# Hospital Staff and Learning Disability Awareness Training

## Results from two surveys

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# Background

The National Development Team for Inclusion (NDTi) was commissioned in 2019 by the South Regional Health Education England Intellectual Disabilities programme to find and share best practice in training people who work in NHS Trusts to support people with learning disabilities. The aim is to support staff development to help them achieve better outcomes when working with people with learning disabilities. Further information about the project can be found here.

It is well established that people with learning disabilities have poorer health and die earlier than people in the general population (Alborz et al., 2005; Disability Rights Commission, 2006; Emerson and Hatton, 2014). Although genetics may play a role in this, most factors that impact on the health and wellbeing of people with intellectual disabilities are modifiable and therefore represent health inequalities. Poor access to health services, delays and problems in diagnosis and treatment are well known causes of health inequalities (Heslop et al., 2013). Many of these factors can be modified by addressing the barriers faced by people with learning disabilities, including the lack of understanding of health issues, difficulties with communication and insufficient support to access health services.

In 2016 the Learning Disabilities Core Skills Education and Training Framework was developed to support the development and planning of the current and future workforce. However, a common theme in the deaths reviewed by the Learning Disability Mortality Review (LeDeR) Programme was the need for better training and awareness of learning disabilities (LeDeR, 2019). The importance of this was acknowledged by the Government when it published its response to the consultation on proposals for introducing mandatory learning disability and autism training for health and social care staff. It has made a commitment that all health and social care staff will receive training on autism and learning disabilities and there will be funding to evaluate trial training packages, ahead of wider roll-out. The findings from NDTi's project to identify best practice in training people who work in NHS Trusts to support people with learning disabilities therefore are particularly pertinent and timely.

## Surveys

One aspect of NDTi's work has been to conduct surveys with hospital staff. We developed two surveys which were shared with staff working in NHS Trusts in the South region:


Survey 1 was for staff involved in delivering the learning disability awareness training and aimed to find out more about the content and format of the training. We refer to this as the delivery staff survey.


Survey 2 was open to all staff working in the Trusts and explored their experiences and views on learning disability awareness training. We refer to this as the general staff survey.

In the general staff survey, we were interested in exploring the learning disability training received by the non-specialist workforce and therefore our focus was on staff working in **Tier 1** and **Tier 2** as defined in the Learning Disabilities Core Skills Education and Training Framework:

**Tier 1:** roles that require general awareness of learning disabilities

**Tier 2:** roles that will have some regular contact with people (children, young people and adults) with a learning disability

This report draws on the responses to both surveys to identify key findings in relation to the content, format and experiences of learning disability training for the non-specialist workforce. The findings from the surveys have also been used to inform other elements of this work - the contents of a Delphi Survey and topic guides for interviews with hospital staff.

# Findings from the surveys

Survey 1

## Delivery Staff Survey respondents

A total of **32** individuals representing different training departments across the South regional HEE Intellectual Disabilities, completed the delivery staff survey. Eleven respondents who were not involved in delivery of the learning disability training or did not have knowledge of the learning disability training were excluded from this analysis.

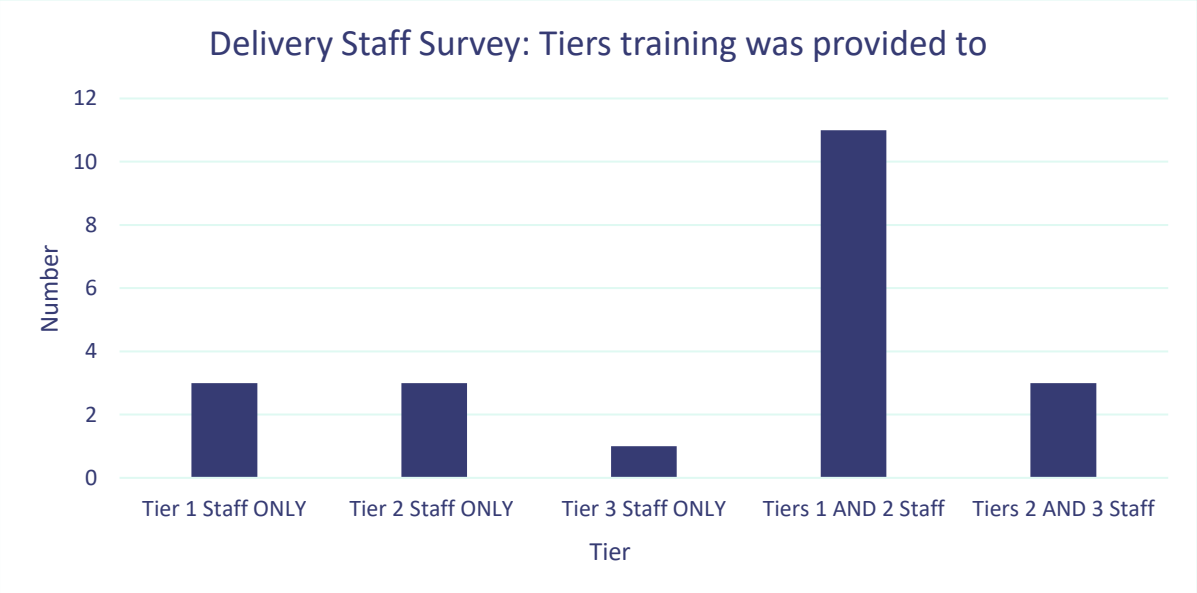
Of the remaining 21 respondents, 18 worked in a training department and delivered the learning disability training, the remaining 3 worked in the training department and had knowledge of the learning disability training.

Most of the training run was aimed at both **Tier 1** and **Tier 2** staff (11). There was one respondent whose training department only offered training to Tier 3 staff. Tier 3 staff are described in the Core Capabilities Framework as:

> *Health, social care and other professionals with a high degree of autonomy, able to provide care in complex situations and/or may also lead services for people with a learning disability.*

This respondent has been excluded from the remainder of this document as Tier 3 was not the focus of this piece of work.

**Chart 1: Delivery Staff Survey: Tiers raining provided to**




The rest of the reported data from the delivery staff survey focuses on the 20 responses relating to **Tier 1** and **Tier 2** training.


## General Staff Survey respondents

A total of 199 respondents completed the general staff survey about the learning disability training available in their trusts from across the South regional HEE Intellectual Disabilities area. Of these respondents, 69 worked in **Tier 1** roles, 102 in **Tier 2** roles and 28 in Tier 3 roles. As the focus of this study was not Tier 3 staff, the data provided by these respondents has not been included in our analysis.

