Evaluation of the Oliver McGowan Mandatory Training Trial in Learning Disability and Autism

NDTi

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Executive summary

Background

Oliver McGowan was an autistic teenager who was admitted to hospital with seizures. Oliver did not have a mental illness or psychosis, but he was given antipsychotic medication against his and his family's wishes. Oliver was intolerant to this medication and died. His parents believe his death could have been prevented, and his mother Paula McGowan's campaign resulted in funding being made available to develop and test a range of learning disability and autism training packages.

This training aims to ensure that staff working in health and social care are better able to understand the needs of autistic people and people with a learning disability, resulting in improved services, less health inequality and the elimination of avoidable death.

The Department of Health and Social Care (DHSC) invested £1.4million to develop and test the Oliver McGowan Mandatory Training in collaboration with Health Education England (HEE) and Skills for Care (SfC). The aim of this work is to produce a standardised training package suitable for mandatory training.

What we did

The National Development Team for Inclusion (NDTi) was appointed as the independent evaluation partner, in partnership with bemix and My Life My Choice.

Trial and evaluation partners co-produced, co-delivered and co-evaluated the training. Autistic people, people with a learning disability and their families were involved at every stage. The evaluation ran from August 2020 to March 2022.

NDTi used a range of methods to evaluate the training packages including observations, surveys, interviews and group discussions. Quantitative and qualitative data were collected and analysed by the Evaluation Team.

Three different training packages were trialled and evaluated (Training A, B and C). Each training package had two components:

- Tier 1 Training, designed for those who require a general awareness of autistic people/people with a learning disability and the support needed.
- Tier 2 Training, designed for those who may need to provide care and support for autistic people/people with a learning disability.

The evaluation was limited by the fact that these training packages were delivered in different ways, covering different topics and by different organisations, making comparisons difficult. The impact of COVID-19 meant that fewer staff received training, resulting in less/insufficient data.

What we found about Tier 1 Training

The quality of the evidence

Training A: We have low quality evidence and cannot rely on it because:
- a small number of people completed all the parts (modules) of Tier 1;
- feedback was sometimes about modules and not the whole training;
- we were unable to determine the response rate accurately.

Training B: We have good evidence and can use it because:
- a large number of people were trained;
- those trained completed all parts of Tier 1 Training;
- we had an 80 per cent response rate.

Training C: We have low quality evidence and cannot rely on it because:
- the complete training package was not delivered to anyone;
- there is no evaluation data from anyone who completed the whole package.

What people told us about the training

Across all Tier 1 training packages and modules:
- High proportions of respondents agreed or strongly agreed that the pitch, pace and content of the training were right for them.
- The involvement of experts by experience was clearly identified as a strength of the training.
- The videos were highly rated, especially those involving people with lived experience.
- The opening video discussing Oliver's story was most likely to be cited as a standout feature of the training.
- Respondents rated their knowledge, skills and confidence in working and communicating with people with a learning disability or autistic people more highly directly after the training than before. Where there was sufficient data, analysis showed these increases were maintained at follow-up.
- Most people reported doing something different when supporting someone autistic or with a learning disability since their training.

There was a lack of consensus among respondents about the appropriateness of the length of the Tier 1 Training. Opinions about the length varied extensively and were not obviously related to the actual length of the course people attended.

Tier 1 Training was delivered through a mix of e-learning, live online training and face-to-face training. Most people agreed the delivery mode of the Tier 1 Training they received worked well for them.

Conclusion

There is insufficient evidence to draw conclusions for training A or C, but good evidence for training B. The evidence for training B is that it was fit for purpose, good quality and well received.

Recommendation

Tier 1 Training B (1.5-hour e-learning followed by 0.5-hour online interactive webinar with an expert by experience) is suitable and ready to be used.

There is some evidence from participants that the Training B package could be improved by extending the webinar length to one hour and including at least two experts by experience with different personal expertise.

What we found about Tier 2 Training

The quality of the evidence

For Training A: we have low quality evidence and cannot rely on it because:
- a small number of people received the training;
- it is unclear if people had received all parts of the training;
- we were unable to determine how many people completed all of it.

For Training B: we have moderate evidence and can use it with caution because:
- a reasonable number of people were trained;
- we had a 50 per cent response rate;
- all respondents received all the training.

For Training C: we have moderate quality evidence and can use it with caution because:
- a small number of people received all the training;
- there was a 90 per cent response rate;
- there was insufficient follow up data to tell us what people retained about what they had learned.

What people told us about the training

Across all Tier 2 training packages and modules:
- High proportions of respondents agreed or strongly agreed that the pitch, pace and content of the training were right for them.
- The involvement of experts by experience was clearly identified as a strength of the training.
- The videos were highly rated, especially those involving people with lived experience.
- The opening video discussing Oliver's story was most likely to be cited as a standout feature of the training.
- Case studies, scenarios and having verbal discussions suited people's learning styles.
- Respondents rated their knowledge, skills and confidence in working and communicating with people with a learning disability or autistic people more highly directly after the training than before.
- Most people reported doing something different when supporting someone autistic or with a learning disability since their training.

The length of training was difficult to get right but concerns can be mitigated by managing expectations and ensuring an adequate number of breaks of a sufficient length are included.

Tier 2 Training was delivered through a mix of e-learning, live online training, face-to-face training and hybrid training. Most people agreed the delivery mode of the Tier 2 Training they received worked well for them. The hybrid model trialled by Training Partner B at Tier 2 did not work as well.

Conclusion

There is insufficient evidence to draw conclusions for Training A. There is moderate evidence for Training B and C. The evidence for Training B and C is that both were fit for purpose, good quality and well received.

Both B and C have Tier 1 Training integrated into Tier 2 Training, so people doing Tier 2 Training would not need to complete Tier 1 first.

Training B takes one day to complete and Training C takes two days to complete.

Recommendation and considerations

There is insufficient data to recommend a clear outcome for Tier 2 Training. DHSC/decision-makers may wish to take into account the following considerations:
- Training C demonstrates slightly better outcomes, particularly in relation to learning, awareness and new skills.

- Training C requires two days to deliver which is likely to be a challenge for employers to implement.
- The evidence suggests that all three training packages were well-received and effective.
- There is learning from this evaluation that could inform the content of a new Tier 2 training package if one is required.

Overall conclusions

Developing a standardised training package that is effective for large groups of staff across different settings will inevitably pose a challenge.

The Oliver McGowan Training is a unique opportunity to make a difference to the lives of autistic people and people with a learning disability.

While the data can inform decisions about the content and mode of training, the main challenge now will be how to ensure consistent, high-quality delivery of the training and to ensure it leads to an improvement in the delivery of care and support to people with a learning disability and autistic people.

There is a need for longer-term work to explore the impact of this training on health and social care provision for people with a learning disability and autistic people.

Glossary

We have defined some terms that we use in this report:

Trial Partners

These are the groups that led the different types of training packages being trialled. Each had a lead organisation that worked with a number of other organisations, self-advocacy groups and people to design and deliver the Tier 1 and Tier 2 Training that was trialled.

Evaluation Team

This is the team that delivered the evaluation, carrying out the evaluation activities such as surveys, observations and interviews. It is made up of a group of people with various lived and professional expertise.

Advisory Group

This is a group of experts with lived and professional expertise, from universities, training organisations, health and social care, who advised the Evaluation Team. They were independent of all the other groups.

Operational Delivery Group (ODG)

This is the group that came together to discuss the operational sides of delivering the trial. Led by HEE and Skills for Care, it included members from the Trial Partners, the Evaluation Team and a number of people with lived and professional experience.

Strategic Oversight Group (SOG)

The SOG came together to oversee the trial and hold the operational delivery group accountable. This group was made up of people from the lived experience advisory board, DHSE, Skills for Care and HEE. It was co-chaired by Skills for Care and members of the lived experience advisory board.

Core Capability Frameworks

The content is based on the Capabilities Framework for Supporting People with a Learning Disability and the Capabilities Framework for Supporting Autistic People. See the capabilities frameworks.

These frameworks identify the different tiers of skills and knowledge that staff need in order to support people. They were developed with autistic people and people with a learning disability, including their families of all ages.

There are two frameworks because learning disability and autism are different and social care and health staff need to clearly understand this. They share a similar format to make them as straightforward as possible for workers and employers to use.

Tiers

The Core Capability Frameworks describe three different tiers of learning that people in different types of job role need to have, relating to their work with people with a learning disability or autistic people. The Oliver McGowan Mandatory Training covers Tier 1 and Tier 2. These are the descriptions of the tiers from the frameworks:

Tier 1 - In my role, I require a general awareness of autistic people / people with a learning disability and the support they need.

Tier 2 - In my role, I have responsibility for providing care and support for autistic people / people with a learning disability but would seek support from others for complex management or complex decision-making.

Tier 3 - In my role, I have a high degree of autonomy and provide care in complex situations and/or lead services for autistic people / people with a learning disability.

Lived experience or experts by experience

These terms refer to anyone who is autistic, has a learning disability or is a family member of someone who experiences either of those. It is important to remember that there is not a simple dichotomy between lived or professional experience. Many people bring multiple experiences, so someone autistic might also be a professional in social care or health, and a trainer might also have a learning disability or be the parent of someone with a learning disability. For the purposes of this evaluation, we try to draw out the relevant primary expertise and ensure that all these voices are heard.

E-learning

E-learning refers to online learning that is carried out by the learner alone, in their own time and on a computer. It does not involve directly interacting with a trainer.

Blended learning

Blended learning is made up of a mix of e-learning, and then a training course facilitated by trainers.

Face-to-face training

This training is carried out in a classroom with one or more trainers and a group of learners.

Online training or face-to-face online training

This is where training is directly facilitated by trainers, with live discussion and interaction with the learners, and it is carried out online using a platform like Zoom or MS Teams.

Hybrid training

Hybrid training is a mix of face-to-face training and online training happening at once. The trainers facilitate the group in the room and the training is live-streamed to people on their computers, who also interact and get involved in the learning activities and discussions.

Quality measures

These are the subjective measures used in the surveys to determine what individuals thought of the training they received. They were asked to rate the training on a variety of factors, including length, pitch and quality.

Competency measures

These are self-rated measures used in the surveys to understand the impact of the training on learners' skills, confidence and knowledge.

Quantitative data

This is information that can be counted. It is about numbers.

Qualitative data

This is information about how people feel and what they think. It is about words.

These terms are in bold and in **dark pink** colour the first time they are used.

Chapter 1: The Oliver McGowan Mandatory Training Trial in Learning Disability and Autism

This chapter provides a short introduction to the overall funded programme of work. This includes information about the evaluation approach and the range of data collection methods used.

Background

> The training is named after Oliver McGowan, whose death shone a light on the need for health and social care staff to have better training.

Oliver McGowan was an autistic teenager who was admitted to hospital having focal partial seizures. Despite Oliver not having a mental health illness or psychosis, he was administered antipsychotic medication against his and his family's wishes. Oliver was known to be intolerant to all forms of antipsychotic medication. This led to Oliver's brain swelling, resulting in his death. An independent Learning Disability Mortality Review found that Oliver's death was potentially avoidable.

The Learning Disabilities Mortality Review (LeDeR) Programme (now known as the Learning from lives and deaths – People with a learning disability and autistic people programme) has consistently shown that people with a learning disability have a lower life expectancy and are more likely to have preventable, treatable and overall avoidable medical causes of death compared to the general population. In 2017 the LeDeR Programme's annual report recommended that: "Mandatory learning disability awareness training should be provided to all staff, and be delivered in conjunction with people with a learning disability and their families." (2017, page 8). Every subsequent LeDeR annual report has made further reference to training needs[1].

Following Oliver's death, Paula McGowan led a campaign for more training for health and social care staff to provide them with the confidence and skills to understand the needs of people with a learning disability and/or autistic people in their care.

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[1] https://leder.nhs.uk/resources/annual-reports

Her petition received over 52,000 signatures and led to a debate in parliament and subsequently a consultation about the issues around the training and development staff need to better support people with a learning disability or autistic people. There were over 5,000 responses to the consultation and in 2019 the government set out their commitment to mandatory training in their consultation response in 'Right to be heard'. This included the announcement of funding to develop and test a learning disability and autism training package that could be deployed. This is the Oliver McGowan Mandatory Training in Learning Disability and Autism.

> The aim of the training is to ensure staff working in health and social care are better able to understand the needs of autistic people and people with a learning disability, provide improved services, reduce health inequality, and eliminate avoidable death.

The aim was to trial a range of forms of training, evaluate them and produce a standardised training package suitable for broader adoption. The Department of Health and Social Care (DHSC) invested £1.4million to develop and test the Oliver McGowan Mandatory Training in collaboration with Health Education England (HEE) and Skills for Care (SfC). Trial and evaluation partners were appointed to co-produce, co-deliver and co-evaluate training. Every stage including consultation, planning and procurement, and delivery has included the direct involvement of autistic people, people with a learning disability and their families, as well as professional expertise. The content of the training needed to be based on the Capabilities Framework for Supporting People with a Learning Disability and the Capabilities Framework for Supporting Autistic People. These frameworks identify the different **tiers** of skills and knowledge staff need to support people with a learning disability and/or autistic people. They were developed with autistic people and people with a learning disability and their families.

In June 2020, four **Trial Partners** were appointed to co-produce and co-deliver the training in a trial across the health and social care sector. Each Trial Partner was a consortium of organisations. The National Development Team for Inclusion (NDTi) was appointed through HEE's procurement processes as the independent evaluation partner, in partnership with bemix and My Life My Choice. A timetable for the trial and evaluation can be found in Appendix A (see table A1).

This final evaluation report summarises the data collected from the trial and makes recommendations based on the analysis of these data to inform the design and next steps of the Oliver McGowan Mandatory Training.

Training design

Tier 1 and Tier 2 training packages were delivered by three Trial Partners. Across the Trial Partners there were 8,374 completions of the training packages.

Due to the impact of the COVID-19 pandemic in the north-west, one Trial Partner had to drop out of the trial. This report therefore only describes the trial outcome of three Trial Partners. An interim report was published in November 2021 to demonstrate how progress was being made on the trial.

Evaluation method

The Evaluation Team used triangulation of observations, surveys, interviews and focus groups to gather feedback from a range of perspectives.

With co-production at the heart of the evaluation, NDTi, in partnership with bemix and My Life My Choice, built an evaluation team to ensure that the necessary breadth of knowledge, skills and experience required for the project were in place. We have worked together to design and deliver the evaluation. In this report we refer to this team of people as the **Evaluation Team**. The Evaluation Team was made up of people with evaluation expertise, expertise in workforce development, people who are autistic and people with a learning disability. There were other team members who ensured people were supported to be fully involved in the co-production of the evaluation throughout. We were supported by our **Advisory Group** who used their personal and professional expertise to support, challenge, and hold the Evaluation Team to account. Members of the Advisory Group included experts by experience, family carers, academics and other experts.

The evaluation was designed to establish the impact of training, including:

1. Improvement of staff understanding of learning disability and autism in the context of their job role.

2. Improvement of delivery of care and support to people with a learning disability and autistic people.

3. The efficacy of training delivery methods (such as e-learning, face-to-face, blended learning) in each setting to improve understanding and care.

4. The experience and views of service users and families.

5. Identification of the challenges and barriers, and potential ways to address them as part of a 'lessons learnt' exercise.

NDTi achieved this using the **Kirkpatrick Four-Level Training Evaluation Model**[2] as a framework. This considers learning at four levels (see Figure 1). This helped to frame our analysis of the impact of the different training models trialled.

Figure 1: The Kirkpatrick Model

1 — **Reaction** - a measure of how participants found the training.

2 — **Learning** - whether the training increased the knowledge, skills and confidence of the participants.

3 — **Behaviour** - an analysis of the extent to which participants are applying what they learned and if the training has led to a change of behaviour.

4 — **Results** - the degree to which the desired goals of the training were achieved.

In addition, we also considered the impact of the training programme on **experts by experience**[3], who were involved in designing or delivering the packages, with potential impacts including increased confidence and skills or more practical benefits, such as paid employment. We used a modification of Kirkpatrick's model for summative evaluation of educational interventions, adding in Level 1b, as proposed for such purposes by Morgan and Jones (2009). This considered service-user views on their involvement experience.

In this report we will present the evidence collected about each training package for each of the Kirkpatrick levels, in order to report on the findings in relation to points 1 to 3 above.

People with lived experience (including family members) have been involved in the design and delivery of the training and their reflections on this process have been sought and used as a basis for guidance for health and social care employers on the involvement of people with lived experience in the delivery of training, including their remuneration. The findings of this work are available in a separate report. Given the timescales of the trial, it has not been possible to include the experience and views of people who use health and social care services in order to understand what their experiences have been in relation to their use of services following training to the staff delivering that care. Suggestions have been made for how this could be done moving forward.

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[2] https://www.kirkpatrickpartners.com/Our-Philosophy/The-Kirkpatrick-Model

[3] In this report, we use the term expert by experience or people with lived experience to refer to autistic people or people with a learning disability, as well as family carers.

Through surveys and interviews we collected data about the challenges, barriers and possible facilitators related to:

- health and social care staff implementing what they learnt in the training;
- the delivery of the training.

The findings from this work are available in a separate report.

Summary of the data collection methods:

Benchmarking	We mapped each training package against the specific capability training frameworks to show the capabilities covered.
Observation	Training sessions were observed by experts by experience working on the programme[4]. This included members of the Evaluation Team, the Advisory Group, and the **Strategic Operational Group**. The Evaluation Team developed a quality checklist to complete when observing the training.
Pre and post user survey	Pre- and post-training surveys were designed and sent to participants by Trial Partners. These asked for staff members' perceptions of changes in their understanding of learning disability and autism and gave feedback on the effectiveness of training delivery methods.
Follow-up survey	A short online follow-up survey was sent to training participants from two-to-three months after they had completed the training. This aimed to capture any longer-term impacts of the training and explore any changes in practice.
Semi-structured interviews	Telephone or online interviews were conducted with a representative sample of training attendees a minimum of two-to-three months after they had completed the training. We interviewed health and social care staff working in a range of roles and settings, and ensured the involvement of a mix of people with varied levels of contact with autistic people or people with a learning disability in their day-to-day work roles and lives. The interviews built on the follow-up survey to capture in more depth some of the longer-term qualitative outcomes of the training in the context of participants' roles.

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[4] Training C T1 on learning disability was not observed as it was cancelled due to trainer sickness, and then new COVID-19 restrictions meant it was not run again.

Focus group discussions	Focus group discussions were conducted with people involved in the design and delivery of the training. The focus group discussions enabled people to share and compare experiences of designing and delivering the training, as well as approaches to, and levels of, real co-production.
Analysis of costs	We collected details from each Trial Partner about what the costs were to run each training course.

There were **4,919 responses** to the post-training survey across all the training, representing a response rate of 56 per cent of people that had received some Oliver McGowan Mandatory Training.

We conducted a total of **67 post-training interviews** with people who had received training.

We ran **eight focus groups** with people involved in the design and delivery of the training.

We have drawn on all the data sources to write this report and to make recommendations. Appendix A presents further details of each of the evaluation activities and the number of respondents for all stages of data collection.

By the end of the trial 8,374 people had been trained across both tiers. There were a total of 4,727 pre-survey responses (a 56 per cent response rate from those who received training).

Pre-survey analysis

- The cohort of people who completed the pre-training survey is broadly representative of the health and social care workforce in terms of age and gender but less representative in terms of ethnicity.
- The training was delivered to people working in a broad range of roles within health and social care, as well as to people working in other sectors.
- The working tiers (defined in the Core Capabilities Framework) do not appear to be widely recognised by health and social care staff in relation to their roles.
- If respondents had received training on supporting people with a learning disability or autistic people before, it was most likely to have been at least two days.
- A higher proportion of respondents suggested they had received no prior training about supporting an autistic person (27 per cent), than about someone with a learning disability (21 per cent).
- Our respondents were more likely to interact with autistic people (78 per cent) or people with a learning disability (79 per cent) within their work than outside of work (21 to 22 per cent).

Further analysis of this pre-survey data can be found in Appendix A.

