of e-learning on learning disability which aims to provide training which can meet the needs of staff whose roles are determined to require knowledge and skills in Tier 1.

It may be appropriate for staff in Tier 1, to receive additional, face-to-face training; in effect, that undertaken by Tier 2 staff. In particular it should be recognised that many ostensibly Tier 1 staff, may play roles crucial to mitigating the inequalities faced by people with learning disability or autism and ensuring the accessibility of services.

Tiers 2 and 3 provide coverage of subjects in greater breadth and depth.

Tier 2 - knowledge and skills for roles that will have some regular contact with people (children, young people and adults) with a learning disability.

This is relevant to workers in health and social care settings who are not specialists but are likely to have regular contact with people with a learning disability, for example, GPs, community nurses, physiotherapists, occupational therapists, dentists, dieticians, opticians, speech and language therapists, ambulance staff, A&E staff, pharmacists etc.

The social care equivalent would be social care workforce group 2 i.e. staff frequently providing care and support, including care assistants or disability support workers working in residential or home care and personal assistants. Tier 2 also underpins the more specialist skills and knowledge required at Tier 3.

In many respects, this is the crucial group - those who will support people with learning disability and autism, but who have received no specialised training. Its boundaries are fluid, and might include non-clinical staff, where their role is functionally critical to accessing or receiving care, or key information and other support. We would envisage that face-to-face training would be needed for this group, with e-learning potentially playing a role in refresher training. In addition, we recognise the important role of practice leadership in developing and continuously improving the skills of people providing direct support through on the job-coaching.

Tier 3 - knowledge and skills for those providing care and support for people (children, young people and adults) with a learning disability.

This is relevant to staff working intensively with people with a learning disability including those who take a lead in decision making and developing or disseminating good practice. For example, this may include learning disability nurses, clinical psychologists, psychiatrists, GPs with special interest in learning disability, social workers etc

The equivalent in social care would be social care workforce group 3: registered managers and other social care leaders with responsibility for services which provide care and support to people with a learning disability; and social care workforce group 4: social care practice leaders, managers and a range of key staff including social workers who work intensively with people affected by a learning disability.

This group of staff will comprise those whose professional or pre-registration training will already have included a significant element of training in learning disability, and whose professional practice may provide opportunities to meet and learn from people with learning disability.

This can be enhanced and reinforced by ensuring all curricula for pre-registration and care certificate training has a suitable content, and training involves people with learning disability and autistic people. This will be reflected by a common set of requirements relating to skills and knowledge of learning disability and autism in professional standards.

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¹ <https://www.mencap.org.uk/press-release/93-health-professionals-recommend-better-training-how-care-people-learning-disability>

² <https://digital.nhs.uk/data-and-information/publications/statistical/health-and-care-of-people-with-learning-disabilities/experimental-statistics-2017-to-2018>

³ <http://www.bristol.ac.uk/sps/leder/news/2018/leder-annual-report-2016-2017.html>

⁴ <https://petition.parliament.uk/petitions/221033>

⁵ <https://www.gov.uk/government/publications/government-response-to-the-learning-disabilities-mortality-review-leder-programme-2nd-annual-report>

⁶ <https://www.legislation.gov.uk/ukxi/2014/2936/contents/made>

⁷ <http://www.skillsforhealth.org.uk/news/latest-news/item/450-coming-soon-learning-disabilities-core-skills-training-framework>

⁸ <https://www.england.nhs.uk/ourwork/accessibleinfo/>

⁹ <https://www.england.nhs.uk/learning-disabilities/about/ask-listen-do/>

¹⁰ <https://www.bih.org.uk/learning-disability-and-autism>

¹¹ <https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/good-medical-practice>

¹² <https://www.england.nhs.uk/learning-disabilities/improving-health/stomp/>

¹³ <https://www.gov.uk/government/speeches/positive-and-safe-reducing-the-need-for-restrictive-interventions>

¹⁴ <https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics/august-2018>

¹⁵ <https://www.skillsforcare.org.uk/NMDS-SC-intelligence/Workforce-intelligence/publications/The-state-of-the-adult-social-care-sector-and-workforce-in-England.aspx>

¹⁶ Adult Social Care Activity and Finance Report: Detailed Analysis - England 2017-18, NHS Digital <https://www.gov.uk/government/statistics/adult-social-care-activity-and-finance-report-england-201718>

¹⁷ <https://www.gmc-uk.org/education/standards-guidance-and-curricula/standards-and-outcomes/generic-professional-capabilities-framework>

¹⁸ Paula Jean Manners, Paul Adeline, Gary Butler, 'Supporting patients with learning disability', https://www.gmc-uk.org/learningdisabilities/St_Georges_course.pdf_65763680.pdf

¹⁹ https://www.gmc-uk.org/-/media/documents/st-george-s-university-of-london-report_pdf-51939445.pdf

²⁰ <https://www.legislation.gov.uk/ukxi/2014/2936/contents/made>

²¹ Regulation 4(5) of the 2014 regulations applies where the service provider is an individual or partnership and requires the service provider to have the necessary qualifications, skills and experience to carry on the regulated activity.

²² Regulation 5(3)(b) of those regulations applies where the service provider is a body other than a partnership and provides that a service provider must not appoint or have in place a director or someone who performs the functions of or functions which are similar to the functions of a director unless they have the qualifications, competence, skills and experience which are necessary for the relevant office or position or the work for which they are employed.

²³ Regulation 6(3) of those regulations requires applies where the service provider is a body other than a partnership and provides that the registered service provider or registered manager must take all reasonable steps to ensure that the nominated individual has the necessary qualifications, competence, skills and experience to properly supervise the management of the carrying on of the regulated activity.

²⁴ Regulation 7(1) of those Regulations provides in effect that a registered manager must have the necessary qualifications, competence, skills and experience to manage the carrying on of the regulated activity.

²⁵ <https://www.england.nhs.uk/nhs-standard-contract/2017-19-update-may/>

²⁶ <https://www.cqc.org.uk/guidance-providers/healthcare/staff-skills-knowledge-healthcare-services>

²⁷ <https://www.skillsforcare.org.uk/NMDS-SC-intelligence/Workforce-intelligence/Our-work/Our-data.aspx>