Respondents came from a variety of regions across the South of England with most Sustainability and Transformation Partnership (STPs) areas represented. However, the data is not representative because there were high responses from two areas compared to the others. Table 1 shows where the geographical areas that respondents worked in.

**Table 1: Geographical areas**

| Region | Responses for Delivery Staff Survey (N=20) | Responses for General Staff Survey (N=171) |
|---|---|---|
| Bath STP | 0 | 1 |
| Bristol | 1 | 3 |
| Buckinghamshire STP | 1 | 0 |
| Cornwall & The Isles of Scilly STP | 1 | 20 |
| Devon STP | 0 | 4 |
| Dorset STP | 3 | 2 |
| Frimley Health and Care | 0 | 0 |
| Gloucestershire STP | 1 | 5 |
| Hampshire & The Isle of Wight STP | 3 | 8 |
| Kent & Medway STP | 4 | 68 |
| North Somerset | 0 | 0 |
| Oxfordshire & Berkshire STP | 1 | 0 |
| Somerset STP | 1 | 1 |
| South Gloucestershire STP | 0 | 1 |
| Surrey Heartlands Health and Care Partnership | 2 | 14 |
| Sussex Health and Care Partnership | 2 | 39 |
| Swindon and Wiltshire STP | 0 | 5 |

Of the **171** **Tier 1** and **Tier 2** respondents in the general staff survey, only 54 had received learning disability training and 117 had not. Table 2 shows how many respondents had received training by the tier they worked in.

**Chart 2: General Staff Survey: Have you done any learning disability awareness training?**


The next section presents data about **Tier 1** and **Tier 2** training from the delivery staff survey respondents (N=20) and the general staff survey respondents who had undertaken some learning disability awareness training (N=54).

# Format and delivery of training

Survey 1

## Delivery Staff Survey responses

### Mode of delivery

**Tier 1**

A total of **14 of the 20** respondents' training departments ran training for Tier 1 staff.

**Tier 2**

**17** respondents reported about learning disability training run for Tier 2 staff.

A total of 14 of the 20 respondents' training departments ran training for **Tier 1** staff. Most of this training was face-to-face with or without video (9) or using online software (4). One department used an Open Discovery Session as a method of providing training. This session involved an information stand providing attendees with information on the following subject areas: learning disability awareness; equality, diversity, and inclusion in learning disability care; and support. This stand was available to all **Tier 1** staff during their induction.

Seventeen respondents reported about learning disability training run for **Tier 2** staff. This training was being carried out face-to-face (16); 1 respondent stated that the training was still being developed and as a result, the remainder of this respondent's responses have been excluded from the discussion here (see chart 3).

### Length of training

The 14 respondents who delivered training sessions for **Tier 1** staff reported that these ranged from 15 minutes (Open Discovery Sessions) to half a day.

Of the 16 respondents who delivered **Tier 2** training, the majority report this being delivered in 1-2 hour sessions (9), with others running a 30-45 minute session (2), a half-day session (1), a full day session (1) or it being incorporated into other training (1). One respondent said their Tier 2 training was still in development. (see chart 4)

Survey 2

## General Staff Survey responses

### Mode of delivery

The majority of the **13 Tier 1** respondents received their training:

- **face to face: 8 (62%)**
- **online: 5 (38%)**

The majority of the **41 Tier 2** respondents received their training:

- **face to face: 27 (66%)**
- **online: 10 (24%)**
- via reading materials: **2 (5%)**
- at a conference: **1 (2.5)**
- via a block of training and an 8-month placement in learning disabilities: **1 (2.5%)**

(see chart 3)

### Length of training

Of the **13 Tier 1** respondents:

- 5 said it lasted **1-2 hours**
- 6 received **half-day training**
- 1 had **a full day of training**
- 1 reported **1-2 days of training**

Of the **41 Tier 2** respondents:

- 1 received this training in a **30-minute session**
- 23 received this training in a **1-2 hour session**
- 8 in **half a day session**
- 5 in **full day session**
- 1 in a course that ran for more than 2 days
- 1 had training scattered throughout their professional training
- 2 couldn't remember how long the sessions lasted for (these respondents had done their training either in the last 1-5 years or over 5 years ago).

(see chart 4)