Limitations and quality of the evaluation data

> There are a number of important limitations to the design of the trial and the data collected that must be considered when decisions are taken about the next steps of the training.

Limitations to the design of the trial and the data collected included:

- COVID-19 had direct implications on what was legally possible to deliver, meaning fewer staff received the training than had initially been planned. This meant there was insufficient data for some of the planned analysis.

- The evaluation relied on self-reported, subjective data in relation to the quality and competency measures. This meant the data reflected individuals' opinions and as such the evidence about some aspects of the training is inconclusive, as there was no strong consensus.

- There were responses that were inconsistent with what was delivered. For example, respondents commenting on the online training when they attended a face-to-face training session. Data cleansing addressed this where possible, but response bias may have affected the accuracy and reliability of the results.

- There are many confounding factors in the design of this trial. The training packages were delivered in different modes (e.g. online, face-to-face or hybrid) and this is likely to have impacted upon how the content was received.

- There were different trainers from different organisations delivering the training across each package trialled. This means that differences between the data cannot be attributed solely to the design and content of the training but will be impacted by other factors, such as the experience and skill of the trainers.

- It will take longer to determine the long-term and sustained impact on delivery of care and support. The timescale of the programme meant it was necessary to conduct follow-up data collection two-to-three months after the training, and change will inevitably take time.

- Analysis of differences between training packages was not possible because some training packages focused solely on learning disabilities, some on autism and some on both.

- Some of the Trial Partners needed to make changes in the delivery of their training after the evaluation had commenced. This resulted in data being collected from some respondents before they had completed the entire training, meaning data from the Trial Partners was not always directly comparable.

- The Oliver McGowan Mandatory Training requires training on both learning disability and autism. Some of those receiving Training A (Tier 1) and Training C (Tier 1 and Tier 2) only undertook part of the training.

In view of the limitations and the varying quality and amount of evidence in relation to each training package, we have taken the approach of making recommendations as well as points for consideration:

Recommendations – these have been made where the evidence is considered to be strong enough to base a decision on, and the recommendation being made is something that has been directly tested.

Considerations – these are founded on reasoned arguments on the basis of the analysis of the wider evidence. They are suggestions about what could be done differently and, although evidence-based, have not been directly tested.

Chapter 2: Tier 1 Training

In this chapter we present a description of the content and delivery of the Tier 1 Training and the analysis of the data we have collected across all three Trial Partners. This includes data from the surveys, interviews, focus groups and observations of the training. We review the strength of the evidence base and report on what respondents thought about the training they received, what they think they learnt and how they have been able to apply the training in their work. Recommendations and points to consider for the future delivery of Tier 1 Training are based on this analysis.

Content and delivery of Tier 1 Training

The Oliver McGowan Mandatory Training is based on the capabilities and learning outcomes described in the [Capabilities Framework for Supporting People with a Learning Disability](#) and the [Capabilities Framework for Supporting Autistic People.](#)

Given the breadth of these frameworks, during the development phase of the training when all Trial Partners were co-designing their training packages, it was agreed collectively across all groups involved in design and governance that the following topics of learning would form the minimum content in each training package:

- What is a learning disability?
- What is autism?
- How do they affect people?
- How to see invisible disability
- Reasonable adjustments – what are they and how to make them
- Self-reflection on own attitudes and behaviour

All trial training packages also included Oliver's film, along with time for discussion and reflection. Despite the overall consistency of content across all training packages, there was some variation in training design (the following descriptions are not exhaustive; see [Appendix B](#) for further detail).

Trial Partner A Tier 1 Training was run as two separate courses: one about understanding learning disability, the other on understanding autism. Each had an e-learning module for learners to undertake, made up of a mix of presentations, tests of learning, case studies and examples. This was completed at any time selected by the learner ahead of 1.5-hour long tutorials with at least one expert by experience. The Tier 1 courses covered topics such as understanding of what autism or learning disabilities are, preferred language, historical attitudes and support, key legislation, ways of thinking and communicating, and adaptations people could make in their own workplaces.

Training Partner B Tier 1 Training included a 1.5-hour e-learning prior to a 0.5-hour online face-to-face tutorial with someone with lived experience. The content covered introductions to learning disabilities and autism.

In addition to Oliver's story, the e-learning included a wide selection of films on learning disability and/or autism from people with different **lived experience**. The films covered different experiences and support needs relating to topics such as diagnosis, sensory experiences, communication and health issues, as well as dealing with others' attitudes and things that can improve experiences, such as reasonable adjustments. 'Ask Listen Do' provided a structure for reflection in each section. The tutorial provided an opportunity for face-to-face discussion to explore what had been learnt and to hear and ask directly about the experiences of the person running the tutorial.

Trial Partner C Tier 1 Training was run as two separate courses: one on autism, the other on learning disabilities. Each was designed to be run as a face-to-face 3.5-hour workshop, co-facilitated with two trainers, at least one of whom had lived experience. The autism module was also delivered as an interactive online workshop where COVID-19 or other factors required this. Both courses covered the content described in the Tier 1 list above and encouraged participants to recognise their own attitudes as well as organisational attitudes. The aim was to build understanding of other conditions autistic people or those with a learning disability may live with, and the potential triggers and challenges this group of people may face in health and social care settings, along with changes that can be made in these settings.

Table 1: A comparative summary of the design and delivery of Tier 1 Training across the three Trial Partners

Aspects of training	Training Partner A	Training Partner B	Training Partner C (Learning Disability)	Training Partner C (Autism)
Delivery methods summary	E-learning followed by online face-to-face tutorial with experts by experience and topic expert trainers.	E-learning followed by short drop in tutorials with trainers with lived experience and topic experience.	Face-to-face workshop delivered by a training expert with input from an expert by experience.	Interactive face-to-face or online training. Co-delivered by two trainers, at least one of whom was autistic.
Autism / learning disability separate or mixed	Separate autism and learning disability courses.	Autism and learning disability.	Learning disability only.	Autism only.
Involvement of people with lived experience in training delivery	Yes Tutorial includes trainers with relevant lived experience for that topic.	Yes Tutorial with people with a range of lived experience – including autistic people, people with a learning disability and family carers.	Yes Face-to-face sessions include someone with lived experience for part of the session.	Yes Online interactive session co-facilitated by two trainers, one or both with lived experience.
Involvement of people with lived experience in training materials	E-learning includes additional people's stories.	Films of people sharing their personal experiences of being autistic or having a learning disability throughout the training.	Films co-designed and acted by people with a learning disability form part of the training.	Films of people sharing personal experiences form part of the training.
Use of e-learning (non-interactive online learning)	Yes, e-learning precedes face-to-face workshops.	Yes, e-learning precedes tutorial.	No.	No.
Face-to-face (in a room, in person)	No (but some online interactive).	No (but some online interactive).	Yes.	Yes (OR online interactive).

Aspects of training	Training Partner A	Training Partner B	Training Partner C (Learning Disability)	Training Partner C (Autism)
Online interactive (live but run on MS Teams or Zoom)	Yes.	Yes.	No.	Yes.
Hybrid delivery (live workshop in room which is live-streamed for online participants)	No.	No.	No.	No.
Learning materials provided after training	Case studies and information from training on Learning Management System.	Guidebook with materials and links.	PowerPoints provided.	Handbook provided.
Length of learning time	6 hours (based on 1.5 hours e-learning plus 1.5 hours tutorial for each module).	2 hours (based on 1.5 hours e-learning plus 0.5 hour webinar).	3.5 hours.	3.5 hours.
T1 incorporated into T2	N/A	N/A	N/A	N/A
Number of participants	10-15 per tutorial.	On average 15 per tutorial (but this could be up to 100).	Up to 25 (in non-COVID times).	Up to 25 (in non-COVID times).

Tier 1 Training data quality

Data was collected across all Trial Partners. However, variation did exist in the number of trial participants trained, timeframes for responses on surveys and interviews, and how the training was set up. Tables 1 to 4 below summarise how this variation may have affected the quality of evidence for each Trial Partner.

Table 1: Data available for Tier 1 Training A

	Survey data	Interview data
Data available for analysis (1,124 participants reported to have received Training A learning disability module and 833 people received autism module. Number who completed full training unknown)	200 responses to post-training survey following both modules. 62 responses to follow-up survey following both modules.	Four interviews with people who did the complete training. Six interviews with people who had done one of the modules.
Comments on the quality of the data	Changes were made to the delivery after the evaluation had commenced, meaning all respondents commented on the individual modules rather than the overall training. Adequate post-training sample. As the number of participants who received training on both learning disability and autism is not known, we cannot comment on acceptability of sample size at follow-up. Sufficient data to allow analysis of competency measures across all three time-points of learning disability (N=71) and autism (N=80) modules separately.	It was only possible to interview a small sample of people who had completed the full training (in both learning disability and autism).

Table 2: Data available for Tier 1 Training B

	Survey data	Interview data
Data available for analysis (2,699 participants reported to have received Training B)	2,151 responses to post-training survey following full training. 304 responses to follow-up survey following full training.	14 interviews completed with people who did the complete training.
Comments on the quality of the data	All respondents had completed full training and these are larger datasets, so this data can be considered to be robust (with data from 80 per cent of those trained). Sufficient data at all three time-points to allow analysis (N=61).	Sample size sufficient.

Table 3: Data available for Tier 1 Training C

	Survey data	Interview data
Data available for analysis from complete training	2,249 responses to pre-training survey. No data following training.	None.
Comments on the quality of the data	No-one received training on both learning disability and autism training, which is a requirement of the complete Oliver McGowan Mandatory Training package, so there is no data to evaluate the effectiveness of the whole training package.	
Data available for analysis of learning disability module (456 participants reported to have received Training C learning disability module)	299 responses to post-training survey following learning disability module. 37 responses to follow-up survey following learning disability module.	Four interviews completed with people who did the learning disability training module.

	Survey data	Interview data
Comments on the quality of the data	Adequate sample size for post-training survey. Small sample size at follow-up. No data for any respondents across all three time-points (N=0).	Small sample.
Data available for analysis for autism module (688 participants reported to have received Training C autism module)	266 responses to post-training survey following autism module. 135 responses to follow-up survey following autism module.	Seven interviews completed with people who did the autism module.
Comments on the quality of the data	Adequate sample size for post-training survey and follow-up survey. No data for any respondents across all three time-points (N=0).	Sample size sufficient.

In view of the difference sample sizes and set-up of each training package, we have taken a decision as to the overall quality and strength of the evidence base.

Table 4: Summary of the quality of the available data about Tier 1 for each Training Partner

Training Package	Comments on overall quality and reliability of data
Training A	**Low:** Small number of people received the complete training package. Evaluation sample representative of those trained (not possible to be sure of exact response rate). Quality of data limited by respondents commenting on the individual modules, rather than the overall training.
Training B	**Good:** Large number of people trained. Evaluation sample representative of those trained (80 per cent response rate). All respondents received complete training.
Training C	**Very low:** Complete training package not delivered. No evaluation data of complete training package.

What people told us about the training

All of the training packages had good scores and feedback for quality of training, improvements in knowledge and subsequent behavioural and workplace changes. Below we report on what was found in relation to each Kirkpatrick level.

Kirkpatrick Level 1: Reaction for Tier 1 Training

> Across all Tier 1 Training packages, high proportions of respondents agreed or strongly agreed that the pitch, pace and content of the training was right for them.

The post-training survey required respondents to comment on the quality of the training in relation to overall quality, pitch, pace, length, whether it was a good use of the individual's time, the skills of the trainer(s) and the usefulness of the training compared to other training on this subject previously attended.

Figures 2 to 7 present the percentages of people that agreed or strongly agreed with each of these statements.

Figure 2: Pitch of Tier 1 Training

"The training was pitched at the right level for me"
% attendees who agreed

- Training A (Learning Disability): 79%
- Training A (Autism): 82%
- Training B: 89%
- Training C (Learning Disability): 91%
- Training C (Autism): 87%
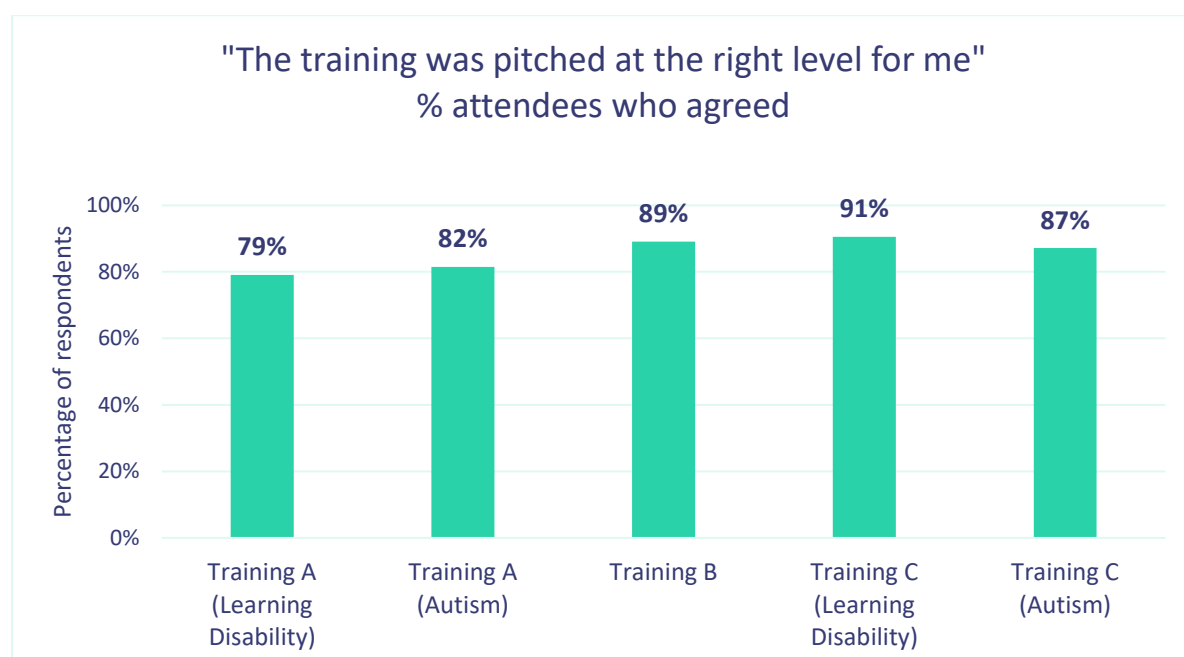
Figure 3: Pace and content of Tier 1 Training

"The pace and amount of content covered was right"
% attendees who agreed

Bar chart showing percentage of respondents:
- Training A (Learning Disability): 87%
- Training A (Autism): 87%
- Training B: 87%
- Training C (Learning Disability): 89%
- Training C (Autism): 88%
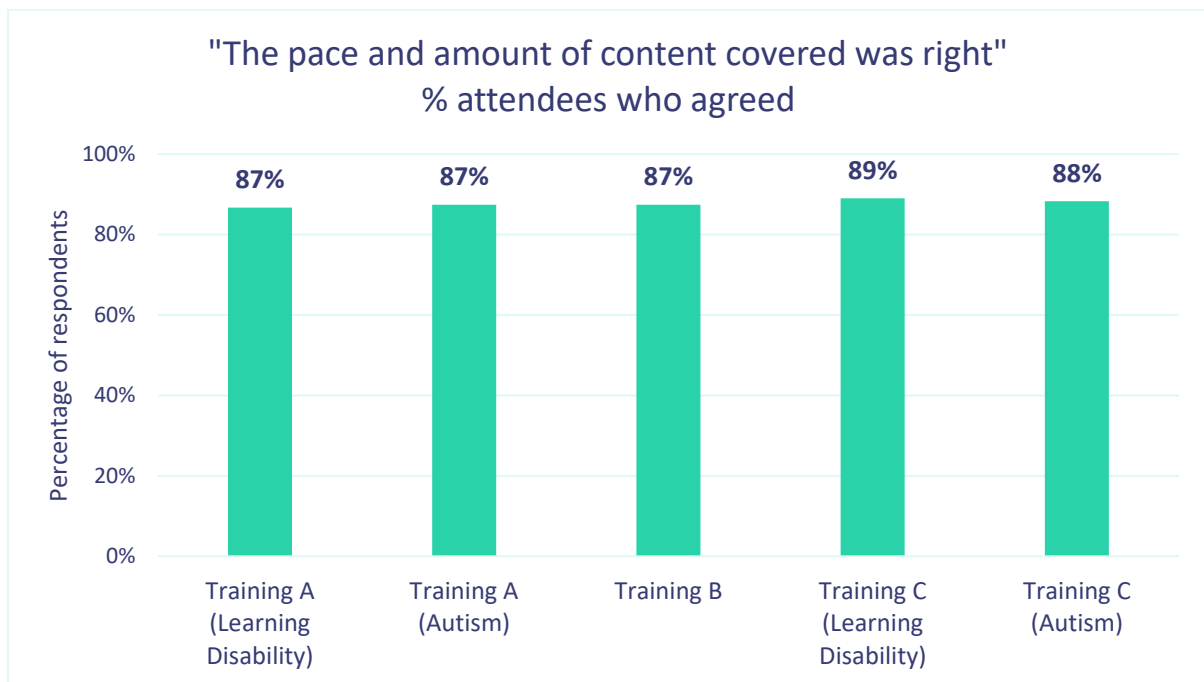
Figure 4: Good use of time in relation to Tier 1 Training

"The training was a good use of my time"
% attendees who agreed

Bar chart showing percentage of respondents:
- Training A (Learning Disability): 83%
- Training A (Autism): 89%
- Training B: 90%
- Training C (Learning Disability): 97%
- Training C (Autism): 95%
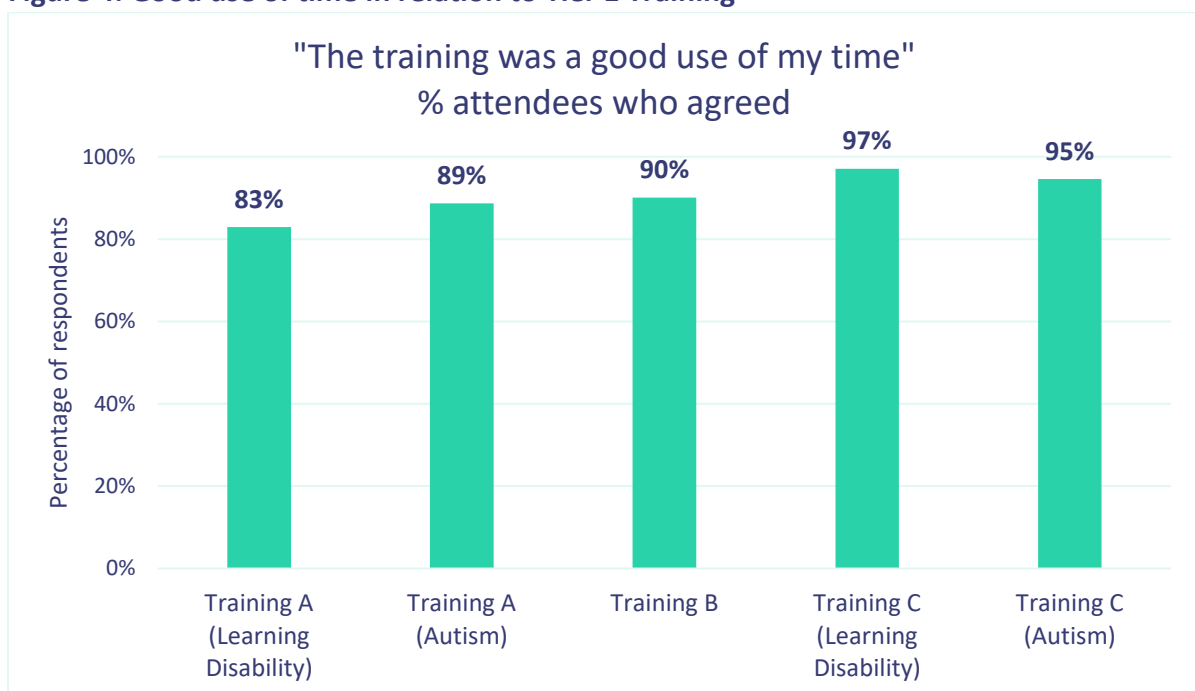
Figure 5: Skills of the trainers in relation to Tier 1 Training