**Chart 3: How the training was delivered**

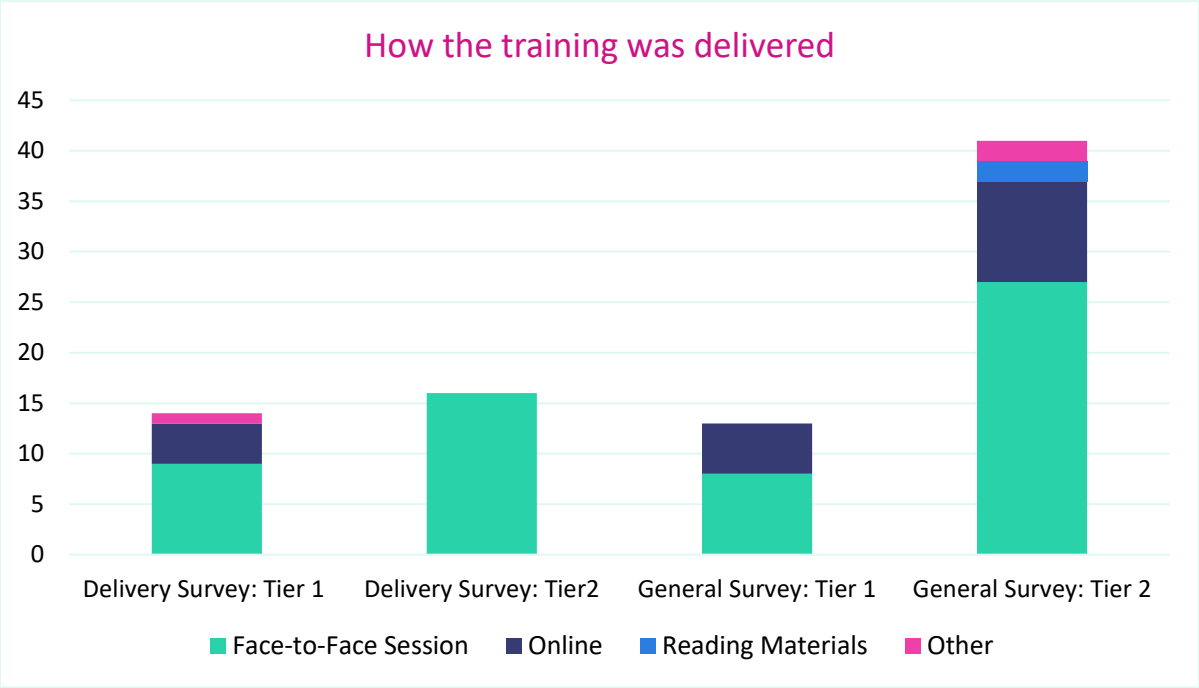
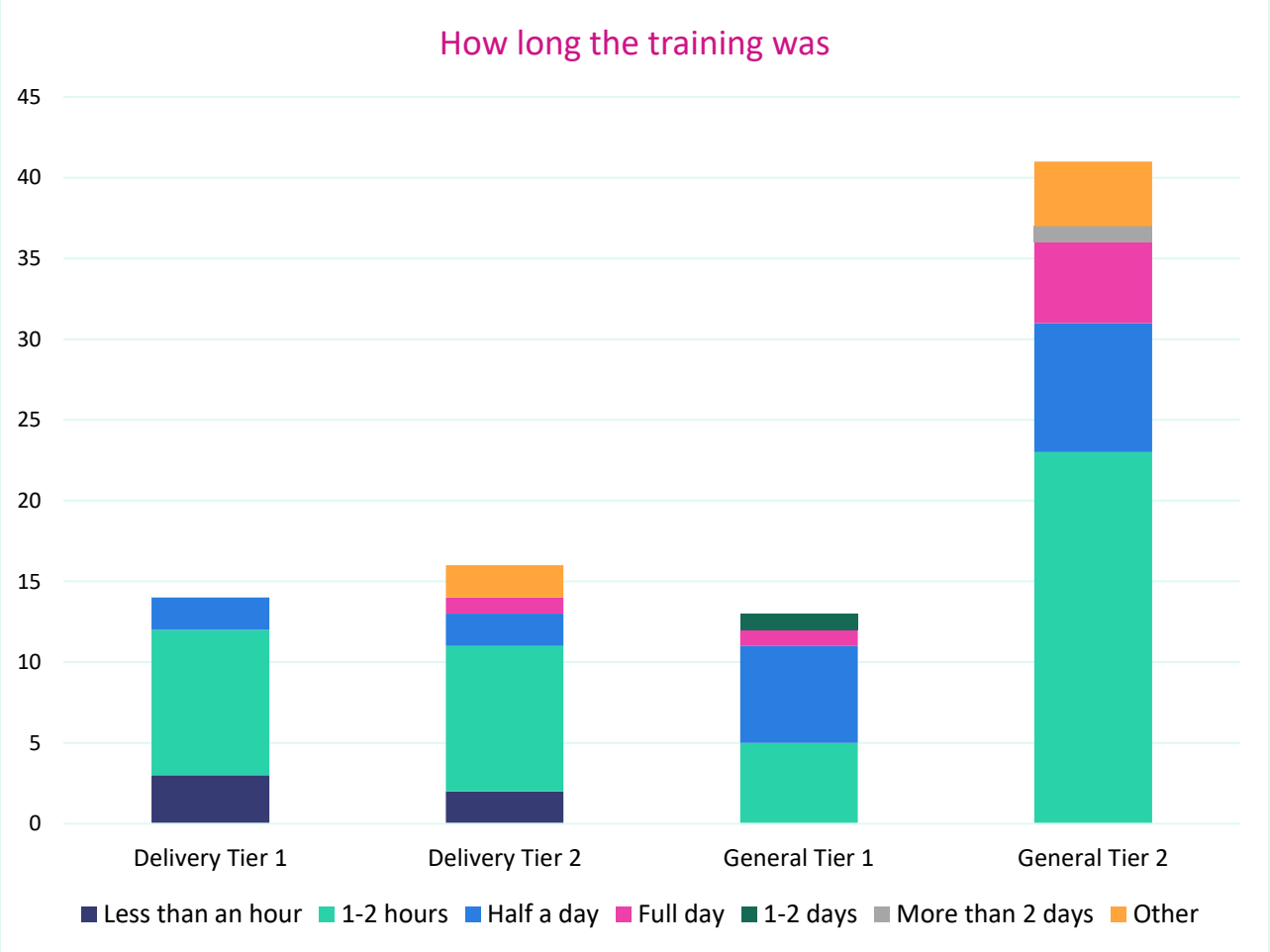