"The trainer/s had the skills needed to deliver the training"
% attendees who agreed

Training	%
Training A (Learning Disability)	94%
Training A (Autism)	90%
Training B	95%
Training C (Learning Disability)	98%
Training C (Autism)	96%

Percentage of respondents (y-axis: 0% – 100%)
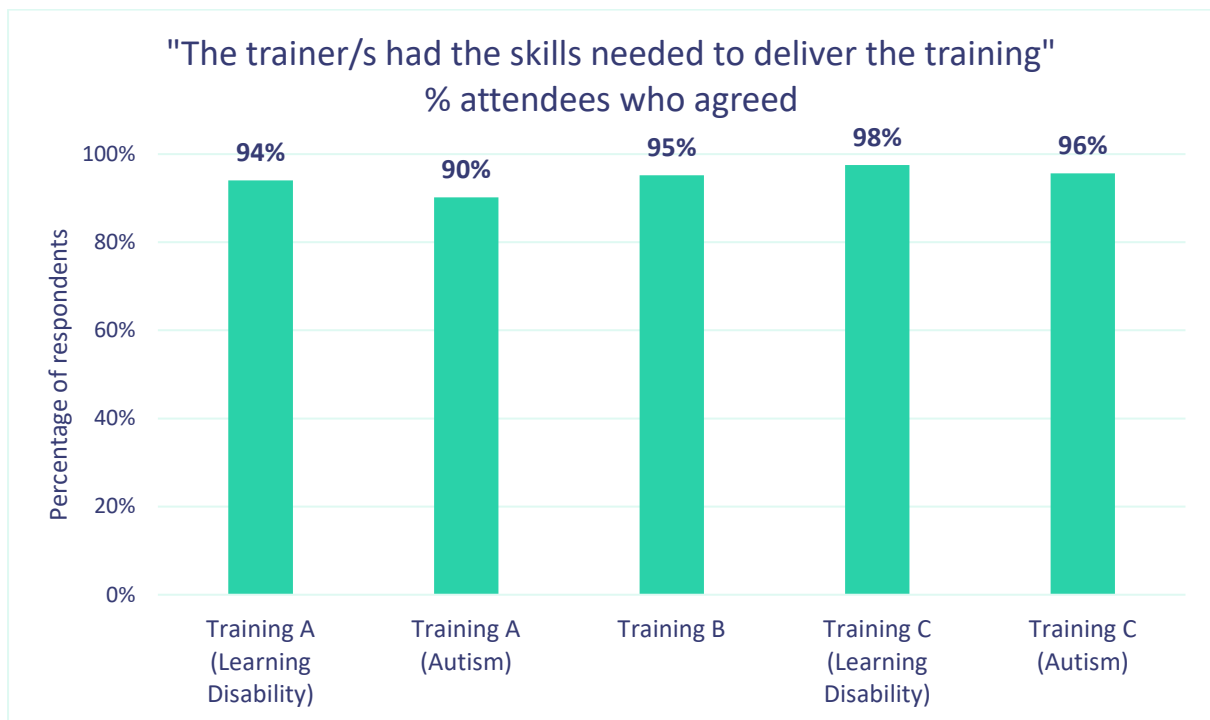
Figure 6: Overall quality of Tier 1 Training

"The overall quality of the training was good"
% attendees who agreed

Training	%
Training A (Learning Disability)	94%
Training A (Autism)	94%
Training B	96%
Training C (Learning Disability)	98%
Training C (Autism)	96%

Percentage of respondents (y-axis: 0% – 100%)
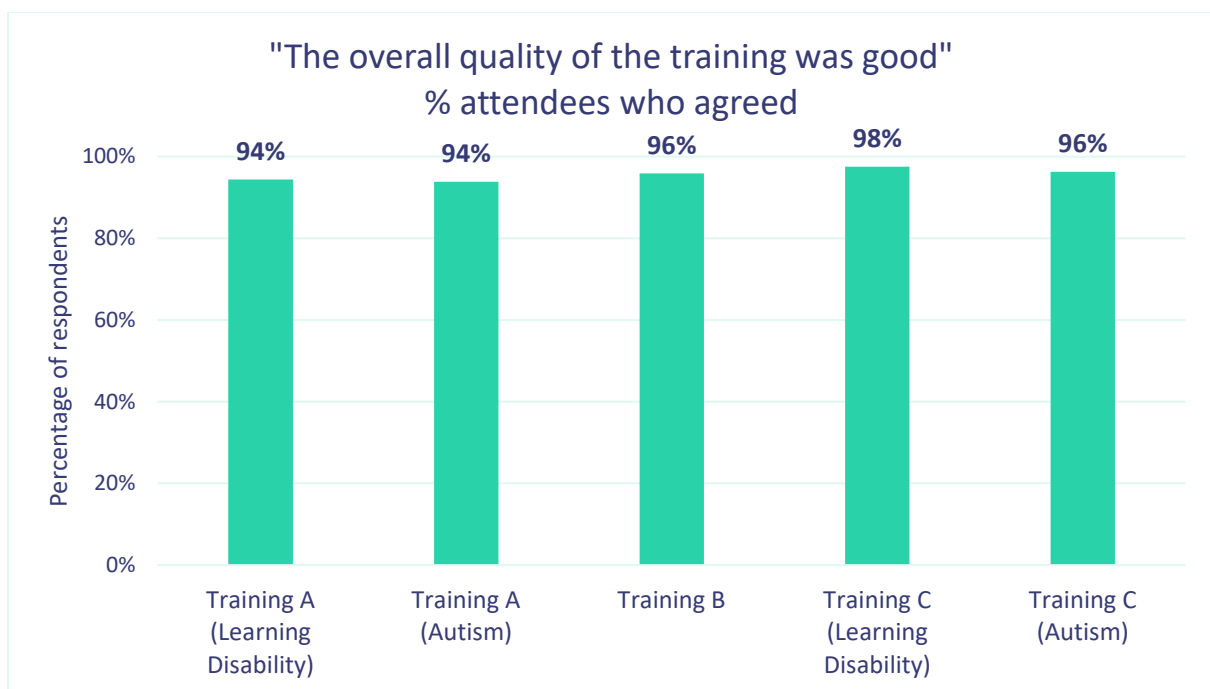
Figure 7: Usefulness of Tier 1 Training in comparison to previous training on this subject

"The training was more useful than previous training I have had on this subject" % attendees who agreed
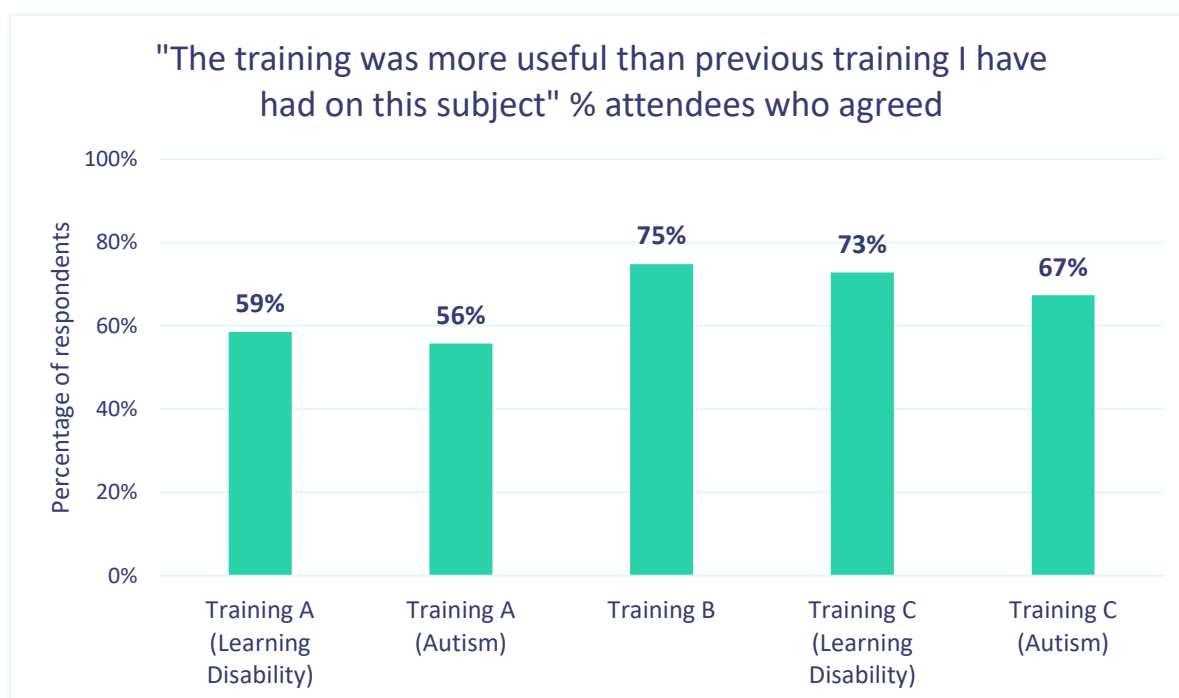
Figures 2 to 7 demonstrate that Tier 1 Training was viewed positively by the majority of respondents on all the **quality measures**. Smaller percentages of people agreed the pitch of Training A was right for them in comparison to Training B and C. Similarly, respondents were less likely to report that Training A was more useful than previous training.

Given that all training packages were delivered to staff working in a wide range of roles with a variety of previous experience, we consider that these responses reflect a high level of satisfaction with all the trialled training packages for Tier 1.

Length of Tier 1 Training

> There was less consensus among respondents about the appropriateness of the length of the Tier 1 Training in comparison to the other quality measures. The opinions about the length of training varied extensively and were not obviously related to the actual length of the course people attended.

The time taken to complete Tier 1 Training varied across the Trial Partners:

- Trial Partner A: six hours in total (two online sessions of 1.5 hours each plus e-learning)

- Trial Partner B: two hours in total (approximately 1.5 hours for e-learning and 0.5 hour for live webinar)
- Trial Partner C: seven hours

The length of training needs to be seen as a quality measure; participant views on this were more varied than on the other quality measures. Table 5 shows respondents' views on length of each training package.

Table 5: Respondents views on the length of the Tier 1 Training

Percentage of respondents who agreed that their training package was too long or too short (%)	Training A (Learning Disability)	Training A (Autism)	Training B	Training C (Learning Disability)	Training C (Autism)
Too long	11%	10%	20%	4%	5%
Too short	10%	11%	9%	22%	17%

More people reported that the shortest training (Training B) was too long compared to the longest training (Training C).

Comments from interviews, free text survey questions and observations support the difficulties of getting the length of the training right for all participants. Respondents receiving the same training had different views on whether the training was too long or too short. One factor related to this may be the different job roles of the participants and their perception of the relevance of the training to their role.

> *"I am a back-office worker with no service-user interactions. The training was far too excessive for my role."* (Survey response, Training B T1)

What could have been better about the Tier 1 Training?

62 to 81 per cent of respondents did not think there was anything that could have been better about the Tier 1 Training they received.

A further measure of respondents' views of overall quality could be gauged from their answers to the question "was there anything that could be better about the training?" in the post-training survey. The percentage of respondents who stated nothing could be better about the training they received is shown in Table 6.

Table 6: Percentage of responses saying nothing could have been better for Tier 1 Training

Trial Partner	Percentage (%)	Number of respondents
Training Partner A Learning Disability	75%	399
Training Partner A Autism	78%	432
Training Partner B Learning Disability and Autism	81%	2,151
Training Partner C Learning Disability	62%	245
Training Partner C Autism	64%	299

Overall, for Tier 1 Training, Trial Partner B had the highest percentage of responses where nothing could be better (81 per cent). This was closely followed by Trial Partner A, with Trial Partner C having the lowest response rate for this measure.

Mode of delivery of Tier 1 Training

> Tier 1 Training was delivered through a mix of e-learning, live online training and face-to-face training.
>
> 85 to 97 per cent of respondents agreed the delivery mode of the Tier 1 Training they received worked well for them.

We know that the Right to Be Heard consultation explored whether face-to-face training was necessary for all staff and reported that 52 per cent of respondents did not think it was. However, the report concluded, "having a face-to-face component is very important" (p.7). As the Trial Partners had to react to COVID-19 lockdowns and restrictions in order to ensure delivery of the training, some planned face-to-face training was moved to online interactive training.

In the post-training survey, respondents were asked to state how well a particular mode of delivery worked for them. The final analysis only took account of responses to the modes of delivery that had actually been received by respondents (see Table 7).

Table 7: Mode of training

Mode of training	Percentage agreeing or strongly agreeing the mode of delivery worked well for their learning style (%)				
	Training A (Learning Disability)	Training A (Autism)	Training B	Training C (Learning Disability)	Training C (Autism)
Delivered face-to-face in a room only	N/A	N/A	N/A	97%	86%
Live online (delivered live through Microsoft Teams, Zoom or similar)	90%	95%	89%	N/A	95%
E-learning (online but not live; can view or complete at any time)	95%	95%	94%	N/A	N/A

The vast majority of people found that the training mode used for Tier 1 Training worked well for them (minimum of 85 per cent). The lowest rate of satisfaction was for face-to-face delivery of the Training C Autism module, while the highest rate of satisfaction with the delivery mode was for the face-to-face delivery of Training C Learning Disability (97 per cent).

> *"You are in the room with the person who is speaking, so you are not as disconnected as you are when you are online."*
> (Interview, estates officer, Training C T1 Learning Disability)

Training C Autism was the only Tier 1 Training delivered both online and face-to-face; respondents were more likely to report the online delivery method worked well for them (95 per cent) compared to the face-to-face delivery (86 per cent).

It was evident from the free text survey responses that for some people there were benefits of doing **online training** or e-learning due to the flexibility and lack of travel:

> *"Excellent idea doing the training online. Even after COVID I think courses should be like this sometimes; it can be hard to travel to different places."*
> (Survey response Training A T1)

> *"I am glad I was able to do the training online in my own time as I was able to choose a time that suited me so I could be fully engaged without any distractions."*
> (Survey response Training B T1)

There were positive comments about the quality of the e-learning from the free text survey responses and interviews:

> *"It was one of the most profound e-learning programmes I've ever undertaken."*
> (Interview, associate director of organisational development, Training B T1)

The use of the videos in the Training B e-learning seemed to bring the e-learning to life. In an interview, someone spoke about the use of lots of video extracts and how effective this was:

> *"People really showing that they'd been involved in the creation of that training and that they were really sort of signed up to it and really passionate about making a real change… it just felt so coproduced."*
> (Interview, commissioner, Training B T1)

Some respondents liked the combination where the e-learning modules were pre-learning for live online sessions:

> *"I liked the mix… The e-learning bit beforehand was very useful for an overview of it. The online session was really good."* (Complaints officer, Training A)

Despite very high rates of satisfaction with the e-learning packages, a small percentage (one to five per cent across the training packages) of people suggested a preference for face-to-face training when asked what could have been done better in the training.

> *"I prefer face-to-face training but this is obviously difficult during the pandemic but still very good training."* (Survey response, Training C T1)

Some technical challenges with e-learning were reported:

> *"It was a bit difficult navigating the log-on pages."* (Survey response, Training A T1)

However, there were also technical issues with the face-to-face training; several people mentioned technical problems that meant some of the videos could not be viewed.

Training methods and activities

- The involvement of experts by experience was clearly a strength of the training for many respondents.
- Videos were often cited as the standout takeaway from the training, especially those involving experts by experience.
- The opening video discussing Oliver's story was particularly impactful but for some trainers and participants it was too emotive and overwhelming.

Almost all respondents across all training packages (95 per cent or more) agreed that sharing of information by someone with lived experience or a video involving someone with lived experience suited their learning style. 95 per cent of respondents or more also agreed that involving a professional who worked with someone with a learning disability and/or an autistic person suited their learning style.

The interview and survey data showed that having experts by experience involved in delivering training made it different and refreshing. They said that the personal experiences and character of the trainers with lived experience added interest and meaning, and made the training more memorable.

> *"It made everything seem more real, more personal… You can read about it, but to hear from someone who lives it – it brings it home, it makes it stick."* (Interview, complaints officer, Training A T1)

However, it was noted by observers of the training and in focus groups that experts by experience needed training to ensure they had the skills to present the materials effectively. As one observer noted about a Tier 1 training package:

> *"There is a balance to be struck with personal anecdotes to bring life to the training and making it entirely about your story to the point that it excludes other autistic experience."* (Observation by AG member, Training A T1 Autism)

Some interviewees and observers noted that the expert by experience had not been available on the day, which they perceived as a missed opportunity, or that the expert had not attended for the full training. In the focus groups, experts by experience said the training should not go ahead without an expert by experience present because they were integral to the training. To ensure good co-delivery, it was essential that trainers with and without lived experience worked well together; they needed to meet beforehand and to plan and prepare their session (see separate report for further learning about good co-delivery). Interviewees and observers commented when the co-delivery worked well and when it didn't. Good co-delivery was noted for the webinars for Training B T1:

> *"They seemed to have a very good relationship… They worked well together definitely. The instructor was very mindful of making sure everything was alright and not too much."*
> (Interview, recovery worker for a drugs and alcohol service, Training B T1)

The videos were also viewed very positively and many interviewees commented on the power and impact of them. However, there were suggestions that the videos could have portrayed people with a greater range of needs:

> *"Would have been good to involve someone with a learning disability who was less able at communicating."*
> (Survey response, Training A T1 Learning Disability)

This issue was also picked up in the observation work:

> *"People both learning disabled [sic] and autistic who have no speech needs to be addressed."* (Observation by **SOG** member of Training B T1)

The video about Oliver's story was particularly highlighted for its power, emotive messaging and for providing the basis for the training. When respondents were asked to identify the **one thing** about the training that stood out, this film was the most likely aspect to be flagged. Across all training packages, 13 per cent of respondents cited this as the standout feature:

> *"Oliver McGowan's story told by his mother really stood out for me, it highlighted the importance of the training we were about to receive and motivated me to make the most out of the training session."* (Survey response, Training C T1)

However, for some trainers and trainees this was overwhelming:

> *"I personally think there should be a formal trigger warning before the video by Oliver's mum. While the video is amazing it can also be quite upsetting for people who've had previous experiences with similar medical situations and or the medications mentioned."* (Survey response, Training C T1 Autism)

One trainer felt it did not provide a positive start to the training:

> *"It wasn't the easiest of things to start the training with. It framed the training session and it didn't give me the hooks I needed for the training day."*
> (Focus Group, trainer with lived experience)

There were some suggestions that this 20-minute video could be shorter.

Over 80 per cent of respondents agreed that the use of case studies / scenarios and having verbal discussions suited their learning style. This was particularly high for the face-to-face learning disability training (97 per cent and 98 per cent respectively), as this enabled interaction and discussion. This was also the case for any question-and-answer sessions held, although many comments from the surveys and interviews stated that they wanted more time for this regardless of training mode. This was particularly the case for Training B

T1, where the webinar was 0.5 hours and a longer webinar would have been appreciated by trainees and observers of the training.

Some Trial Partners provided written resources and 85 to 93 per cent of participants agreed this suited their learning style, and survey respondents and interviewees noted it was useful to have something to go back and refer to. Group and individual quizzes used at Tier 1 received more mixed feedback but overall suited 68 to 89 per cent of people.

Kirkpatrick Level 2: Learning for Tier 1 Training

Level 2 of the Kirkpatrick model relates to whether the training increased the knowledge, skills and confidence of the participants. People who took part in the training were asked to rate their knowledge, skills and confidence (**competency measures**) when working with people with a learning disability and autistic people (see Appendix A, page 7). They rated these on a five-point Likert scale before and after attending the training, as well as at follow-up. Statistical tests were used to explore differences in the scores before and after the training. Further details of this analysis are presented in Appendix B.

> Across all Tier 1 Training, respondents rated their knowledge, skills and confidence in working and communicating with people with a learning disability or autistic people more highly directly after the training than before. Where there was sufficient data, analysis showed these increases were maintained at follow-up.