**Chart 4: How long was the training**



## Benchmarking against core skills framework

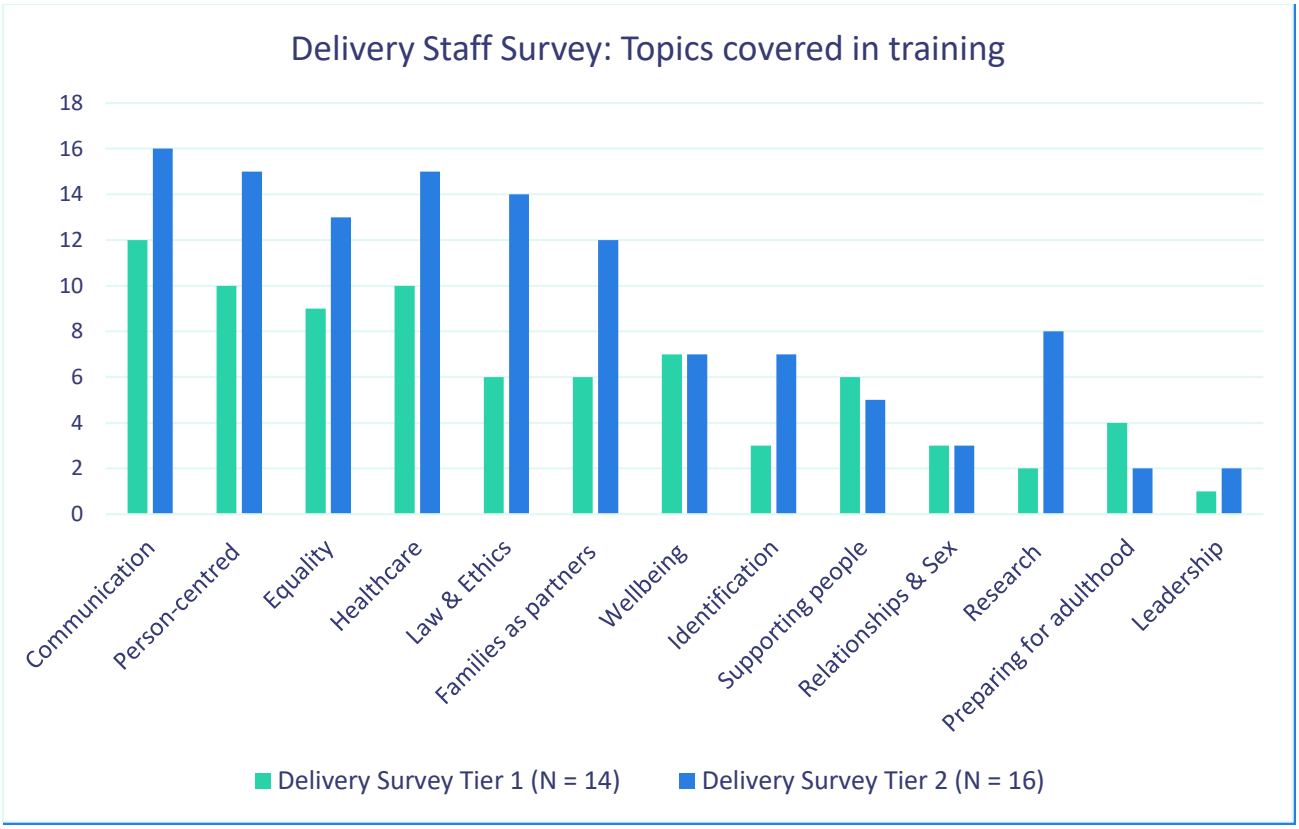
The Learning Disabilities Core Skills Education and Training Framework (2016) was developed to support the delivery of "appropriate and consistent cross-sector learning disabilities education and training"[1] (Page 6).

It provides guidance and standards for the delivery of learning disability training and indicates the subject areas that should be covered for staff working in different Tiers alongside the related desired learning outcomes. For **Tier 1** staff the only subject identified as relevant is "learning disability awareness". There are 13 other subject areas identified as relevant to **Tier 2** staff.


### Delivery Staff Survey responses

Of all 20 respondents, 13 reported covering some of the additional subjects from the framework but none of the 16 respondents delivering **Tier 2** training covered all these subjects. (See chart 5)

**Chart 5: Delivery Staff Survey: Topics covered in training**



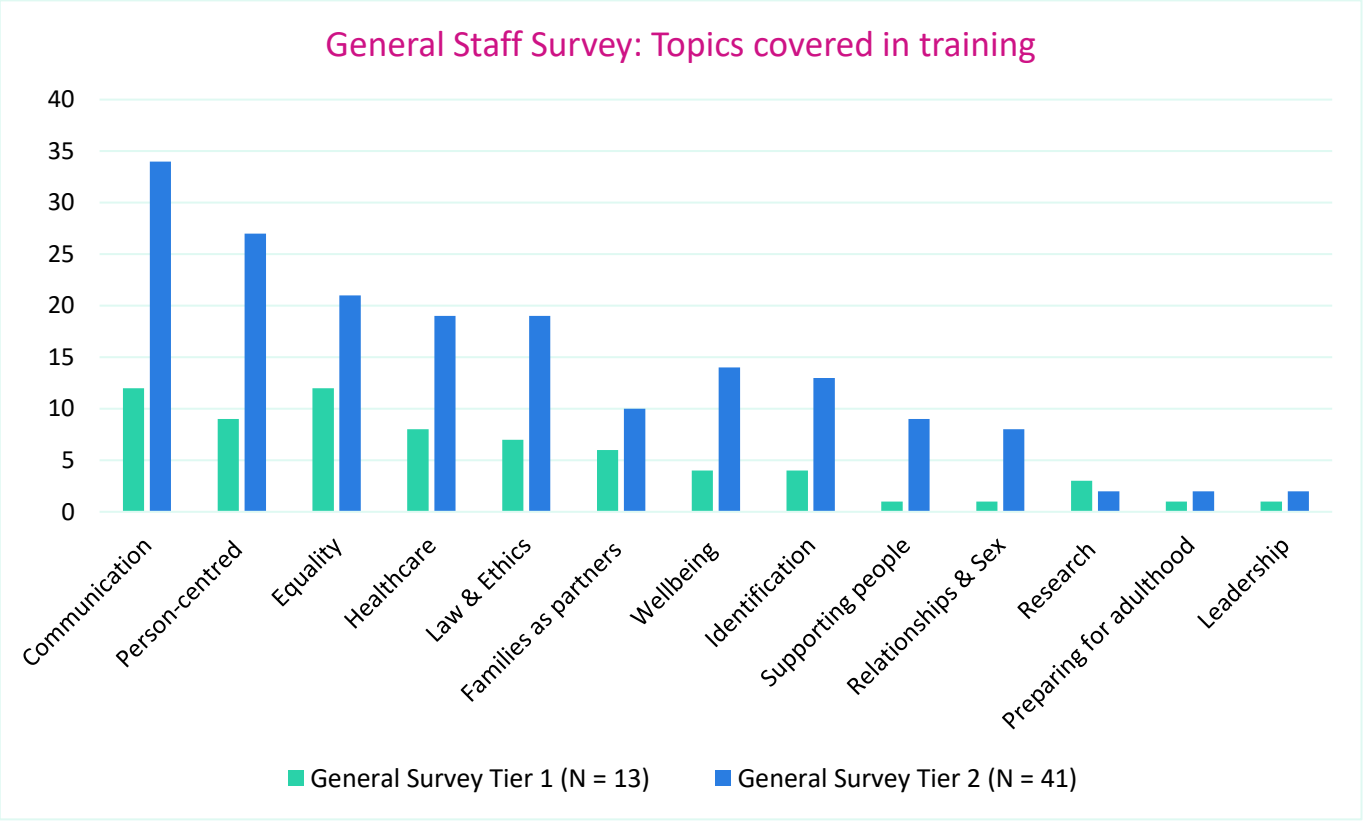

[1] This framework was updated in 2019 but our survey was based on the 2016 version, as this is what would have informed the training we were asking about.