Results indicated that, compared to before the training, people rated themselves significantly higher on the following domains after attending the training:

- People felt that they had more **knowledge** about working with people with a learning disability and autistic people.
- People felt they had the **skills** that they need to work with people with a learning disability and autistic people.
- People felt more **confident** working with people with a learning disability and autistic people.
- People felt more **confident in communicating** with people with a learning disability and autistic people.
- People were more likely to agree that they had an **important role to play** to meet the general health needs of people with a learning disability and autistic people.
- People were more likely to agree that people with a learning disability and autistic people **face significant challenges in healthcare settings.**

These changes were significant across all the training packages at Tier 1 (see Tables B1 to B6 in Appendix B), suggesting that all the training led to an improvement in people's self-rated competencies beyond what would be expected by chance.

Respondents were asked to rate themselves again on these domains two-to-three months after attending the training. Statistical tests were used to explore differences in scores from pre- and post-training, as well as pre- and follow-up time-points to determine if changes were maintained over time. This analysis was only possible for the Tier 1 Training A and Training B, due to small numbers of people completing the follow-up survey. Results are presented in Tables B7 to B10 in Appendix B.

Results suggest that improvements were maintained at follow-up on the following domains:
- People felt that they had more **knowledge** about working with people with a learning disability and autistic people.
- People felt they had the **skills** that they need to work with people with a learning disability and autistic people.
- People felt more **confident** working with people with a learning disability and autistic people.
- People felt more **confident in communicating** with people with a learning disability and autistic people.

Analysis of the qualitative data (interviews and free text survey comments) supported these self-ratings, and showed that the training had a positive impact on participants' awareness and understanding of learning disability and autism. Preconceptions and assumptions were challenged, and respondents said they understood the need to do things differently.

> *"The course has made me more aware of listening and watching at an individual level."* (Interview, clinical, Training B T1 Learning Disability & Autism)

Several respondents who had not yet made changes said that learning on the course, especially about communication, environmental and sensory issues, equipped them for future interactions.

> *"I had no idea how people might be affected by light or noise… I was given real practical tools and simple ways I could make adjustments…"*
> (Interview, clinical, allied health professional, Training C T1 Autism)

Some respondents who were knowledgeable about learning disabilities and autism before training said it had refreshed and updated their knowledge, confirming and embedding their knowledge.

> *"Refreshed practical knowledge of RAs."*
> (Interview, clinical, Training B T1 Disability & Autism)

Several interviewees said they felt more confident to question or challenge poor practice after the training. Some highlighted that an environment where staff are trained, aware and can question each other is important in healthcare.

> *"A wake up call to challenge bad practice."*
> (Interview, clinical, Training B T1 Disability & Autism)

While it is encouraging that the **quantitative** and **qualitative** data indicate that respondents learned a lot, we have noted that some of the language used in the surveys and interviews did not always reflect the messages about language given in the training. For example, some respondents continued to refer to "people who have autism" or "learning disabled people". This demonstrates that it does take time and iteration to embed learning and change behaviours.

Kirkpatrick Level 3: Behaviour changes for Tier 1 Training

From the data reported above, we can conclude that all the Tier 1 training packages were effective at Levels 1 and 2 of the Kirkpatrick Training Evaluation Model, as people were positive about the quality of the training and reported it had increased their knowledge, skills and confidence.

To truly determine that the training is effective, we do want to see evidence that participants have been able to apply what they have learned, and examples of a change in working behaviour (Kirkpatrick Level 3). The follow-up surveys and the interviews explored this.

63 to 72 per cent of people who had done Tier 1 Training reported doing something different when supporting someone autistic or with a learning disability since their training.

The interview and survey data showed that some people left Tier 1 Training feeling very inspired to make change.

> *"How do I apply this to my role? What can I do with my energy and enthusiasm for this now?"* (Survey response, Training C T1 Learning Disability)

The data from the follow-up surveys must be viewed with caution for two reasons:

- As reported in [Appendix A](#) (Table A3), the number of responses to the follow-up surveys was low. The sample sizes within the Trial Partners ranged from N=37 to N=346.
- The follow-up time was two-to-three months after training and it is likely it will take longer for the impact on behaviour to become apparent.

Firstly, we asked if, to their knowledge, people had come into contact with someone autistic or with a learning disability since the training. If they had, we then asked if they had done anything to support them. The rates of people who said they had not come into contact

with someone ranged from 33 to 65 per cent of those who had done Tier 1 Training. These rates may have been higher if the follow-up time after the training was longer. It is possible though that the training did not equip staff to be able to confidently identify if the person they were supporting was autistic or had a learning disability. However, there were staff receiving the training who worked in non-patient-facing roles and there were also students on the training. Therefore, we cannot assume that people were mistaken when they reported they had not come into contact with anyone autistic or with a learning disability, but this may be something to follow up in the longer term.

Of the staff that had come into contact with someone autistic or with a learning disability, it was encouraging to see that most people reported doing something different to support them. These figures ranged from 63 to 72 per cent of people who had done Tier 1 Training:

- Trial Partner A: 64%
- Trial Partner B: 63%
- Trial Partner C: 72%

If Tier 1 Training is undertaken only by staff who do not have any contact with autistic people or people with a learning disability, the data on changes in behaviour may have less of an implication for future training than some of the other measures. However, we wanted to explore the types of changes people did report making and, in view of the limitations of the quantitative survey data, we have primarily drawn on the interviews and the qualitative survey responses in order to do so. The following areas were most commonly reported in terms of changes made when supporting an individual:

Communication and giving time

Examples included:

- more telephone calls and texts;

- producing accessible information;

- using different communication tools, such as using pictures in a safety plan to support understanding;

- giving more time and avoiding rushing by booking double appointments;

- speaking more slowly to allow for different processing speeds.

Person-centred support

Examples included:

- avoiding assumptions;

- aiming to find out what works for the individual;

- offering face-to-face meetings, including home visits, if the person preferred this.

Working with families and supporters

Examples included:

- making efforts to work with the family and supporters of patients as a result of the training;

- making time to contact them in advance of appointments, as well as forwarding afterwards.

Implementing reasonable adjustments

Examples included:

- putting learning about reasonable adjustments into practice since the training;

- giving more time, finding a quiet space and adjusting for environmental and sensory issues;

- moving to a quieter environment for someone with auditory sensitivities.

Recognition and support of people with a learning disability and autistic people

Examples included:

- recognising autism or learning disability in either a patient, colleague or family member as a result of the training;

- positive interactions and increased opportunities for support;

- training being useful in life outside work;

- adapting behaviour by giving someone autistic more space.

Implementing changes in the workplace

27 to 44 per cent of people, working in roles where they could make changes to how things are done in their workplace, reported doing so following their Tier 1 Training at the time of follow-up.

Creating systems changes or updating processes were reported less frequently than making individual changes to behaviour, but 27 to 44 per cent of respondents said they had already done so by time they completed their follow-up survey.

- Trial Partner A: 44%
- Trial Partner B: 27%
- Trial Partner C: 40%

The same caveats about the small and wide-ranging sample sizes apply to the quantitative data on this.

Changes to workplace practice or processes (or system changes) take time to implement, and the follow-up time with people had to be reduced from three months to two months after they had done the training in order to collect more evaluation data in the time available. It is not suprising, therefore, that most people had not yet made changes, but this data suggests that some people had already been able to do so, while others gave examples of intentions to make change.

"Organisationally we are looking at the use of talking mats and carrying out a LeDeR review." (Survey response, Training A T1)

The qualitative data collected from the surveys and the interviews has given further insight into the sorts of system and process changes that people have been able to make. Changes were primarily reported in the following main areas:
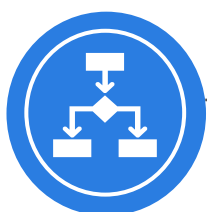
Training

Participating in the Oliver McGowan Mandatory Training clearly emphasised the importance of training in this area.

Examples included:
- promoting the training to colleagues;
- encouraging a wide uptake or making it mandatory for their teams;
- incorporating what they learnt into other training.

Policies and processes

Some respondents were able to provide examples of how the training had fed into the development of, or change to, policies or specific processes.

Physical environment

A small number of people participating in the training reported changes that have been implemented or planned in the physical environment, particularly those taking sensory needs into consideration.

Provision of accessible information and advice

While many people talked about supporting individuals around communication and providing accessible information (see 'Communication' above), some people referred to a more system-wide approach to provision of accessible information, including the use of easy-read materials.

Culture change

There are some early signs of culture change, for example in the conversations people are having. Awareness-raising at all levels was identified as important for delivering better care.

In Appendix B (pages 46 to 53) there are further quotes from surveys and interviews where respondents have reported changes they have made either when supporting an individual or to systems within their workplaces.

Kirkpatrick Level 4: Results for Tier 1 Training

Ultimately the aim of the Oliver McGowan Mandatory Training is to lead to improved outcomes for autistic people and people with a learning disability. This has not been possible to ascertain within the timescale of this programme but suggestions are made in the final chapter for exploring this in the future.

Delivery costs

We were asked to estimate the costs of delivering the different training packages trialled.

To calculate this, we asked each Trial Partner to provide information on:

- how much it cost to pay trainers per session;
- how many trainers were needed per session;
- how long the training was;
- the average number of people trained in each session;
- estimates of relevant expenses;
- running costs such as for the online platform or the room hire;
- any additional costs, such as administration and planning.

From this information we were able to calculate the comparative cost of delivery for a single package within the trial, exclusive of development expenses. The rates paid to trainers did not vary enormously between Trial Partners. The variables most significant to costs were the number of trainers, duration, and the number of people trained in each session. In order to standardise our estimates, we calculated cost based on 25 trainees per session. This is not a recommended number; it is used only to provide consistency for comparison.

The estimated delivery costs per head, rounded to the nearest pound for training 25 people in Tier 1, are as follows:

- Trial Partner A: £11

- Trial Partner B: £8
- Trial Partner C: £47

Please note that these figures do not include any of the related design costs that have been funded as part of the trial. The design costs would include:

- costs of planning the content and format of the training;
- costs of creating the content, including making videos;
- costs of training people with lived experience to deliver the training;
- costs of the quality assurance process.

From the information we have been given, the lowest delivery cost was for Training B. As Training B is also the shortest training package, any costs relating to staff time to undertake the training would also be lower.

Conclusion

There is insufficient evidence to draw conclusions for Training A or Training C. There is good evidence relating to Training B. This evidence shows that Training B was fit for purpose, good quality and well received. On this basis, we recommend that the blended learning package developed by Trial Partner B should be used. While it may not have scored the highest of all the packages on **every** quality metric, the feedback from the surveys, interviews and observations were generally very positive, despite this being the shortest of the Tier 1 training packages. We have evaluation data from over 2,000 people, meaning this data is more robust than from some of the other Trial Partners, and all these people received a full Tier 1 Oliver McGowan Mandatory Training package.

Comments from Advisory Group and SOG members who carried out observations of this training (with both lived experience and relevant professional experience) were very positive about the Training B blended learning package.

> *"The editing was very good so they got a lot into a short time. Nothing was too long or too short. It was inspired the way they did it. It follows a proper arc."* (Observation from Advisory Group member, Training B T1)

> *"I am impressed with this training; it has a depth and clarity I have not seen elsewhere."* (Observation from SOG member, Training B T1)

Two experts by experience undertaking observations of the training expressed having prior concerns about the combination of learning disability and autism training, but concluded it actually worked very well.

> *"I am confident that a learner on this course would know and develop an understanding that learning disability and autism are different, and what the differences are."* (Observation from SOG member, Training B T1)

The observations suggested that the only improvement to the e-learning session would be to add something about communicating with people who do not use speech. This was supported by the survey data. Additionally, three people (one per cent) who made

suggestions for an improvement in the survey also suggested that the film would be improved if the subtitles could be moved so they do not cover people's faces.

Alongside the e-learning, people taking part in Training B attended a half-hour live webinar with an expert by experience. Of the 400 comments made about what could have been better with Training B T1, 12 per cent were requests for the online webinar to be longer.

> *"Apart from having a longer Q and A session, I don't think it could be improved."*
> (Survey response, Training B T1)

There were also suggestions that this session could include another person with lived experience.

> *"Would like to do the same with someone with autism."*
> (Survey response, Training B T1)

The online webinar was originally planned as a face-to-face drop-in. We believe that this could be done in both modes. We have suggested considerations about these sessions with experts by experience. They could be:

- extended to an hour;
- organised to include at least one autistic expert by experience and one expert by experience with a learning disability;
- offered face-to-face or online.

We also think it could be beneficial to include a family carer who supports someone with profound and multiple learning disabilities, or an autistic person who does not use words to communicate. Alternatively, these sessions could be hosted by small groups of experts by experience in order for people to meet a wider range of autistic people and people with a learning disability, and to hear varying perspectives. Extending the length of the sessions and increasing the number of experts by experience would add to the delivery costs that we have calculated.

Given that the e-learning is ready now, Tier 1 could start quickly and build on the momentum already created. A bank of experts by experience would need to be recruited for the webinar/online interactive drop-in sessions, but given the work done already by all the Trial Partners, we anticipate there is likely to be a cohort to approach. Although these experts by experience will still need support to help them prepare for these sessions and debrief afterwards, there is not the need for the level of training skills that those delivering Tier 2 Training will require.

The qualitative data showed that people attending the training valued resources they were given and often asked for more. We recommend the provision of an electronic handbook containing the training materials and links to resources. Ideally there would be the facility for this to include signposting to local resources and services. Previous research has also suggested the value of toolkits to support patient care of people with a learning disability or dementia in hospital (Surr et al., 2017; Read & Rushton, 2013).

Recommendations for content and next steps for Tier 1

- The **blended learning** module developed by Training Partner B is ready to be used now.
- Tier 1 Training is not complete until both elements (e-learning and live webinar) are undertaken.
- The training should provide an electronic handbook that is updated and has the capacity to have local information added.

Considerations for content and next steps for Tier 1

- The e-learning should be accompanied by a one-hour live drop-in session or online session with at least two experts by experience with different personal expertise.
- There needs to be clarity about the length, focus and aims of the Tier 1 Training and an accurate description provided.
- DHSC / decision-makers may wish to consider a move from describing the training as Tier 1 and Tier 2.
- A quality assurance process could be set-up to enable regular review and refreshing of the course materials and content.

Chapter 3: Tier 2 Training

In this chapter we present a description of the content and delivery of the Tier 2 Training and analysis of the data collected from across all three Trial Partners. This includes data from the surveys, interviews, focus groups and observations of the training. We review the strength of the evidence base, report on what respondents thought about the training they received, what they think they learned and how they have been able to use the training in their work. Recommendations and points to consider for future delivery have been based upon this analysis.

Content and delivery of Tier 2 Training

As with Tier 1, Trial Partners all designed their training to be delivered in different ways. However, as agreed across all partners during the design phase, there was some core content that needed to be covered in all Tier 2 Training:

- All of Tier 1, plus avoiding diagnostic overshadowing, frequently co-occurring conditions (co-morbidities).
- The laws**:** Mental Capacity Act, Human Rights Act, Autism Act.
- Reasonable Adjustments: what are they in health. Hospital passports. Culture (professional bias and subconscious beliefs), professional behaviour and impact on outcomes and other people's behaviour.
- Communication. How to communicate in an accessible way. How to understand what the person (and their family) is saying. Reference ASK – LISTEN – DO.
- Learning from LeDeR, annual health checks.

Below, we provide a short description of the different Tier 2 training packages. Further detail of the content can be found in Appendix C.

Trial Partner A Tier 2

This Tier 2 programme was delivered as a combined course covering learning disabilities and the autistic experience across four key sections. These sections mirror the following three key domains from both competency frameworks:

- health and wellbeing;
- personalised support and communication;
- law, rights and safety.

Each section was delivered through an e-learning course completed at a time of people's choosing, followed by a face-to-face or online facilitated interactive workshop involving trainers with and without lived experience. The facilitated learning was designed to take a day of face-to-face classroom learning but interactive online workshops in separate sections offered an alternative approach if required.

Trial Partner B Tier 2

This course was designed as a whole-day programme for classroom-based learning. Given the restraints of COVID-19, it was also offered as **hybrid training**, in which the workshop was live-streamed to an online group who also took part in group discussions and made use of the chat function. Each course was facilitated by someone with lived experience of learning disabilities and/or autism, a family member and a clinician. A further facilitator supported the online group and technology.

The course included learning outcomes for both T1 and T2 so that participants did not need to attend T1 beforehand. It was framed around the life course, moving through life experiences from birth to end of life (Cradle to Grave approach). Each section was framed with the reflective questions of 'Ask, Listen, Do'. Learning activities included a series of presentations, quizzes, films and discussions.

Trial Partner C Tier 2

Trial Partner C included two sets of training – one on learning disability and one on autism – designed and facilitated by different groups, relevant to their professional and personal expertise. The autism training included autistic trainers throughout the day. The learning disability training involved an expert with learning disability joining for a particular section of the training. The Tier 2 Training incorporated Tier 1 learning outcomes.

To complete the full Oliver McGowan Mandatory Training, learners would need to attend a full day on learning disabilities and a full day on autism. Below we report on the responses of people who attended the learning disability training, the autism training, or both.

All training was carried out in classroom-based face-to-face settings. The training programmes differed slightly depending on whether the audience were from health or social care roles although the content was comparable, following the same structures and topics. The training comprised a mix of presentation and films, with group discussion and reflection.

Table 8: A comparative summary of the design and delivery of Tier 2 across the different Trial Partners

Aspects of training	Training Partner A	Training Partner B	Training Partner C (Learning Disability)	Training Partner C (Autism)
Delivery methods summary	E-learning followed by face-to-face, grouped in four separate topics. These can be done all in one day face-to-face, or over four separate online interactive courses, again with two trainers, both with lived experience and workplace expertise.	Face-to-face or joining the same room online (hybrid delivery). The day covers the full range of T2 and uses a life course format, taking the group through from birth to death. Facilitated by four trainers with a range of personal and work-based expertise.	Face-to-face course covering learning disabilities, run by a clinical or workplace expert with an expert by experience joining for part of the day.	Face-to-face course co-led by an expert by experience and either another person with lived experience and/or a workplace expert.
Autism / learning disability separate or mixed	Learning disabilities and autism covered in one course.	Autism and learning disability.	Learning disability only*.	Autism only*. *NB learners need to attend both learning disability and autism training to cover the whole of a T1 or T2 course.
Involvement of people with lived experience in training delivery	Yes Interactive online or face-to-face sessions co-facilitated by trainers with lived experience.	Yes Two trainers co-facilitate throughout who have lived experience as an autistic person or with a learning disability or both, plus a family carer.	Yes Person with lived experience joins for an hour of the session.	Yes Full day programme co-facilitated by two trainers, either both or one with lived experience.
Involvement of people with lived experience in training materials	E-learning includes additional people's stories.	Films of people sharing their personal experiences throughout training.	Films co-designed and acted by people with a learning disability.	Films of people sharing personal experiences form part of the training.

Aspects of training	Training Partner A	Training Partner B	Training Partner C (Learning Disability)	Training Partner C (Autism)
Use of e-learning (non-interactive online learning)	Yes: e-learning in four topics precede face-to-face or interactive live online learning sessions.	No.	No.	No.
Face-to-face (in a room, in person)	Yes.	Yes.	Yes.	Yes.
Online interactive (live but run on MS Teams or Zoom)	Yes.	In hybrid session.	No.	No.
Hybrid delivery (live workshop in room which is live-streamed for online participants)	No.	Yes.	No.	No.
Learning materials provided after training	Case studies and information from training on Learning Management System.	Guidebook with materials and links.	PowerPoints provided.	Handbook provided.
Length of learning time	One day (plus prior self-learning online).	One day.	One day.	One day.
T1 incorporated into T2	No – participants have to do both T1 and then T2.	Yes.	Yes.	Yes.
Numbers of participants	10 to 15 per face-to-face or online interactive course.	Maximum 50 in hybrid course: 25 in room and 25 online.	Up to 25 (in non-COVID times).	Up to 25 (in non-COVID times).

Pre-learning for Tier 2

> ### Consideration for Tier 2 pre-learning
>
> Consideration should be given to using the e-learning from Trial Partner B Tier 1 as pre-learning for Tier 2.

Before we report the data collected about the Tier 2 Training, we would like to reflect on the benefit of the Tier 1 Training in relation to those working in Tier 2 roles.

It is our understanding that any staff working in health and social care roles where they **ever** have patient contact will be required to undertake Tier 2 Training. The data we have collected clearly shows that, after receiving Training B Tier 1:

- 100 per cent of staff reported increased knowledge, skills and confidence (including those in patient-facing roles who would require Tier 2 Training).
- 63 per cent of staff that had come into contact with someone autistic or with a learning disability reported doing something different to support them.
- 27 per cent of people, working in roles where they could make changes to how things are done in their workplace, reported doing so at the time of follow-up.

As staff needing Tier 2 Training must also have had Tier 1 Training, then Tier 2 must either build on Tier 1 or have it directly incorporated into the Tier 2 package. It was clear all recipients reported positive outcomes from the Tier 1 Training. Therefore, we believe that the e-learning aspect of this package would benefit all staff and it could be considered as pre-learning for Tier 2 Training.

The Tier 1 data showed that some respondents particularly liked the combination where the e-learning modules were pre-learning for live online sessions. In interviews and focus groups there were comments on the value of the Tier 1 training packages:

> *"Excellent lived experience films… This would be a good session for all acute care staff."* (Interview, safeguarding lead adults & children, Training B Tier 1)

> *"I think a receptionist can get a lot from Tier 1."* (Focus Group, Trial Partner lead)

Using the e-learning from Training B Tier 1 has the practical benefit that a much larger number of staff could begin to receive training more quickly. The data has also shown across all Trial Partners that many people receiving some training are then keen to do more, which may help build momentum for the Tier 2 Training.

We recognise that this pre-learning would mean more total training time (and hence additional costs) for Tier 2, which must be considered when making a final decision.

Data quality

Data has been collected across all Trial Partners but differences in numbers trained, response rates and how the training was set-up means the quality of the evidence varies. Below is information about how these factors have affected the quality of the evidence relating to each Training Partner.

Table 9: Data available for Tier 2 Training A

	Survey data	Interview data
Data available for analysis (291 people reported to have received Training A)	232 responses to post-training survey. 77 responses to follow-up survey.	Nine interviews completed with people.
Comments on the quality of the data	This training was delivered as four modules. The survey was designed to be filled in once people had completed all the training. We cannot be sure this was the case. Some respondents filled in the survey multiple times and there was no clear indication which modules people had completed. Adequate post-training and follow-up samples. Insufficient data at all three time-points (N=2) to allow analysis.	Sample size sufficient. Interview data shows that not everybody had completed the pre-requisite Tier 1 Training. Some people may not have completed all the Tier 2 modules.

Table 10: Data available for Tier 2 Training B

	Survey data	Interview data
Data available for analysis (678 people reported to have received Training B)	302 responses to post-training survey. 90 responses to follow-up survey.	Nine interviews completed with people who did the complete training.
Comments on the quality of the data	All respondents had completed full training. Adequate post-training and follow-up samples. Insufficient data at all three time-points (N=8) to allow analysis.	Sample size sufficient.

Table 11: Data available for complete Tier 2 Training C

	Survey data	Interview data
Data available for analysis (174 people reported to have received both modules of Training C)	157 responses to post-training survey following both modules. Six responses to follow-up survey following both modules.	Seven interviews completed with people who did the complete training.
Comments on the quality of the data	Adequate post-training sample. Small sample at follow-up means results must be viewed with caution. No data at all three time-points (N=0) so no analysis across all time-points was possible.	Sample size sufficient.

In Tables 12 and 13 we present information on the data collected about the separate modules for Tier 2 Training C. This data cannot be compared with that relating to those that did the complete Tier 2 Training C. Analysis of the data from the separate modules was conducted to explore learning around the co-production and co-delivery of autism and learning disability training, but cannot be considered to be an evaluation of the full training.

Table 12: Data available for Tier 2 Training C – learning disability module

	Survey data	Interview data
Data available for analysis (978 people reported to have received Training C learning disability module)	413 responses to post-training survey following learning disability module. 51 responses to follow-up survey following learning disability module.	Three interviews completed with people who did the learning disability training module.
Comments on the quality of the data	Adequate sample size for post-training survey. Small sample size at follow-up. Sufficient data at all three time-points to allow analysis (N=21).	Small sample.

Table 13: Data available for Tier 2 Training C – autism module

	Survey data	Interview data
Data available for analysis (464 people reported to have received Training C autism module)	266 responses to post-training survey following autism module. 53 responses to follow-up survey following autism module.	Four interviews completed with people who did the autism module.
Comments on the quality of the data	Adequate sample size for post-training and follow-up surveys. No data at all three time-points (N=0) so no analysis across all time-points was possible.	Small sample.

In view of the difference in sample sizes and set-up of each training package, we have taken a decision as to the quality and strength of the evidence base.

Table 14: Summary of the quality of the available data about Tier 2 for each Training Partner

Training package	Comments on overall quality and reliability of data
Training A	**Low:** Small number of people received the training. Evaluation sample representative of those trained (80 per cent response rate). Insufficient follow-up data. Quality of data limited by indications from interview and survey data that some respondents had not received the full training.
Training B	**Moderate:** Reasonable number of people trained. Evaluation sample representative of those trained (50 per cent response rate). Insufficient follow-up data. All respondents received complete training.
Training C	**Moderate:** Small number of people received the complete training. Evaluation sample representative of those trained (90 per cent response rate). Insufficient follow-up data from those that did the complete training.

What people told us about the training

All of the training packages had good scores and feedback for quality of training, improvements in knowledge and subsequent behavioural and workplace changes. Below we report on what was found in relation to each Kirkpatrick level.

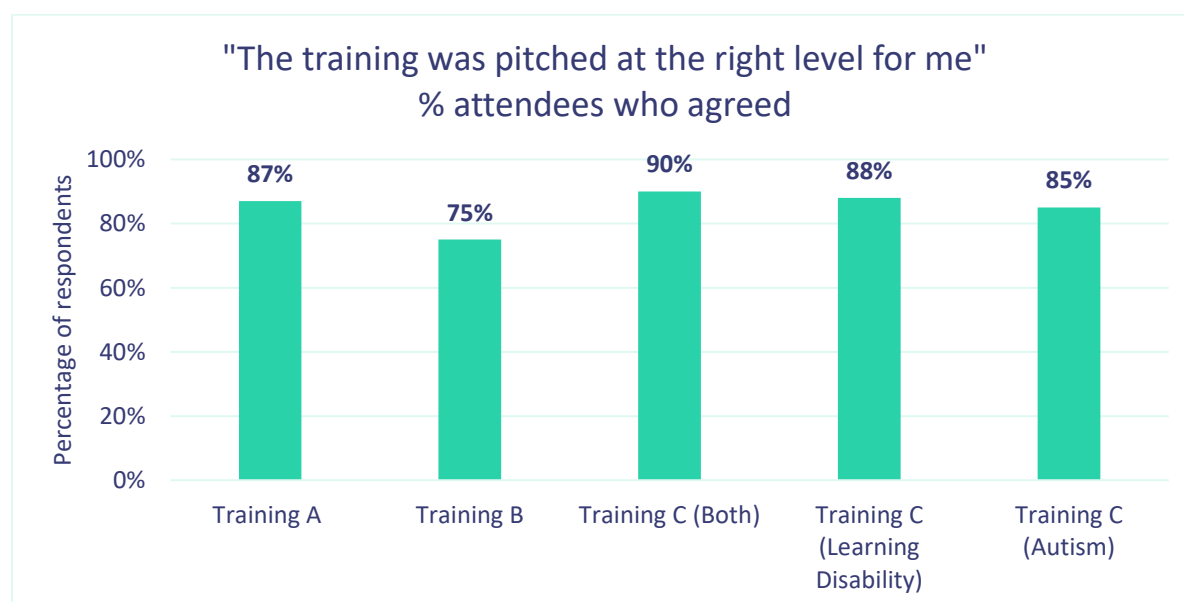## Kirkpatrick Level 1: Reaction for Tier 2 Training

> Across all Tier 2 Training packages, high proportions of respondents agreed or strongly agreed that the pitch, pace and content of the training were right for them.

The post-training survey required respondents to comment on the quality of the training in relation to overall quality, pitch, pace, length, whether it was a good use of time, the skills of the trainer(s) and the usefulness of the training compared to other training previously attended.

Figures 8 to 13 present the percentages of people that agreed or strongly agreed with each of these statements.

Figure 8: Pitch of the training

"The training was pitched at the right level for me"
% attendees who agreed

Training A: 87%
Training B: 75%
Training C (Both): 90%
Training C (Learning Disability): 88%
Training C (Autism): 85%

Figure 9: Pace and content of the training

"The pace and amount of content covered was right"
% attendees who agreed

Percentage of respondents

- Training A: 88%
- Training B: 70%
- Training C (Both): 86%
- Training C (Learning Disability): 84%
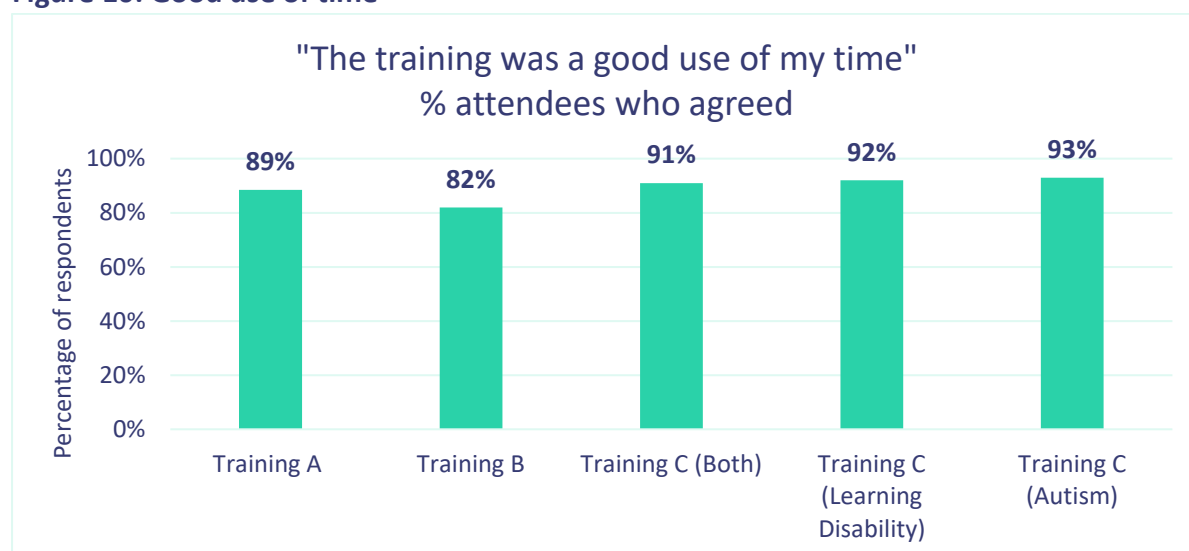- Training C (Autism): 84%
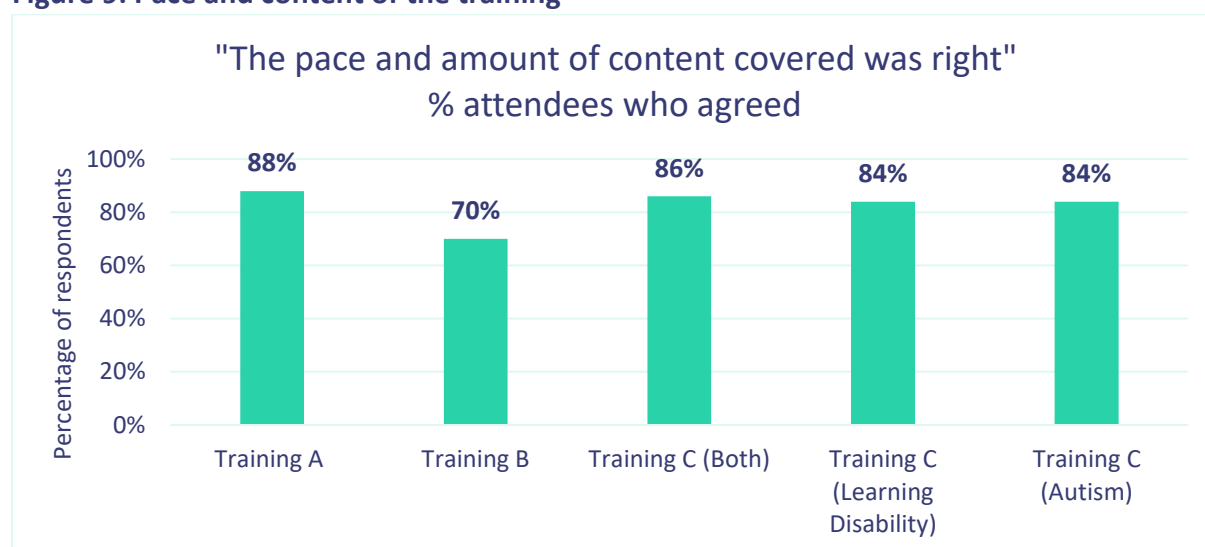
Figure 10: Good use of time

"The training was a good use of my time"
% attendees who agreed

Percentage of respondents

- Training A: 89%
- Training B: 82%
- Training C (Both): 91%
- Training C (Learning Disability): 92%
- Training C (Autism): 93%

Figure 11: Skills of the trainers

"The trainer/s had the skills needed to deliver the training" %
attendees who agreed

Percentage of respondents

- Training A: 97%
- Training B: 91%
- Training C (Both): 91%
- Training C (Learning Disability): 96%
- Training C (Autism): 95%
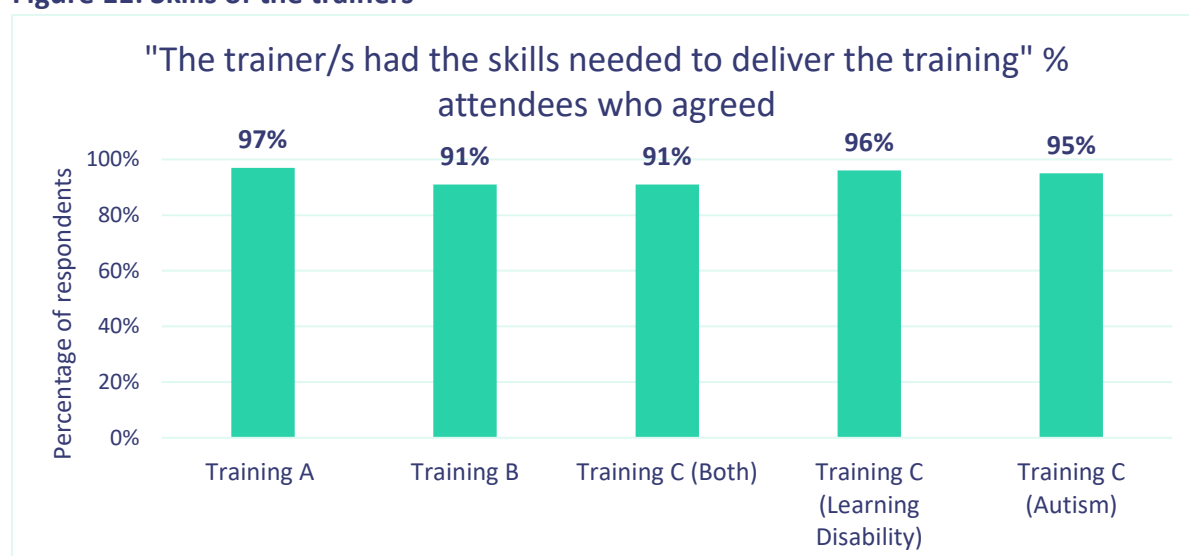
Figure 12: Usefulness of training in comparison to previous training

"The training was more useful than previous training I have had on this subject" % attendees who agreed

Training A: 64%
Training B: 61%
Training C (Both): 71%
Training C (Learning Disability): 69%
Training C (Autism): 71%

(Y-axis: Percentage of respondents, 0% to 100%)
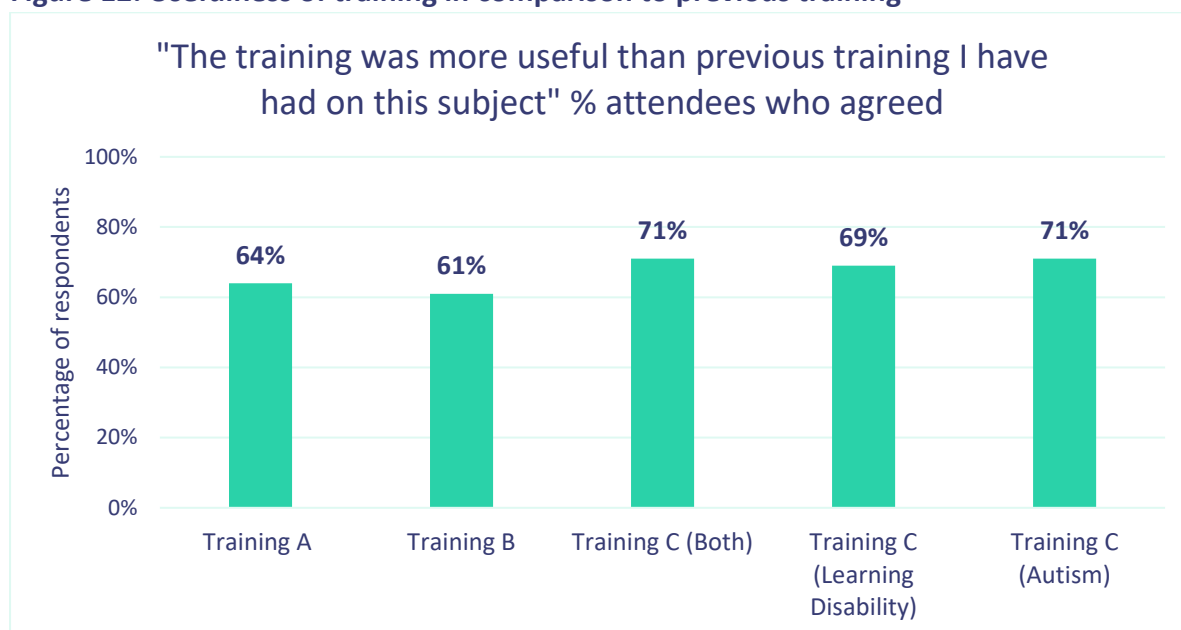
Figure 13: Overall quality

"The overall quality of the training was good" % attendees who agreed

Training A: 97%
Training B: 90%
Training C (Both): 94%
Training C (Learning Disability): 94%
Training C (Autism): 93%

(Y-axis: Percentage of respondents, 0% to 100%)
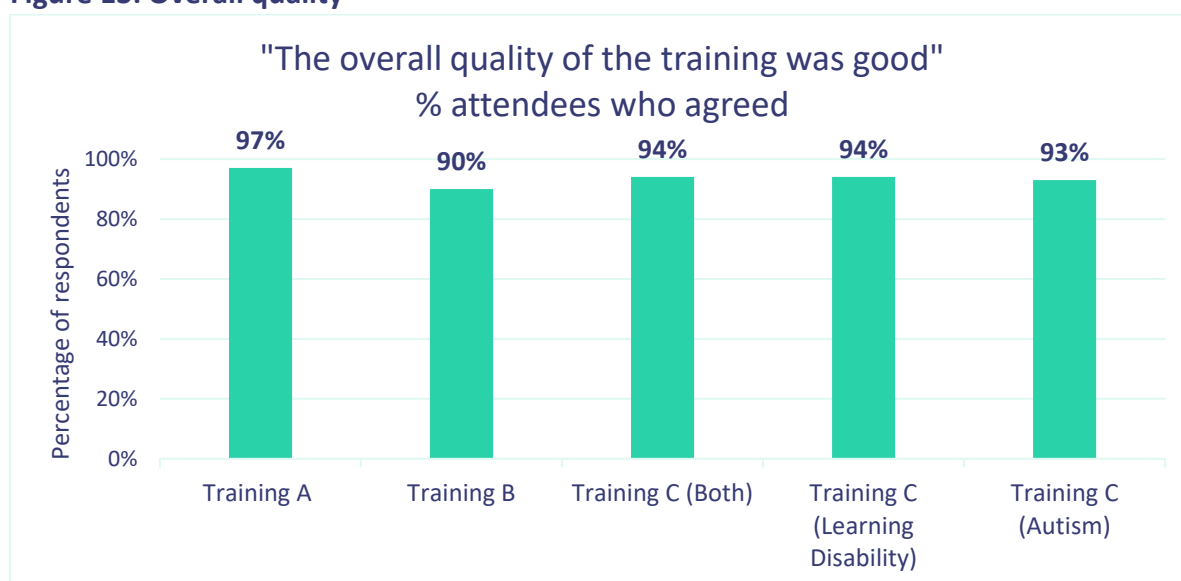
Figures 8 to 13 show that the Tier 2 Training was viewed positively by most respondents on all the quality measures. Training A was rated the highest on overall quality. Training from Trial Partner B was rated lowest on all the measures, but this should be viewed in the context that almost 90 per cent of respondents still agreed that the overall quality of the training was good.