## General Staff Survey responses

Respondents were asked about the subject areas they could remember their training covering. These subjects were taken from the Learning Disabilities Core Skills Education and Training Framework.

All of the 13 **Tier 1** respondents were able to remember topics that had been covered in addition to learning disability awareness. The 41 **Tier 2** respondents reported that other than learning disabilities awareness, none of the other subjects identified as relevant to **Tier 2** staff were covered in all the training. (See chart 6)

**Chart 6: General Staff Survey: Topics covered in training**




This is the full list of subject areas taken from the Learning Disabilities Core Skills Education and Training Framework listed in order of frequency of inclusion across all staff responses to both surveys (with the subjects covered most frequently at the top):

- Communication in learning disability care and support
- Person-centred care and support for people (children, young people and adults) with learning disabilities
- Healthcare for people (children, young people and adults) with learning disabilities
- Equality, diversity and inclusion in learning disability care and support
- Law, ethics and safeguarding in learning disability care and support
- Families and carers as partners in learning disability care and support
- Wellbeing and independence

- Identification and assessment of learning disabilities
- Supporting children and young people with learning disabilities
- Leaderships and management in learning disability care and support settings
- Preparing young people with learning disabilities for adulthood
- Relationships, sexuality and sexual health
- Research and evidence-based practice in learning disability care and support

As can be seen in charts X and X, the **Tier 1** training delivered covered considerably more than general learning disability awareness as set out in the Core Skills Education and Training Framework. However, none of the **Tier 2** training covered all the subject areas.

# Training Delivery

## Involvement of people with learning disabilities


### Delivery Staff Survey

Only 4 of the 14 respondents who delivered **Tier 1** training said people with learning disabilities were involved in the creation and/or delivery of this. Of the 10 respondents who did not have people with learning disabilities involved, 7 did not feel that their involvement would be beneficial; 3 did feel that it would be beneficial.

Eleven of the 16 respondents who delivered **Tier 2** training stated that people with learning disabilities were involved in the design or delivery of this. Involvement included:

- creating the training as well as delivering the training through sharing their experiences
- helping host an 'Learning Disability support simulation' for course attendees
- being 'mystery shoppers' providing feedback on departments conduct after having received training
- being in videos shown to course attendees.

Of the five respondents who did not have people with learning disabilities involved in the creation and/or delivery of their **Tier 2** training, 4 stated they feel it would be beneficial if they were involved, whilst 1 did not feel it would be beneficial.

## General Staff Survey

Survey 2

Of the 13 **Tier 1** respondents, 6 reported that people with learning disabilities were involved in their training. They were involved in the delivery of the course for 5 respondents, but in the creation of the course content for 1 respondent. Each of these respondents felt that having people with learning disabilities involved in the training was positive (as written by respondents):

*It was excellent! Their lived experience added so much to my understand of LD [sic] and the issues they face in day to day living. They were really enthusiastic too and clearly enjoyed being part of the training.*

*It was good, it's important that people learn about learning disabilities from people who have it.*

*It was really effective as they could give real life experiences.*

For the 7 respondents who did not have people with learning disabilities involved in their training, 6 said they would have liked to have had them involved for a variety of reasons, including:

*Have had people with learning difficulties give a teaching session in the past on end of life wishes. This was very informative as the individuals covered different methods of communication nurses can apply to ensure people with learning difficulties.*

*They are more aware of the barriers that they come across.*

*Get a true picture of how experience difficulties in the NHS and they are able to facilitate appropriate training.*

Just one respondent did not feel that having people with learning disabilities in the training was important. They did not provide a reason why.

Of the 41 **Tier 2** respondents who had done training, 7 reported that people with learning disabilities were involved in the delivery of the training either in person or via videos shown. Each of these respondents felt the involvement of people with learning disabilities was beneficial to the training with several describing their involvement as ***'essential'*** to improve staff understanding. Hearing firsthand from someone with lived experience was described as the most beneficial part of their involvement.

Of the 34 **Tier 2** respondents who had attended training where people with learning disabilities had not been involved, 27 would have liked them involved in the training. Reasons given for this, included:

- the training being more interesting
- the accounts being more personal and the training more 'real'
- providing firsthand examples of the challenges faced when trying to access healthcare and what adjustments can be made by health care staff
- to allow staff to spend more time with people with learning disabilities.

The 7 who did not want people with learning disabilities involved in the training did not give a reason for this response.

## Involvement of family carers


### Delivery Staff Survey

Only 1 of the 14 respondents said family carers were involved in the creation of the **Tier 1** training about learning disabilities run by their departments. Five of the remaining respondents felt that having family carers involved in the creation and/or delivery of the training would be beneficial, whilst eight did not.

Of the 16 **Tier 2** respondents, 5 stated that their departments involved family carers in the creation and delivery of **Tier 2** training. Of the remaining 11 respondents, 8 stated that they think family carers being involved in the creation and/or delivery of the training would be beneficial to the training, whilst 3 did not think it would be beneficial.


### General Staff Survey

Only 1 respondent (out of 13) received **Tier 1** training where a family carer was involved in the delivery. The respondent commented that this element of the training was valuable because:

*You never know the full burden, time and responsibility that a carer goes through to care for someone with a learning disability.*

Of the 12 respondents who did not have family carers involved in their training, 6 would have liked them to have been involved and 6 would not. The reasons given for wanting them to be involved included:

*To know what their experiences have been and how we may improve on future training and processes.*

*They are more aware of the barriers that they come across.*

*I feel families can often give nurses an insight into how best to communicate with their family member who have learning difficulties. We are all individual and this most certainly applies to people with learning disabilities.*

*Gives an alternative perspective - carers have an important role in the delivery of support to people who use our services.*

Seven respondents (out of 41) attended **Tier 2** training that involved family carers in the delivery and course materials. Feelings were split about the benefit of involving family carers in the training, 3 felt their views were ***'essential'*** to the training, 2 felt they were ***'really useful'*** whilst another stated ***"ticks the box to secure service user involvement..."***.

Of the 34 respondents who did training with no family carer involvement, 27 would have liked their involvement. The reasons for this included:

- their insight bringing the training to life through their expert knowledge
- to provide insights from their perspectives especially with regards to how they can work with clinicians
- and to provide family carers with a voice that is not included in the triangle of care.