Training A and Training B delivered the content about learning disability and autism together, whereas the full Training C package consisted of one day on autism and one day on learning disability. The data from these quality measures suggests that both approaches worked well and there is no conclusive evidence to support separating them out or ensuring they are delivered jointly.

Length of Tier 2 Training

> The length of training was difficult to get right but concerns can be mitigated by managing expectations and ensuring an adequate number of breaks of sufficient length are included.

As can be seen in Table 15, the time taken to complete Tier 2 Training covering both autism and learning disability varied across the Trial Partners:

- Trial Partner A: 1 day (plus prior e-learning)
- Trial Partner B: 1 day
- Trial Partner C: 2 days

As with Tier 1, there was a lack of consensus from respondents about the suitability of the length of Tier 2 Training. See Table 15 for respondents' views on length of each training package.

Table 15: Respondents views on the length of the Tier 2 Training

Percentage of respondents who agreed that their training package was too long or too short (%)	Training A	Training B	Training C (both modules)	Training C (Learning Disability)	Training C (Autism)
Too long	20%	40%	17%	9%	9%
Too short	7%	4%	12%	16%	10%

Comments from interviews, free text survey questions and observations support the suggested difficulties in getting the length of training right, with respondents reporting the same training as being too long and too short.

There did appear to be some consistency from the qualitative responses to the survey, in that those who had received either the Learning Disability or the Autism module from Training Partner C wanted longer training. However, both these training packages were described to participants as being learning disability **and** autism training, and some respondents commented on missed training.

> *"It was billed as a learning disability and autism training, but there was hardly any focus on autism."* (Survey response, Training C T2 Learning Disability)

The requests for longer training might reflect feelings that aspects of training were missing.

Some respondents suggested that outlining the timescale and content of the training at the beginning would help manage participants' expectations. In addition, there was some

consistency among respondents around the view that breaking down the training into manageable sections with clear breaks between sessions would be helpful. One survey respondent stated:

> *"It could have been spread over a couple of days due to the amount of information for one day. Might be shorter breaks but more often would help. Or, split the training in two half days' training so it gives time for people to assimilate all the information given."*
> (Survey response, Training B T2)

There was also an added justification for this, as illustrated by survey responses:

> *"Less learning outcomes. It is physically impossible to cover that much or learn that much in a day. It runs the risk of actually causing people to learn less as they are overloaded."*
> (Survey response, Training C T2 Autism)

Analysis of the qualitative survey comments about what could have been better about the Tier 2 Training presents a slightly different picture to the quantitative data. The qualitative data showed that those that had received the two days' training on autism and learning disability were more likely to comment that it should be shorter. Those who had received a full day on either autism or learning disability were more likely to suggest the training should be longer when asked what could have been better.

> *"Longer training course, such as two days, or even the option to book on for further training as an optional opportunity."*
> (Survey response, Training C T2 Learning Disability)

Over 12 per cent of people who had two full days of training felt that this was still not long enough, which suggests there is an appetite for further learning for some staff and this should be encouraged. There were some explicit responses where people wondered what they could do with their newfound knowledge and passion; it is vital that such enthusiasm is harnessed.

What could have been better about the Tier 2 Training?

> 44 to 75 per cent of respondents did not think there was anything that could have been better about the Tier 2 Training they received.

The responses to the question "was there anything that could be better about the training?" included higher proportions of respondents making suggestions about what could be improved about the Tier 2 Training they received in comparison to the Tier 1 Training (see Table 16 for Tier 2 data).

Table 16: Percentage of responses saying nothing could have been better for Tier 2 Training

Trial Partner	Percentage	Number of respondents
Training A Learning Disability and Autism	45%	233
Training B Learning Disability and Autism	55%	302
Training C Both	75%	157
Training C Learning Disability	57%	413
Training C Autism	44%	265

Those who had received both the autism and the learning disability modules from Training Partner C were most likely to respond that nothing could have been better with this training (75 per cent), and this was supported by interview comments.

> *"Don't know that it could have been better. I came away thinking oh wow I thought I knew it, but I really didn't."*
> (Interview, Training C T2 Both)

However, it should be noted that this training covered exactly the same content as both Training C Learning Disability and Training C Autism, for which more respondents thought there could be improvements. Therefore, this should be viewed with some caution. This is evidence that the perceived quality of training does not only relate to the content, but also to how it is delivered. It may also relate to people's expectations about what the training would cover.

Mode of delivery of Tier 2 Training

Tier 2 Training was delivered through a mix of e-learning, live online training, face-to-face training and hybrid training.

78 to 99 per cent of respondents agreed the delivery mode of the Tier 2 Training they received worked well for them.

The hybrid model trialled by Training Partner B at Tier 2 did not work as well.

Table 17: Responses about the mode of delivery

Mode of training	Percentage agreeing or strongly agreeing the mode of delivery worked well for their learning style				
	Training A	**Training B**	**Training C**	**Training C (Learning Disability)**	**Training C (Autism)**
Delivered face-to-face in a room only	88%	N/A	99%	99%	97%
Live online (delivered live through Microsoft Teams, Zoom or similar)	89%	N/A	N/A	N/A	N/A
Delivered face-to-face in a room and live-streamed; I attended in person	N/A	83%	N/A	N/A	N/A
Delivered face-to-face in a room and live-streamed; I joined online due to restrictions e.g. travel, COVID-19	N/A	78%	N/A	N/A	N/A
E-learning (online but not live; can view or complete at any time)	91%	N/A	N/A	N/A	N/A

As with Tier 1 respondents, many people would have preferred face-to-face delivery but recognised this was not possible due to the pandemic, while others would have preferred online delivery. Trial Partner C reported that the take-up for Training C T2 Autism was slower for the face-to-face option than for the online option.

While the quantitative data showed most people found the hybrid model from Training Partner B worked well for them (78 to 83 per cent), the figures were lower than for other modes and there were negative comments from some survey respondents who had received the hybrid model from Training Partner B's T2.

> *"I appreciate that it was a trial to do the blended learning but for me it really didn't work. It was hard to stay focused on what was being spoken about at times."* (Survey response, Training B T2)

This was mirrored by comments in the interviews, such as:

"I would prefer to have it totally online or face-to-face…no hybrid or there needs to be multiple cameras with a good voice control system."
(Interview, Support worker, Training B T2)

The observations of the hybrid training sessions also noted that it was hard to see how online participants could engage in discussions taking place in the room. It was noted by trainers in focus groups and free text survey respondents that face-to-face delivery was more effective at promoting discussion between attendees.

"And also it gives you the opportunity to ask questions back and get a feel of the rest of it. You know the people in the room. How it's going and obviously networking is really important, and I think it works a lot better face-to-face."
(Interview, assistant practitioner, Training C T2 Learning Disability)

In the focus groups, the trainers without lived experience spoke about the conversations being "richer" in the classroom and how the discussions online could be more stilted. Some of the trainers with lived experience preferred delivering training face-to-face and said that being in a room with people made it easier to:

"Target your message to the staff and give them practical examples that link to their work." (Focus group, trainer with lived experience)

Some of the trainers with lived experience noted challenges with online delivery, observing that people did not always engage and many kept their cameras off:

"Asking to see people's faces on screen made it easier to read the reactions."
(Focus group, trainer with lived experience)

Other trainers with lived experience preferred delivering online and spoke about feeling more comfortable delivering from the space they were familiar with, and without unpredictable sensory or access issues.

Focus group participants pointed out how much they had learned in recent years about working online and how digital inclusion had improved for people.

Many participants recognised that if training was face-to-face then the environment should be considered. Lecture theatres are not conducive to discussion and there were negative comments about the temperature of rooms, the noise, the seating and accessibility. Ensuring the physical environment is conducive to learning will be an important factor for the comfort of participants and trainers.

Of those that made a suggestion aboug wf9wf1 0 595.()-4(h)-4(ag)7(wv)-3(en)-6ssiones arhad imprs come,

Most respondents (91 per cent) who completed e-learning for Tier 2 agreed that this worked well for them. Although it was noted that:

> *"The e-learning could have been more interesting in its presentation. I thought it had generally quite interesting content, but the presentation was sometimes hard to keep engaged with."*
> (Interview, manager in social care setting, Training A T2)

Sometimes the training was delivered to particular groups of staff, for example support workers. There were mixed opinions about this with some survey feedback supporting the mix of training groups.

> *"It was helpful being in the room with people from secondary care… For me the mix of people and roles worked well… It was interesting to hear their perspectives."*
> (Interview, clinical, Training C T2 Autism)

In the focus groups, the trainers with lived experience spoke about the challenges of delivering the training to very mixed audiences.

> *"Receptionists and consultants in same training group makes it difficult to target to people's needs… I felt I wasn't meeting individual needs."*
> (Focus group, trainer with lived experience)

There was a general consensus from the trainers with lived experience that it is best to train health and social care staff separately.

Training methods and activities

- The involvement of experts by experience was clearly a strength of the training for many respondents.
- Videos were highly rated, especially those involving people with lived experience.
- The opening video discussing Oliver's story was most likely to be cited as a standout feature of the training.
- Case studies, scenarios and having verbal discussions suited people's learning styles.

The data collected about Tier 2 Training supported the findings from Tier 1 Training about the value added by the involvement of experts by experience.

Almost all respondents across all training packages (95 per cent or more) agreed that sharing of information by someone with lived experience or a video involving someone with lived experience suited their learning style. From the survey responses it was evident that having experts by experience involved in the training was the standout feature for many of them. It made the training real and authentic.

"Hearing the experience from an autistic person and how he communicates and experiences life gave me a different perspective on how it is like to live as an autistic person." (Survey response, Training C T2 Autism)

Between 86 and 93 per cent of post-training survey respondents agreed that sharing of information by trainers without lived experience suited their learning style and this was highest for the Training C T2 Learning Disability and Training C Both. A standout feature for many survey respondents was the passion and enthusiasm shown by the trainers both with and without lived experience. When asked about the **one thing** about the training that stood out, over 13 per cent of people commented on the passion of the trainer for Training C Learning Disability.

"The trainer!! Fabulous lady who was clearly not only very knowledgeable but also very passionate about providing excellent care for individuals with a learning disability, changing perceptions and making a difference. I could have listened to her all day and longer." (Survey response, Training C T2 Learning Disability)

As with Tier 1, the evidence showed it is important to get the right balance between the trainers with and without lived experience. It was noted by observers that the Training Partner C's T2 Learning Disability training was run primarily by the trainer without lived experience while the expert by experience only participated in part of the session, and many survey respondents wanted more balanced input.

The videos, particularly those involving experts by experience, were also viewed as the standout feature of the training for many respondents, and many interviewees commented on the power and impact of these videos. However, the trainers with lived experience noted the need for the videos to be more representative.

"More social care rather than health-orientated videos would have been helpful for social care participants."
(Focus Group, trainer with lived experience)

"Video clips were really good with autistic actors – they generated lots of discussion. But all were men – could do with some women!"
(Focus Group, trainer with lived experience)

As with Tier 1 respondents, there were many comments about the video about Oliver's story. When asked to identify the **one thing** about the training that stood out, Oliver's film was highlighted most often. Across all training packages, 15 per cent of respondents cited this as the standout feature.

"I also feel that having training connected to Oliver's story enhances the importance of the overall aim as he is not just a statistic; he was a young man whom the current NHS system failed."
(Survey response, Training C T2 Learning Disability)

Other videos highlighted as being particularly powerful and memorable were the video on sensory overload used by Training Partner B T2 and the final video used in the Training A T2

featuring people with lived experience pledging to advocate for Oliver. There is a case to be made for a bank of the best videos to be made available for use in future training.

Between 86 and 98 per cent of respondents agreed that the use of case studies, scenarios and having verbal discussions suited their learning style. The rate of agreement was particularly high for those Trial Partners where face-to-face delivery took place, as this enabled interaction and discussion. Those receiving training in the hybrid mode were least likely to agree that case studies and verbal discussions worked well (86 to 88 per cent), although most people still reported that it worked well for them.

The question-and-answer sessions were well received, with 92 to 94 per cent of people saying these sessions suited their learning style. Many comments, both from the surveys and interviews, called for more time for discussions and question-and-answer sessions regardless of training mode. When asked what could be done better, many respondents suggested that Training B and Training C Autism could be made more interactive.

> *"Maybe more interactive with group activities instead of slide shows."*
> (Survey response, Training B T2)

Some Trial Partners provided written resources and 82 to 94 per cent of participants agreed this suited their learning style. Survey respondents and interviewees noted it was useful to have something to go back and refer to. There was a slight preference for group quizzes and activities, with 80 to 95 per cent saying these worked well, compared to 76 to 87 per cent supporting individual activities. No Trial Partners used role play but Training Partner B had a participatory communication exercise and 75 per cent of respondents agreed this suited their learning style.

Content

In Tier 2, particular content stood out for respondents and was highlighted in observations:

- The way that unconscious bias was addressed by Training Partner B.
- The Cradle to Grave approach taken by the Training Partner B was particularly praised.
- The use of the 'Ask, Listen, Do' approach by both tiers of the Training Partner B training was highlighted by many in the survey and by interviewees.
- The use of reasonable adjustments was covered well by Training Partner A.
- Statistics and legislation were highlighted for the Training Partner C Learning Disability training, in particular the way this was introduced at the beginning of the session.

One issue that was a recurring theme for some Trial Partners was the blaming attitude taken towards hospital staff, in particular doctors.

Focus group feedback highlighted that for some training this appeared to follow on from the tone set by the opening video on Oliver's story, and for others it was the general approach

taken by trainers. Survey comments suggested that Training Partner B appeared to get the balance right, with trainers including more positive examples. It is vital that the correct balance is achieved, as 'Dr blaming' is not conducive to learning and to ensuring that doctors attend the training. One doctor who attended the course stated:

> *"I'm not sure that repeatedly telling us how rubbish we are is good for learning. Some examples of best practice would be good. Additionally, this would give us some idea of what to do, rather than just what not to do."*
> (Doctor on Training C T2 Learning Disability)

A further quote supported this:

> *"I felt that people's opinions of healthcare professionals didn't really need to be spoken about as much, as Oliver's mother said this training is not to point fingers but to educate."* (Survey response, Training C T2 Learning Disability)

The content also needs to be considered in relation to sectors being trained. There were comments from survey respondents and interviewees that the content was rather health/medical-focused and therefore less appropriate for social care staff. For example:

> *"Content was focused on medical settings (though I appreciate it's challenging to cater for all)."* (Survey response, Training C T2 Autism)

Therefore, more social care content should be included to make it relevant for that sector. Some survey respondents felt that more bespoke training should be offered for different groups.

> *"I feel that different structured tiers of training need to be included according to experience and job role. I did question if a split between health/social care staff would have been useful?"* (Survey response, Training B T2)

Kirkpatrick Level 2: Learning for Tier 2 Training

Across all Tier 2 Training, respondents rated their knowledge, skills and confidence in working and communicating with people with a learning disability or autistic people more highly directly after the training than before. Where there was sufficient data, analysis showed these increases were maintained at follow-up.

Those who had received Training C were most likely to strongly agree, and to agree overall, that the training had increased their learning and their awareness.

Statistical tests were used to explore differences in self-rated competencies before and after the training. Further details of this analysis are presented in Appendix C.

Results indicated that, compared to before the training, people rated themselves significantly higher on the following domains after attending the training:

- People felt that they had more **knowledge** about working with people with a learning disability and autistic people.
- People felt they had the **skills** that they need to work with people with a learning disability and autistic people.
- People felt more **confident** working with people with a learning disability and autistic people.
- People felt more **confident in communicating** with people with a learning disability and autistic people.

These changes were significant across all the training at Tier 2 (see Tables C1 to C8 in Appendix C), suggesting that all the training led to an improvement in people's self-rated competencies beyond what would be expected by chance.

The following items were rated significantly higher across all training except Training A (in relation to learning about learning disability):

- People were more likely to agree that they had an **important role to play** to meet the general health needs of people with a learning disability and autistic people.
- People were more likely to agree that people with a learning disability and autistic people **face significant challenges in healthcare settings.**

To explore whether these changes were maintained over time, respondents were asked to rate themselves again on these domains two-to-three months after attending the training. Statistical tests were used to explore differences in scores from pre- and post-training, and before and after follow-up time-points to determine if changes were maintained over time. This analysis was only possible for the Training C (Learning Disability), due to small numbers of people completing the follow-up survey. Results are presented in Table C9 in Appendix C.

Results suggest that improvements were maintained at follow-up on all four domains: knowledge, skills, confidence, and confidence in communicating.

As with Tier 1, respondents who were knowledgeable about learning disabilities and autism before training said it had refreshed and updated their knowledge and reassured them.

> *"For me it was like a good refresher to know that my practice is a good practice."* (Interview, Assistant Practitioner, Training C T2 Learning Disability)

Others highlighted how much they had learned.

> *"I didn't realise there were such significant health inequalities and it made me understand the reasons behind this. It has made me so much more mindful and aware."* (Survey response, Training C T2 Learning Disability)

The quantitative data showed that respondents felt more confident following their training (see Appendix C, Tables C1 to C8) and this was referred to in the surveys and interviews.

Some respondents gave examples of having questioned or challenged colleagues or other healthcare professionals when they observed poor practice, since doing the course:

> *"I recognised a person's needs were not being met. This resulted in the service receiving warning notices and putting in systems and processes to ensure people's individual needs were respected and met."* (Survey response, Training A T2)

> *"Given me much more confidence to be slightly more outspoken and to challenge others. I feel I could speak to a nurse or doctor about things now. I feel I could document it afterwards now as well. Before the course I might not have reported it but now I could highlight if something went wrong."*
> (Interview, security guard, Training C T2 Both)

Individuals and teams shared their learning with colleagues and several interviewees said they were stronger as a team as a result of doing this training.

> *"I helped the team to consider changes in their approach and interventions when working with an autistic person."* (Survey response, Training C T2)

It is encouraging to see the impact of training multiple people in an organisation within this trial of the training.

Respondents were asked in the Tier 2 post-training survey about new learning about autistic people and people with learning disabilites, as well as about awareness of their health needs. See figures 14 to 17.

Figure 14: The training has given me new learning about learning disabilities
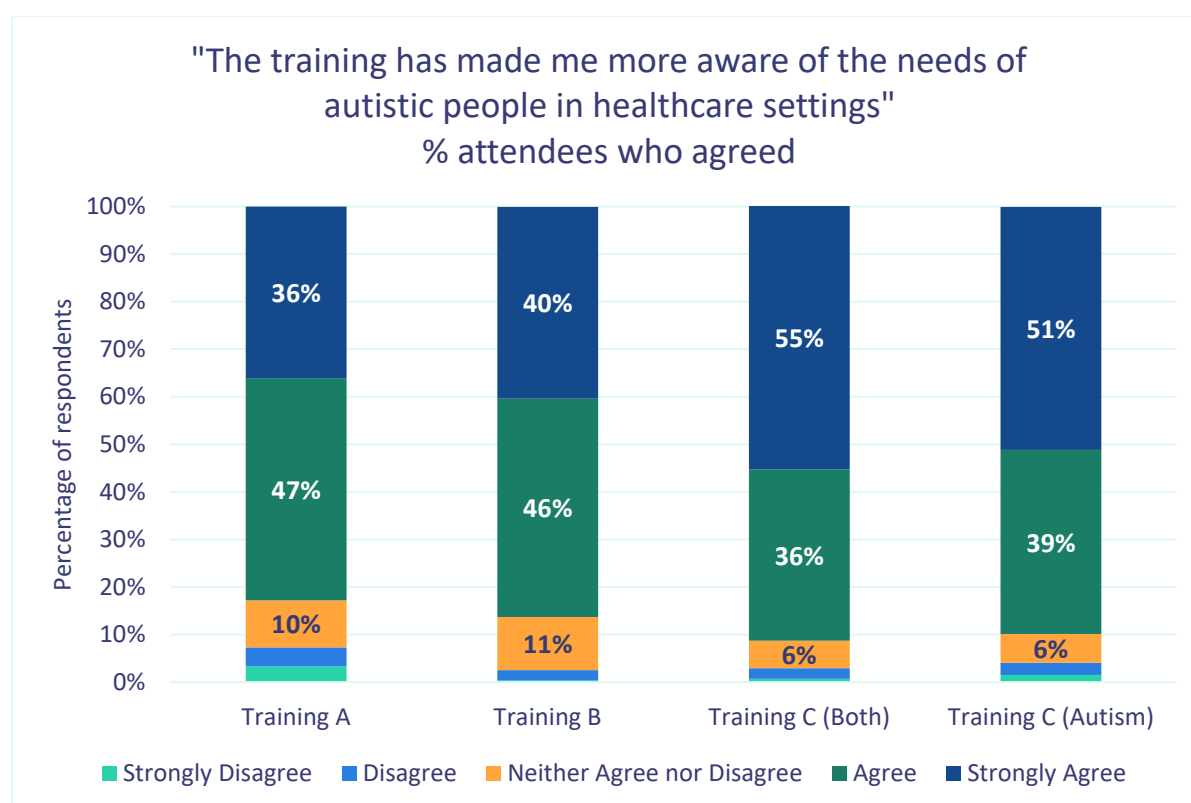

"The training has given me new learning about learning disabilities" % attendees who agreed
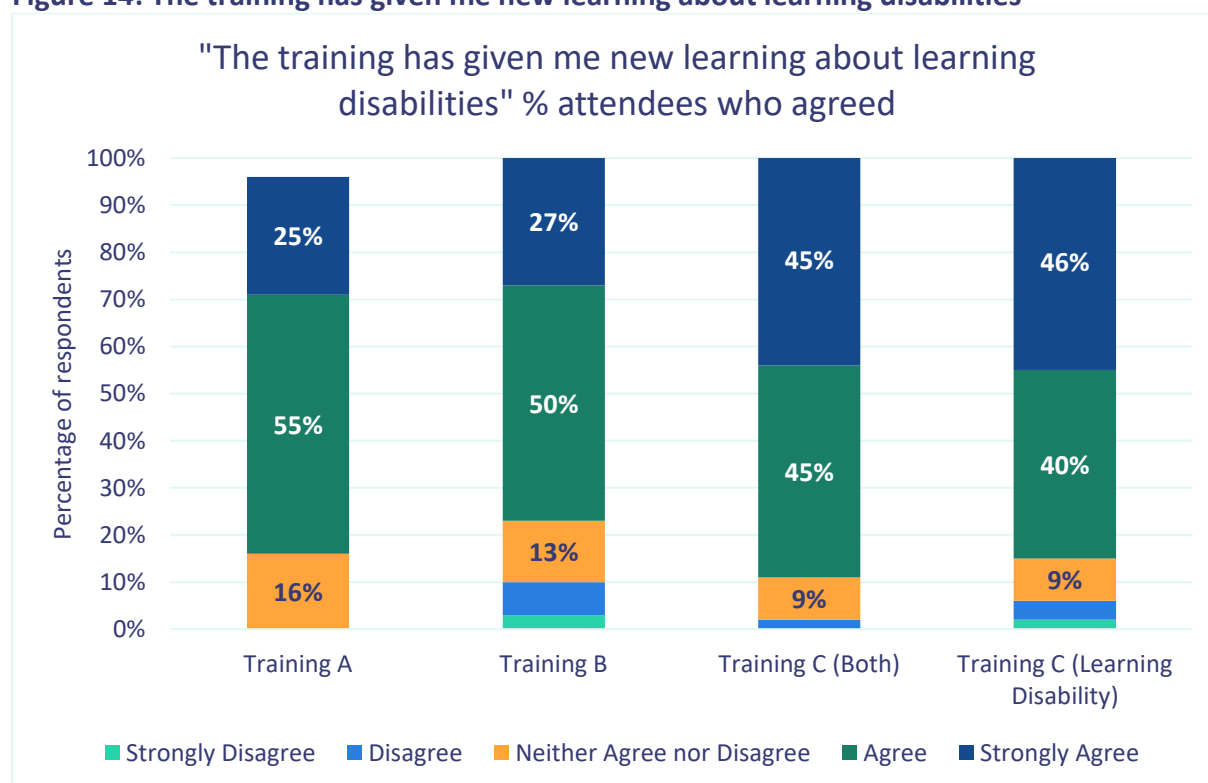
Figure 15: The training has given me new learning about autistic people

"The training has given me new learning about autistic people" % attendees who agreed
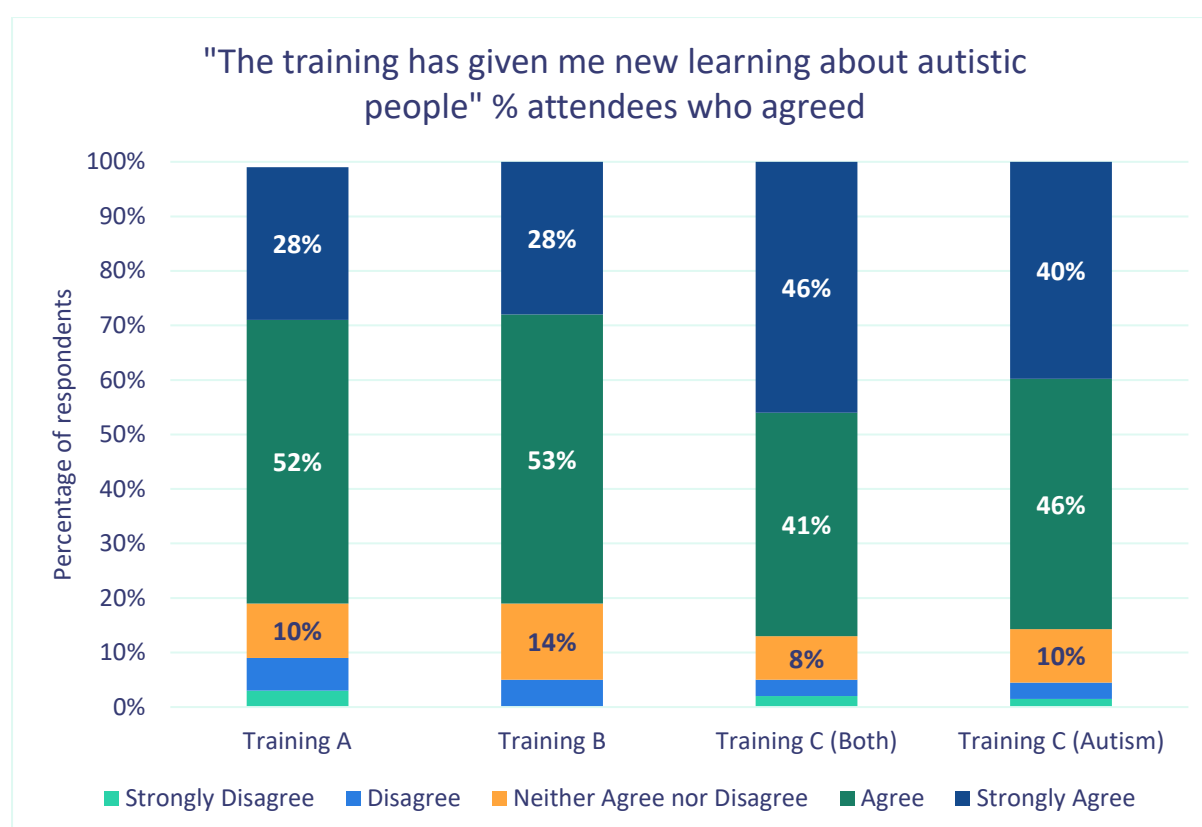
Figure 16: The training has made me more aware of the needs of people with a learning disability in healthcare settings

"The training has made me more aware of the needs of people with a learning disability in healthcare settings" % attendees who agreed
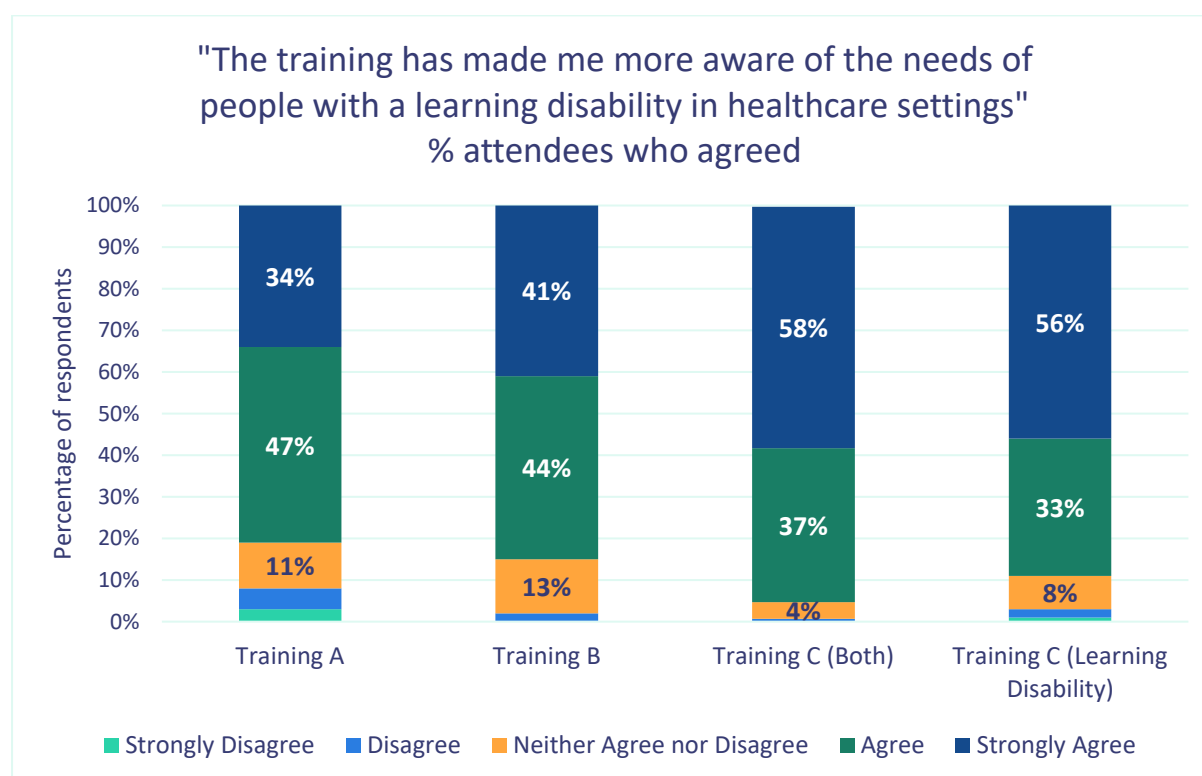
Figure 17: The training has made me more aware of the needs of autistic people in healthcare settings

"The training has made me more aware of the needs of autistic people in healthcare settings"
% attendees who agreed

Legend: Strongly Disagree | Disagree | Neither Agree nor Disagree | Agree | Strongly Agree

Category	Training A	Training B	Training C (Both)	Training C (Autism)
Strongly Agree	36%	40%	55%	51%
Agree	47%	46%	36%	39%
Neither Agree nor Disagree	10%	11%	6%	6%

On every one of these measures, those who had received Training C were most likely to strongly agree, and to agree overall, that the training had increased their learning and their awareness.

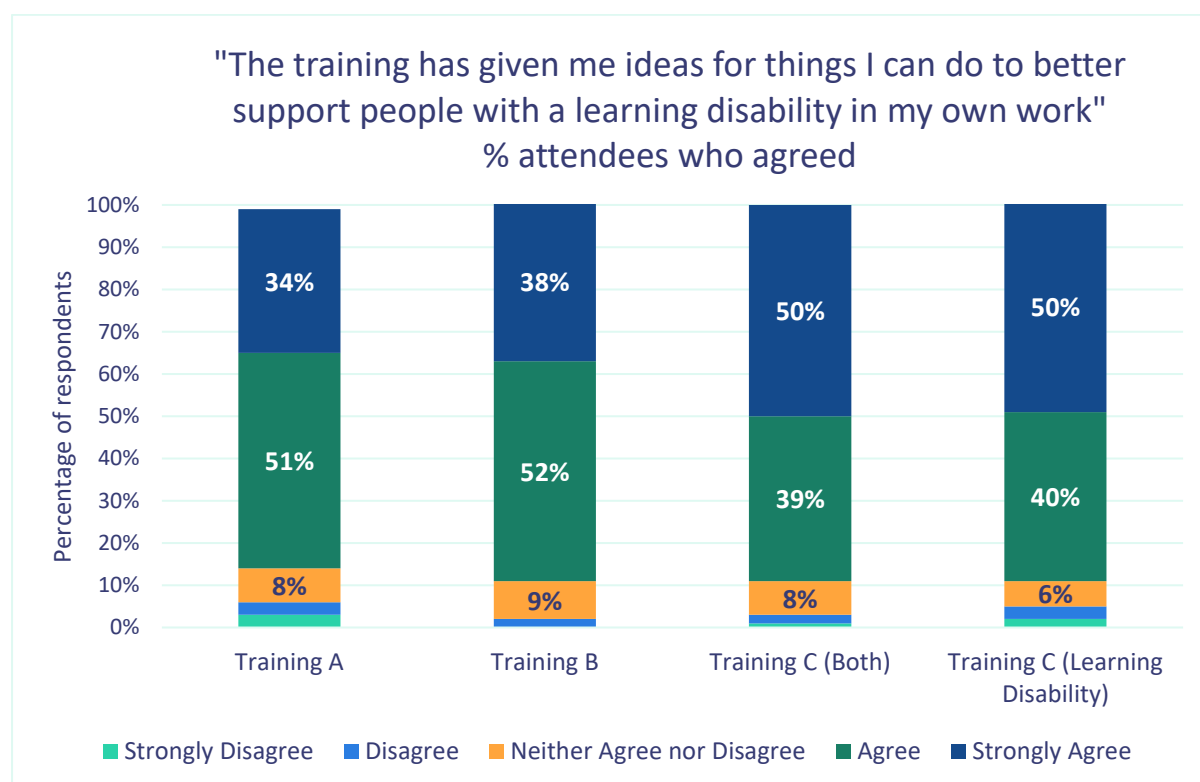## Kirkpatrick Level 3: Behaviour changes for Tier 2 Training

61 to 88 per cent of people who had done Tier 2 Training reported doing something different when supporting someone autistic or with a learning disability since their training.
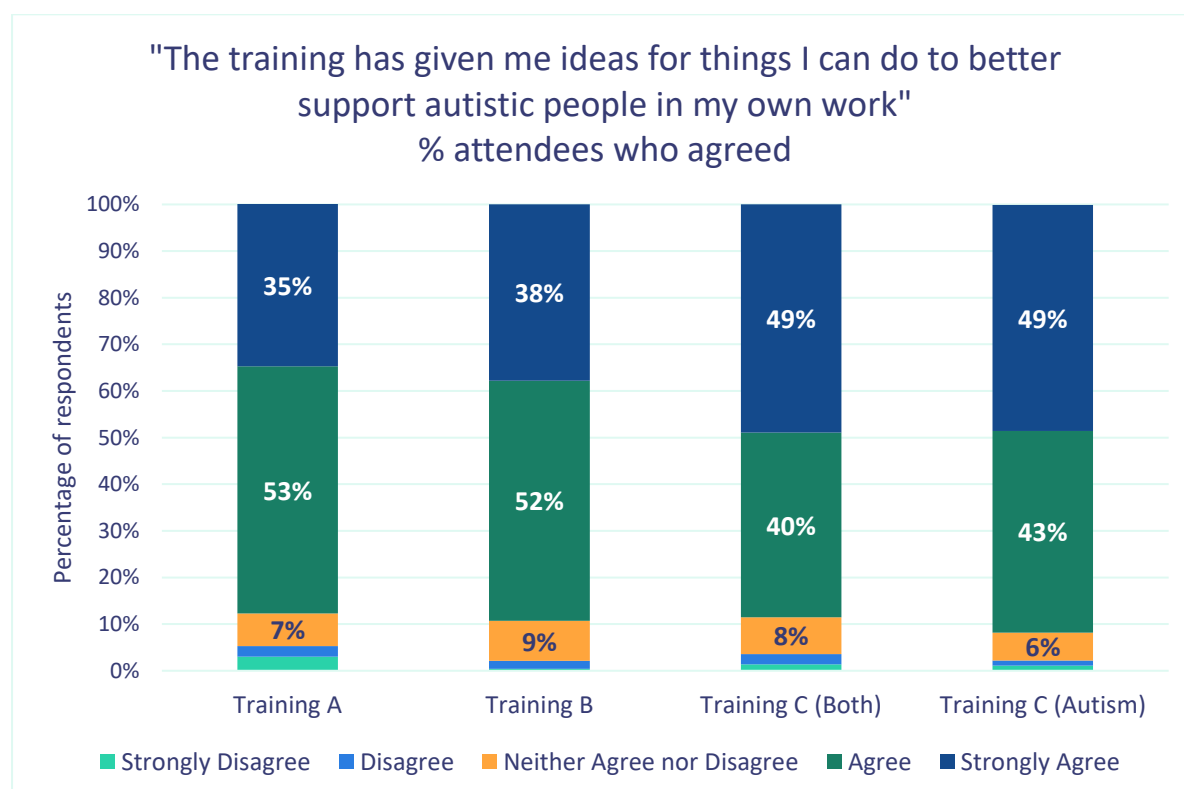
Figures 18 and 19 show the responses when people were asked about the training giving them new ideas for how to support people in their work. Respondents were more likely to strongly agree with this if they had attended Training C.

Figure 18: The training has given me ideas for things I can do to better support people with a learning disability in my own work

"The training has given me ideas for things I can do to better support people with a learning disability in my own work"
% attendees who agreed

	Training A	Training B	Training C (Both)	Training C (Learning Disability)
Strongly Agree	34%	38%	50%	50%
Agree	51%	52%	39%	40%
Neither Agree nor Disagree	8%	9%	8%	6%

Legend: Strongly Disagree, Disagree, Neither Agree nor Disagree, Agree, Strongly Agree

Figure 19: The training has given me ideas for things I can do to better support autistic people in my own work

"The training has given me ideas for things I can do to better support autistic people in my own work"
% attendees who agreed

	Training A	Training B	Training C (Both)	Training C (Autism)
Strongly Agree	35%	38%	49%	49%
Agree	53%	52%	40%	43%
Neither Agree nor Disagree	7%	9%	8%	6%

Legend: Strongly Disagree, Disagree, Neither Agree nor Disagree, Agree, Strongly Agree

Higher proportions (55 to 73 per cent) of the staff doing Tier 2 Training (than Tier 1) reported that they had come into contact with someone autistic or with a learning disability since the training. The majority (60 to 88 per cent) reported doing something different to support them. Again, there was insufficient data to conduct analysis between Trial Partners, so we have primarily drawn on the interviews and the qualitative survey responses to further explore the types of changes that people have made.