## Key learning points about format and content:

- Training for Tier 1 staff was mostly delivered face to face or online and generally lasted for 1-2 hours or half a day.
- Training for Tier 2 staff was mostly delivered face to face and for the majority of people was for 1-2 hours.
- Tier 1 training often goes beyond the framework recommendation, with: communication; equality, diversity and inclusion being the most commonly covered additional topics.
- None of the Tier 2 training covered all the recommended subjects, with: preparing young people for adulthood; leadership and management being the topics least likely to be covered.
- In terms of timing and content there was not much difference reported for Tier 1 and Tier 2 training.

## Key learning points about involvement of people with lived experience:

- Those who delivered training were more likely to involve people with learning disabilities in the creation or delivery of Tier 2 training as opposed to Tier 1 training.
- About half of those who had received Tier 1 training reported that people with learning disabilities were involved in this, but this was only the case for less than 20% of Tier 2 staff. When they had been involved, respondents were overwhelmingly positive about this.
- When people with learning disabilities had not been involved in the training, most respondents thought they should have been.
- Overall, family carers were less likely to be involved in training at either Tier, and there was less consensus about the benefits of their involvement.

# Impact of the training


## Delivery Staff Survey

In order to explore the impact of the training, the survey for delivery staff asked respondents if, and how, they evaluate their training, and what this evaluation has shown.

It was reported that 10 of the 14 training departments that delivered **Tier 1** training evaluated this, 3 did not and 1 planned to do this. Those who did, or were about to, evaluate their training did this by using evaluation forms for course attendees. Most respondents stated that the evaluations showed the training was viewed positively. However, there are some useful learning points from these evaluations, including the following (as reported by the survey respondents):

*Most people strongly agree that it is helpful to their practice, informs their practice and gives then more skill they can use in their workplace.*

*Staff value the examples and case studies used to relate theory to current practice.*

*Well received especially section on what we mean by Learning Disability; feedback from staff is all staff would benefit, currently only offered to Healthcare Assistants on induction.*

*Staff find this topic interesting and the training delivered a valuable resource and the knowledge that within this trust there is a Learning Disability Practitioner who will be available to ward staff for advice and support.*

*The study day is always well evaluated and that staff would like more training. Induction needs to have more time allocated.*

For those departments that reported not evaluating their **Tier 1** training, the reasons given included the training being new and evaluation forms not having been developed (2 respondents) and the course content being reviewed annually by the department but not based on any responses from the respondents.

Of the 16 respondents that delivered **Tier 2** training, 12 stated that their departments evaluated this, and all of these did this via evaluation forms. Additionally, three respondents described working with service user groups to evaluate the training and one respondent used external reviews such as Health Watch Reports.

Respondents suggested that most **Tier 2** course attendees evaluated the training positively; they found it informative to their practice, it helped them gain confidence in their role and allowed them the space and time to understand the different approaches/tools available when supporting someone with a learning disability. However, survey respondents reported that some course attendees would like the sessions to be longer, especially if it was part of their induction. Additionally, one respondent stated that their department is receiving more and more requests for such training, suggesting it has not been reaching everyone it needs to.

Finally, it is interesting to note that one respondent's department is running **Tier 2** as a relatively new venture. They currently evaluate their sessions at the end, but they will be following this up with respondents at the 3- and 6-months mark to measure the impact of the training in the longer term. Our literature review identified a lack of studies measuring change at a behavioral level, which requires follow-up several months later (Marriott and Harflett, 2020).

Of the 4 respondents who stated that their department does not evaluate their **Tier 2** training, the reasons given include:

- the evaluation forms are being developed and not yet in place
- sessions being bespoke and face-to-face
- impact due to be measured 1 year after the course completed and not before
- evaluation not needed, as no specific learning outcomes are available for the course

Survey 2

## General Staff Survey

The general staff survey explored the impact of the training by asking respondents questions about how useful they found the course, if their knowledge had increased, and if the training had made a difference to their practice.

### Usefulness of training:

Of the 13 **Tier 1 respondents**:

**12 (92%)**

felt that the **training was useful** and 1 did not.

Of the 41 **Tier 2 respondents**:

**38 (93%)**

felt that the **training was useful** and 3 did not.

### Increasing knowledge:

Of the 13 **Tier 1 respondents**:

**10 (77%)**

felt that the **training increased their knowledge** about people with learning disabilities and 3 did not.

Of the 41 **Tier 2 respondents**:

**35 (85%)**

felt that the **training increased their knowledge** about people with learning disabilities and 6 did not.

### Changes to Practice

Of the 13 **Tier 1 respondents**:

**9 (69%)**

felt that the **training had made a difference** to their practice and 4 did not.

Of the 41 **Tier 2 respondents**:

**31 (76%)**

felt that the **training had made a difference** to their practice and 10 did not.

The responses given to these questions often overlapped. For example, a predominant theme in the responses saying why people found the training useful was that it had increased or refreshed their knowledge. Therefore, we have collated these responses and analysed them together to explore the impact of the training. Separate analysis was conducted for responses from **Tier 1** and **Tier 2** staff but as the same themes emerged, the results of this analysis are presented together.

The survey directly asked about new knowledge and knowledge gained was also a predominant theme in the responses saying why people found the training useful. We have identified two main aspects relating to knowledge.

## Increasing and refreshing knowledge

Respondents gave many examples of what they had learnt through the training.

*Understanding what is and what isn't a learning disability.*

*I am more aware of different types of disability and the fact that disability is not always visible.*

Many of the examples given related to laws and polices:

*Reasonable adjustments that are required for these patients.*

*Better understanding of communication and mental capacity act.*

There were also examples of the training providing information that could help people to provide better care:

*Gave really useful information on how to care for and assist people with LD [sic] when they come into hospital.*

*Different approaches to communication which will help future assessments and intervention.*

## Raising awareness

In addition to gaining factual knowledge, it was clear from the comments that some of the respondents had found that the training had given them a better awareness of sources of information and support within the hospital and outside that they can refer patients and their families to:

*Highlighted some of the problems we face and what help and support is available for LD patients.*

*Have some notes to refer to and contact numbers/links if I require information in the future.*

## Confidence

Unsurprisingly, given nearly everybody found the training useful and most people felt their knowledge had increased, respondents talked about having increased confidence following the training:

*Feel more confident in implementing things to make hospital visits smoother.*

*It has given me more confidence.*

*Better equipped to approach capacity issues.*

## Changing attitudes and assumptions

The feedback from respondents suggests that the training had helped many of them gain a better understanding of what people with learning disabilities and their family carers face when coming into hospital:

*How scary an experience it can be coming in to hospital and not have the LD [sic] taken in to consideration.*

*Improved understanding of the of the issues individuals and families face.*

Hearing the perspective of people with lived experience had resulted in a greater awareness and changed attitudes and approaches:

*I learnt that people with learning difficulties and especially autism, function and think in a slightly different way to how some other people might think and therefore, some adaptations are required.*

*The involvement of those with LD [sic] and the experience of family members, made you to stop and consider.*

*I am more aware of the ways in which LDs [sic] impact on people.*

*Being made aware of the assumptions that people make, including care givers within an acute Trust environment, about people with LD [sic].*

*Not to pre-judge or make assumptions.*

*You learn to be more patient, see things from another's perspective and to include someone with a learning disability into their own care plan.*

*When dealing with anyone with any disabilities, ask what they require.*

There were also several references to capacity:

> *Conscious effort to ensure that I am understood so that consent can be obtained.*

Whilst it is positive that the responses demonstrated increased knowledge, confidence and a greater awareness of the needs of people with learning disabilities, the training will only make a real difference if staff are improving their practice.

One respondent felt the training had made a difference to their practice, but they were conscious of their limited ability to meet people's needs:

> *Awareness of issues but do not feel more skilled in working with people with these needs particularly.*

This may suggest that some people would benefit from more in-depth training. However, there were many more responses which gave examples of how improved awareness of what people face has led to a better understanding of what needs people have and how respondents might be able to support those in their role.

> *I am now more aware and hopefully can adapt my practice to better meet their individual needs.*

Respondents gave more specific examples of things they had started to do differently or planned to do, following their training. These have been categorized under two broad headings:

## Communications

Most of the examples of changed practice related to communicating and interacting with people with learning disabilities:

> *Awareness of issues but do not feel more skilled in working with people with these needs particularly.*

> *More patient and more willing to listen and let people express themselves they have choice!*

> *Involvement of client.*

*Adapt communication / positioning / tone of voice / type of questioning / simplified amount of information included.*

*Recent session was on communication and reminded me of the number of ways communication can be used to ensure information gained is appropriate for the individual.*

*I am more aware of how to communicate with people with LD [sic], the importance of having them involved in the things that we do - from signposting on hospital sites to hearing their experiences of NHS care.*

## Reasonable adjustments

Reasonable adjustments are a legal requirement under the Equality Act, and it was evident from the answers to the questions about knowledge, usefulness and changed practice that this was a strong focus of the training people had received. In terms of what people had learnt there were several references to the need for reasonable adjustments but some respondents gave examples of specific reasonable adjustments they had made or planned to make:

*You can make a hospital a more calming environment for those with learning disabilities.*

*How to put LD [sic] first on list, passport, quiet environment, give more time allowance.*

*Give time, read care passport.*

*Using the hospital passport.*

We also asked which elements of the training helped improve practice. Across both Tiers, respondents ooverwhelmingly cited:

- course materials both in the sessions and those they could take away
- signposting to individuals/departments in the hospital and websites

A smaller proportion of respondents found peer support groups had been useful.

## Why no impact?

We can also learn from the responses given by those who did not find the training useful or educational or who had been unable to make any changes in their practice.

Of the 13 **Tier 1** respondents, only 1 did not find the training useful. They had done the training online and did not provide any more details as to why it was not useful.[2]

Of the 41 **Tier 2** respondents, 3 did not feel the training had been useful. Of these three respondents, one had done the training online, one through reading and one person and received face-to-face training.

The reasons given by the **Tier 2** respondents who did not find the training useful were:

*Too much about rules and regulations, not enough practical advice.*

*It was an online course to cover Equality and diversity more than those that we care for with learning disabilities.*

Of the 13 **Tier 1** respondents, 3 did not think it increased their knowledge but only 1 respondent gave a reason:

*Do the same training every year.*

This response suggests that the content of their training is not changed year to year and possibly needs to be refreshed.

Of the 41 **Tier 2** respondents, 6 did not find the training increased their knowledge and they gave the following reasons:

*It did not cover basics of understanding and being able to help patient with learning disabilities.*

*E-learning is a terrible way to learn.*

*Impersonal format (e-learning).*

[2] This respondent did say in response to another question that their practice had improved through sign posting to websites/information and peer support groups.

Of the 13 **Tier 1** respondents, 4 reported it did not change their practice and the reasons given included:

*Not front line, therefore interactions or practical use infrequent.*

*If you listen to the patient and take notes then you are more likely to be able to communicate with or without training.*

*I have always been aware and considerate of people with disabilities and although there were a few areas/subjects that I may not have been aware of until the training, I didn't learn anything that would have made me change normal practices.*

Of the 41 **Tier 2** respondents, 10 did not feel that the training has made a difference to their practice. Nine respondents gave reasons for this, with three of them feeling they already had enough knowledge. Some of the comments suggested that there was not enough of a practical focus for the training to make a difference to their practice:

*Not enough practical advice.*

*It did not contain any areas to help with nursing practice and nursing those with learning disability.*

When asked what the training could have done to help these respondents change their practice, the following were identified by staff in both Tiers as potentially useful or supportive:

*Materials to take away from the sessions.*

*Being signposted to individuals/ departments who could help.*

*Peer support groups to speak with after the training.*

## Key learning

Nearly all **Tier 1 staff** found it **useful**:

**92%**

and most felt it **increased knowledge:**

**77%**

Nearly all **Tier 2 staff** found it **useful**:

**92%**

and most felt it **increased knowledge:**

**85%**

The delivery staff survey showed that evaluation of the training provided is mainly reliant on feedback forms completed straight after the training. Respondents reported that evaluation showed a broadly positive response from people undertaking the training.

The majority of those who did not find the training useful did not receive face to face training.

Comments suggested that the training was more likely to be useful when it had a practical focus and included people with lived experience, rather than simply being about rules and policies.

Both Tier 1 and Tier 2 staff were able to identify ways in which their practice has changed because of the training.
There was consensus that course materials, further signposting and peer support groups are all factors that are helpful for making changes in practice.

## Those who had not done any training

Of the 69 **Tier 1** respondents, 56 had not completed any learning disability training as part of their role. Only 2 of these people had been offered learning disability training, 1 had chosen not to do it because:

> *Have completed LD [sic] training in past, don't work with clients who have a LD [sic], previously worked with LD [sic] clients so have good knowledge.*

The other said they had chosen not to do the training but provided no further information about why they had made this choice.

For the 54 of the **Tier 1** respondents who had not been offered any learning disability training, 47 would have liked this training and 7 would not. The 47 who would like this training provided extensive reasons for this, which have been grouped together into the following themes:

- To increase understanding of what a learning disability is and generally raise respondents' awareness in this area
- To improve understanding of how to communicate with people with learning disabilities, their families and carers - both generally and in complex/difficult medical contexts.
- To have a greater understanding of the legal frameworks that surround people with learning disabilities and hospital practice, including, MCA and reasonable adjustments, and how they apply to practice in hospital.
- To ensure that all patients are able to be supported equally in the clinical setting.
- To help respondents work alongside their colleagues with learning disabilities more cohesively

Of the 102 **Tier 2** respondents, 61 had not received any learning disability training as part of their role. Only 1 of these respondents had been offered learning disability training. They had actively turned down this training ***'To save time and I feel I understand enough about it'***.

Of the 60 respondents who had not been offered any training, 55 would like to have been offered this training and 5 would not. All 55 respondents who wanted the training provided reasons for wanting this training. These reasons have been grouped into the following areas:

- To raise awareness
- To enable the best care to be provided to patients
- To enable clear communication with patients with learning disabilities, their families and carers, especially when having to explain complex clinical matters
- To have a better understanding of the legal frameworks that govern practice, including the MCA and Reasonable Adjustments.
- To gain role specific knowledge about how to support with people with learning disabilities.
- To increase confidence in supporting and working alongside people with learning disabilities
- To have knowledge about where to refer/signpost patients with learning disabilities, their families and supporters when they come to hospital for treatment/services

It was evident from the comments that staff working in a range of roles (both administrative and clinical) were able to identify why learning disability awareness training would be useful for them. This was even the case for those whose roles have limited patient contact:

*As a receptionist I often have contact with service users and patients who may have difficulty processing the information I need to give them and knowing how best to help them would be invaluable.*

*So I can tailor my clinical tests to meet the needs of this population.*

*I work within the lab so I often do not have direct contact with patients but I do sometimes have to explain how long a test will take or the process of collecting a sample….it would be useful to know how to explain these procedures in an appropriate way.*

## Key learning

Of the **Tier 1 staff** who had not been offered learning disability awareness training, **87%** would have liked it.

Of the **Tier 2** staff who had not been offered learning disability awareness training, over **90%** would have liked it.

Staff in a range of roles were able to identify why this training would be **useful** to them.

# Conclusion

These surveys were conducted across England and staff responded from many different hospitals. They had received a variety of training and this was not an attempt to evaluate the range of training. It should also be noted that the respondents may not be representative of hospital staff in general. Therefore, we need to be cautious about the conclusions we draw, but the data has given key insights into how learning disability awareness training is received and what helps to make it useful.

It was overwhelmingly clear that learning disability awareness training was wanted by staff working in a variety of roles. When offered it, 87% of **Tier 1** staff and 98% of **Tier 2** staff accepted it. Moreover, 87% of **Tier 1** staff and 92% of **Tier 2** staff who had not been offered training would have liked it. However, only a small proportion of **Tier 1** staff (22%) had been given the opportunity. **Tier 2** staff were more likely to have been offered training but this was still less than half (41%).

The analysis of both the delivery staff survey and the general staff survey showed that there was little difference between **Tier 1** and **Tier 2** training in terms of timing and content. The training was most likely to last for 1-2 hours and be delivered face-to-face. The **Tier 1** training people had received covered considerably more than general learning disability awareness, as set out in the Core Skills Education and Training Framework. However, none of the **Tier 2** training covered all the subject areas.

Our literature review (Marriott and Harflett, 2020) identified that training will be more impactful and memorable if people with lived experience of learning disabilities are involved in the delivery of training. It is interesting to note that the delivery staff responses showed that they are more likely, or think it would be useful, to involve people with lived experience in **Tier 2** training rather than **Tier 1**. However, in the general staff survey **Tier 1** staff (46%) were more likely to report such involvement with than **Tier 2** staff (17%) were. Across both Tiers, those that had been on training delivered by people with lived experience were overwhelmingly positive about this and it was evident that accounts of real-life experiences made it more meaningful for participants.

We also asked about the involvement of family carers of people with learning disabilities in the delivery of the training. They were much less likely to be involved and both those delivering and receiving training were less sure of the value their involvement would add.

Previous evaluations of learning disability awareness training have demonstrated an increase in knowledge and confidence and positive changes in attitudes, (Marriott and Harflett, 2020) and this was reflected in our findings. Across both Tiers, nearly all the respondents found the training useful (92%) and the majority felt their knowledge had increased (77% of **Tier 1** staff and 85% of **Tier 2** staff). Our literature review (Marriott and Harflett, 2020) showed there is a lack of evidence about whether such positive changes are

maintained or if they lead to behavioural change. To explore this, we asked people if the training had made a difference to their practice and 69% of **Tier 1** staff and 76% of **Tier 2** staff reported that it had and many gave examples.

There is though still a need for research to assess if such changes in practice ultimately lead to better healthcare and outcomes for people with learning disabilities.

Our analysis showed that the majority of those who did not find the training useful did not receive face-to-face training. Given this was only a small number of people we cannot draw firm conclusions from this, but we recommend that future work should explore this more rigorously. The comments from respondents indicate that staff appreciated a practical focus to the training as well as the inclusion of people with lived experience.

Comments suggested that the training was more likely to be positively received when it had a practical focus and included people with lived experience, rather than training that was about rules and policies.

As most of our respondents had not been offered any training but said they would like it, we asked what they thought they could gain from it. The responses they gave were very similar to the benefits reported by people who had done training. This suggests that the training that is being delivered would meet the needs of staff in acute settings.

Since we conducted these surveys, Health Education England and Skills for Care have commissioned trials and an evaluation of Oliver McGowan Mandatory Training in Learning Disability and Autism. Our findings suggest that if this training becomes mandatory most staff would be positive about undertaking it, would gain new knowledge and could use this to make improvements to their practice. It is important to note that although almost everybody found the training useful, a smaller proportion had been able to make changes in their practice. This highlights the need for research to explore what is needed in addition to the training, to ensure it results in improved practice. This might include wider changes to systems, settings and structures.