The most commonly reported changes made when supporting an individual can be grouped under the same areas as those reported for the Tier 1 data. Below are some examples from the Tier 2 data:

Communication and giving time

"I made sure I listened, gave the person time to reply to one question at a time (no information overload). I tried to put the person at ease." (Survey response, Training A T2)

Person-centred support

"Following this training I am constantly reminding myself that I should never assume that someone will need this until I have met them and understand their needs fully." (Survey response, Training C T2)

Working with families and supporters

"I've spent more time talking to parents/carers of children with a learning disability to understand better what helps their child." (Survey response, Training C T2)

Implementing reasonable adjustments

> "A child with a learning disability was becoming overwhelmed in a busy waiting area so I moved them to a more quiet area."
> (Survey response, Training C T2)

> "I now regularly ask before my first visit if there are things they like or don't like so I can adapt my practice. This can include patterned clothing or strong smells, or communication needs."
> (Survey response, Training A T2)

Recognition and support of people with a learning disability and autistic people

> "I've been more 'pushy' with getting appointments and second opinions around healthcare needs for one lady we support."
> (Survey response, Training A T2)

> "I have spent more time talking with colleagues who are on the autism spectrum about their experiences of healthcare and the workplace."
> (Survey response, Training B T2)

Implementing changes in the workplace

27 to 43 per cent of people, working in roles where they could make system changes, reported doing so following their Tier 2 Training at the time of follow-up.

The follow-up survey asked if people had made any system or process changes in their own work since the training. As discussed in Chapter 2, changes to systems will occur over the longer term and therefore the timing of the follow-up survey may have been too soon to allow people to make these changes.

Of those that had done Tier 2 Training, 31 to 57 per cent said that making system or process changes was not applicable in their role. As with Tier 1, the data showed that respondents were less likely to have made system changes than changes when supporting an individual. By the time of follow-up, 27 to 43 per cent of respondents, working in roles where they could make system changes, reported they had already done so following their Tier 2 Training. Below are some examples:

Training

"I have been able to influence the new starter induction programme by advising on the conte and introducing Level 1 Oliver McGowan Training in Learning Disabilities and Autism."
(Survey response, Training B T2)
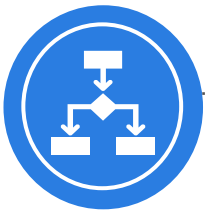
Policies and processes

"Helped create a new pathway with more support for bowel cancer screening for people with a learning disability." (Survey response, Training B T2)

Physical environment

"Have had the go-ahead to change the office into a sensory room... other service users will benefit." (Interview, Social Care Manager, Training A T2)

Provision of accessible information and advice

"We have added more Makaton symbols around our nursery and preschool, and have suggested other places do the same." (Survey response, Training A T2)

Culture change

> *"Just being more aware and opening up a conversation with my senior colleagues to raise their awareness. Making people consider their approach."* (Survey response, Training C T2 Both)

What helped with changes in behaviour?

In the interviews, people reflected on particular aspects of the training that had helped with changes in their work. Although some were not in patient-facing positions, most interviewees said that the presence of experts by experience in this training made them think hard about their own approach and practice. There was agreement that the presence of experts by experience led to a shift from discussion and theory to what could actually work in practice.

> *"I really took those things on board and because she was somebody who said 'yes this would work for me or this would work for other people that I know', so it just gave much more impact."* (Interview, manager in healthcare setting, Training B T2)

Some interviewees were concerned that training focused on what went wrong and said that sharing examples of good practice would have greater impact and help with changes in practice.

> *"It was a lot of retelling of the difficulties that they've had…it would be nice to go the extra step to know how we could have then helped with that and what they would have liked to have seen instead."* (Interview, manager in healthcare setting & allied health professional, Training C T2 Both)

This was backed up by the qualitative survey data, focus groups and observations that highlighted the need for positive examples that avoided blaming and shaming health professionals for poor practice (see Chapter 3).

Kirkpatrick Level 4: Results for Tier 2 Training

As with the Tier 1 Training, it has not been possible to ascertain improved outcomes for autistic people and people with a learning disability within the timescale of this programme, but suggestions are made in the final chapter for the work that should be done to explore the options further.

Delivery costs

As we did for Tier 1, we estimated the cost per head of delivering Tier 2 training to a group of 25 people. Further detail is described in Chapter 2. In summary, costs were estimated based on the following key information provided by Trial Partners:

- costs of paying the trainers;
- the number and experience of trainers needed to deliver the full Tier 2 training;
- how long the training was;
- any associated estimated expenses for the trainers;
- running costs including room hire, equipment and administration.

The estimated delivery costs per head, rounded to the nearest pound, for training 25 people in Tier 2 Oliver McGowan Mandatory Training were as follows:

- Trial Partner A: £30
- Trial Partner B: £67
- Trial Partner C: £98

Much like Tier 1, the primary variables impacting the cost of delivery were related to the length of time required to complete the full tier, and the number and range of trainers needed to run the course.

It should be noted that, for Trial Partners B and C, the Tier 2 Training incorporated Tier 1 Training. For Trial Partner A, the total delivery costs for Tier 2 Training would also include the costs for Tier 1 Training and would therefore be £41 per person in total.

From the information we have been given, the lowest delivery cost for Tier 2 Training is Training A. It is unsurprising that Training C has the highest delivery costs as this training runs for two days, which means any costs relating to staff time to undertake the training would also be higher.

As with Tier 1, these figures do not include any of the related design costs, which have been funded as part of the trial. If the training needs to be updated, there will be cost implications for materials to be reviewed, refreshed, co-produced and quality checked.

The number of people who attended face-to-face sessions was limited by COVID-19 restrictions. The costs of the training could be reduced by increasing the number of people attending each session. However, the face-to-face training is interactive and often involves small group discussions. This aspect of the training has been highly rated, so the data does not support the training being scaled up to be delivered to hundreds of people in one session.

Conclusion

Content

There was insufficient certainty concerning the completeness of Training A by respondents to draw conclusions about this training package. There was sufficient evidence to evaluate Training B and C. Based on the qualitative and quantitative evidence (quality and competency measures and qualitative data), Training C demonstrated slightly better outcome measures in comparison to Training B. Training C requires two days of training while Training B requires one day. Training B uses a hybrid delivery model, which did not work very well for attendees or the trainers in the trial, and this delivery mode is likely to have negatively impacted on the other outcome measures. The duration of the training will have an impact on the speed and feasibility of wider delivery.

The data shows that people had widely varying views about the desirable length of the training. In the interviews, staff working in a range of roles expressed concern about the feasibility of training whole staff teams for even one day. A doctor who had undertaken the full two days of Tier 2 Training was very positive about the training but still felt that (in December 2021) it is:

> *"probably too much of an ask, particularly at the moment."*
> (Interview, medical, Training C T2 Both)

Delivering a single day Tier 2 Training package would enable higher numbers of staff to receive the training sooner.

Overall, respondents rated the Tier 2 Training highly on the quality measures, although there were higher percentages of people who had suggestions for what could be improved than there were for Tier 1. The feedback given about activities and general approach could be used to create a one-day training session for Tier 2, using the most highly rated aspects from all three packages.

We suggest that a revised Tier 2 package includes elements from all the trialled training packages. The evaluation has shown that the final package should:

- start with Oliver's film and reflection on this (with use of a trigger warning);
- make use of existing films that were well-received (e.g. the video on sensory overload used by Training Partner B T2, and the final video used in the Training A T2);
- include films relevant to social care (or develop more if needed);
- find a way to include more input from people with profound and multiple learning disabilities and autistic people who do not use speech;
- include fewer learning outcomes;
- be as interactive as possible;
- include more examples of good practice and ensure the approach of the training is not viewed as 'blaming' by those attending;

- consider use of the approach taken to reasonable adjustments by Training Partner A;
- include the unconscious bias exercise from Training B Tier 2;
- use the 'Ask, Listen, Do' approach to reflect on every discussion section;
- incorporate the statistics and legislation aspect from Training Partner C Learning Disability.

Having learnt from the co-design of the trial training, we suggest a small group of people with varying lived experience is formed to help distil the materials into a final package.

As stated earlier (pre-learning for Tier 2), we have suggested consideration is given to using the e-learning from Training B Tier 1 as pre-learning for Tier 2. We believe this package is ready now.

Mode

Given the lack of consensus about whether the training is best delivered online or face-to-face, it is worth considering the other evidence available on this issue. A systematic review of online training for healthcare professionals compared to other training methods concluded that it is likely that online methods of training are as effective as other methods for the outcomes of knowledge and clinical behaviour (Richmond et al., 2017).

The findings of this evaluation suggest that if the Tier 2 Training is delivered face-to-face, this will suit most people's preferred learning style and it has the benefit of providing opportunities for informal interaction with experts by experience. However, the data shows that some would prefer an online option.

When considering the feasibility of an ambitious training programme like this, we need to bear in mind the current context. Health and social care staff have talked about the impacts of COVID-19 and, in social care particularly, there is a current shortage of staff. COVID-19 has changed the way in which people interact and work together online, and many previous concerns about digital inclusion have been addressed. Providing an online option may ensure the widest possible reach of staff in a range of roles and in a timely manner.

While many of our respondents enjoyed online training, there were many comments suggesting that these sessions can often be too long and this can limit people's learning. An online interactive Tier 2 Training option could be delivered in multiple shorter sessions; this would need to be evaluated. Evidence from a literature review on effective dementia education and training suggested that shorter, multiple sessions are more effective (Surr et al., 2017).

We also know from this evaluation that some of the trainers with lived experience prefer online working. Some people feel more confident when working in a familiar environment and others find travel and working in new places anxiety-provoking. Other experts by experience said they much prefer delivering face-to-face training to be able to interact with, and respond to, the attendees. Therefore, a model with both options may enable a wider

range of experts by experience to benefit from the opportunity to learn new skills and for regular paid employment.

Describing the training

It was evident that where people had not been given accurate information about the content and the timing of the training that they were more likely to be dissatisfied with it. The survey responses suggest that staff do not relate to the tier descriptions and therefore it may be better to move away from the language of "Tier 1" and "Tier 2" training. It is also important that there is clear information about the aims and the content of the training, and the time required to complete any pre-learning.

Recommendations for Tier 2 Training

The e-learning from Trial Partner B Tier 1 should be used as pre-learning for Tier 2 and is ready now.

Where there is sufficient robust evidence, Training C demonstrates slightly better outcomes, particularly in relation to learning, awareness and new skills. This would require two days of training.

The evidence suggests that all three training packages were well-received and effective. In terms of feasibility, DHSC/decision-makers should consider creating a one-day training session for Tier 2, which builds on the evidence base from what has already been trialled.

Considerations for content for Tier 2 Training

- The content of a new one-day training package should be informed by the evidence base about the most effective approach, mode and activities.
- We suggest having a bank of approved films that the trainers can draw upon. This would allow some tailoring to the audience or to local issues.
- The expert group deciding on the final Tier 2 content should include health and social care professionals and experienced trainers, along with experts by experience.
- Tier 2 Training should ideally be run face-to-face, in groups that are small enough to enable group discussions and interactive exercises (with consideration to suitable training venues).
- Tier 2 Training could also be trialled in multiple, shorter, online sessions.

Considerations for next steps for Tier 2 Training

- HEE, SfC, DHSC and other relevant stakeholders may wish to consider working together to take decisions on how this training dovetails with existing training for health and social care staff, including undergraduate medical and nursing training.
- HEE, SfC and DHSC may wish to consider the guidance around appropriate levels of training for different staff.
- There needs to be clarity for people receiving the training about its length, focus and aims, with an accurate description provided.
- DHSC/decision-makers may wish to consider clearer ways of naming the training and move away from describing the training as Tier 1 and Tier 2.
- A quality assurance process should be set up to enable regular review and refreshing of the course materials and content.
- Delivery could be started with those most likely to make changes in their practice, notably people who request to partake in the training, senior staff who can implement systems changes, and teams who wish to take up training collectively.

Chapter 4: Conclusions and further work

As has been evidenced in this report, overall, across all Trial Partners and tiers, the training:

- was well received and highly rated on a range of quality measures;
- led to an increase in knowledge, skills and confidence in working and communicating with autistic people and/or people with a learning disability, with some evidence of this being maintained at a two-month follow-up;
- was used by most people to make changes in how they supported an individual;
- gave some people ideas of changes to be made at a system level.

Recommendations and considerations for training packages

People have different learning styles, levels of knowledge and experience of previous training, as well as a wide range of work roles. Developing a standardised training package that is effective for large groups of staff across different settings will inevitably pose a challenge. The aim is for the Oliver McGowan Mandatory Training to be delivered to approximately 3 million health and social care staff across England who will need to apply that training in different ways. This is an ambitious plan, and we need to accept that completely standardised training delivered in one format will not be rated highly by everybody. Despite the limitations noted above, it is encouraging to see such positive feedback on all the quality measures and most people reporting increased knowledge, skills and confidence, but the data does reflect individual preferences for mode, content and length.

"Never going to achieve a perfect balance when trying to make it so generic. Can't be everything to everyone." (Interview, medical, Training C T2 Both)

The next steps for Tier 1 Training can be informed by the larger, more robust dataset for Training Partner B. The quantitative and qualitative evidence support a recommendation to apply the blended package using the existing e-learning (possibly with minor amendments) and a session with experts by experience. There should be consideration given to extending the session and including more than one expert by experience.

The data for Tier 2 Training is less clear-cut, with between 25 and 56 per cent of respondents reporting improvements that could be made in the Tier 2 Training they received.

If the preference is for one of the three trialled packages to be used in the trialled format, then there is some evidence to suggest Training C Tier 2 may offer slightly better outcomes based on the post-training data. However, it is a small sample size on which to base training for millions of staff and there was insufficient follow-up data. There is supporting data from larger numbers of respondents that received part of the training.

The complete Tier 2 Training C package takes two days for staff to complete. So, if time and cost are not prohibitive factors, and the preference is to select an existing, complete package, then the evidence suggests the full Training C Tier 2 package should be used.

However, assuming cost is a determinant of feasibility, consideration should be given to the creation of new one-day Tier 2 package that can be informed by the feedback collected in this evaluation. This would be a relatively small task given the in-depth co-production that has already gone into designing three well-received training packages. Sign-off from a small expert group on the revised package could happen in parallel with recruitment of experts by experience for the training roles.

While the data can inform decisions about the content and mode of training, the main challenge will be ensuring consistent, high-quality delivery of the training, and ensuring it leads to an improvement in the delivery of care and support to people with a learning disability and autistic people. As highlighted by Baroness Penn in the House of Lords when discussing Amendment 176, which proposed that guidance should be published on how training in learning disability and autism will become mandatory for all health and social care staff, the Government has acknowledged the need to "ensure that the training rolled out is meaningful and impactful" (HL Deb 16 March 2022). If the training is to make a difference, then there must be consideration as to how people are supported in, or blocked from, transforming their learning into action.

Further evaluation

Considerations for further evaluation:

- If there is a decision to offer an online option for Tier 2 Training then delivering this in an increased number of shorter sessions could be trialled.
- Exploration of the benefits of training being delivered within organisations or staff teams, versus being delivered to audiences from both health and social care.
- A decision as to how often the mandatory training is required or how frequently refresher sessions are needed.
- Longer-term work exploring improvement in health and social care provision for people with a learning disability and autistic people, and ultimately their outcomes.

If the decision is taken to develop an amalgamation of the Tier 2 Training packages, then it will need to be evaluated during any future commission, since it is a new package.

As discussed in the limitations section above, there is inconclusive evidence about some aspects of the training and therefore a need for further exploration. A review of evidence about learning disability awareness training for healthcare staff concluded that there are benefits of training in mixed-profession groups (Marriott and Harflett, 2020). These include facilitation of discussion from a range of perspectives and learning more about others' roles. In the present evaluation there were mixed opinions, both from those delivering training and those receiving it, about the value of training within staff teams or having mixed audiences working in different roles and different sectors. Given the scale on which the training will be delivered, we think it is possible to trial some sessions with mixed audiences and to trial some within-organisation or even within-department training.

To suit a range of learning preferences, and for practical and inclusive reasons, we suggest considering making the Tier 2 Training available online as well. There was evidence that people find a whole day online too much, so any online training could be split across at least two sessions. As there is no travel required for online training, this is possible without adding additional time overall. A literature review on effective dementia education and training for the health and social care workforce concluded that training should have a total duration of at least eight hours, with individual sessions of 1.5 hours or more (Surr et al., 2017). It would be possible to trial a larger number of shorter online sessions. This would reduce the amount of learning in each session and the use of multiple training sessions may reinforce the learning from previous sessions.

It was heartening to see that, when asked to rate knowledge, skills and confidence at follow-up, significant improvements were maintained. However, the time gap between the training being delivered and the follow-up surveys and interviews had to be reduced to two months. Given other evidence showing a decline in skills and knowledge in healthcare staff from as little as a month after receiving training and certainly within a year (Ahmed et al., 2021; Yang et al., 2012), it is unlikely that a one-time delivery of this training will have a lasting impact. A panel of international experts reached a consensus that learning disability awareness training for healthcare staff should be refreshed every three years (Taggart et al., 2021). Future work should determine the optimum time for repeating or refreshing the training.

A literature review looking at the impact of service user involvement in healthcare education concluded that:

> *"There is limited evidence that service user involvement leads to changes in behaviour in practice or significantly benefits the service user receiving care."*
> (Morgan and Jones, 2009, p.24)

Given the clear message from people receiving this training, that including people with lived experience helped to improve their knowledge and skills, we would hope this translates to improvements in the delivery of care and support to people with a learning disability and autistic people. However, we have not been able to collect data to establish this.

We used follow-up surveys and interviews to explore changes in working practice but the low response rate for the follow-up surveys limited our evidence on this. Furthermore, while some of the examples of changes when supporting an individual or system changes have been encouraging, we cannot ascertain that these constitute better care and support. In relation to the Kirkpatrick levels of learning, we believe there is good evidence that this training has had a positive impact at the first two levels (reaction and learning), and some evidence of a positive impact on behaviour (Level 3). However, it is not possible to conclude the degree to which the ultimate desired goals of the training were achieved.

There are challenges with collecting follow-up data about behaviour changes; people may not always be aware of how their attitude and approach has changed. However, if there is a robust longer-term evaluation of the Oliver McGowan Mandatory Training then there will be an opportunity to evaluate the effectiveness at Kirkpatrick Level 4 (results). This will require feedback from autistic people, people with a learning disability and their family carers and paid supporters. Additionally, there will need to be a consideration of other data that can demonstrate if the training is leading to better outcomes for people in a range of settings, such as complaints data. If this can be done robustly, then it could be argued there is no need for further research looking at behaviour change, as the impact on the care and support people receive is ultimately the aim.

The timescale on which we could hope to see these changes varies:
- A short-term indicator of improvement could be evident within a year – this might be an increase in the number of reasonable adjustments made.
- A medium-term indicator could be evident within three-to-five years – this might be a reduction in hospital re-admissions and non-attendance rates for autistic people / people with a learning disability.
- A long-term indicator would require 10 to 20 years to be evident – this might be a reduction in early and avoidable deaths (the LeDeR programme should be able to provide this data).

The panel of international experts in Taggart et al's (2021) Delphi Study identified systems-related impact indicators of change that would evidence improvement in the delivery of care and support to people with a learning disability in trusts. Further work is needed to determine the most appropriate short-, medium- and long-term indicators of change for autistic people and people with a learning disability within health and social care settings.

Conclusion

Health inequalities for people with a learning disability have been well-documented for decades now, with work dating back to the last century showing high rates of people with a learning disability dying prematurely (Hollins et al., 1998). In that time, a plethora of reports have acknowledged the need for more – and better – training, including the LeDeR annual report, which recommended that:

"Mandatory learning disability awareness training should be provided to all staff, and be delivered in conjunction with people with a learning disability and their families." (LeDeR annual report, page 8, 2017)

There is also a growing body of evidence that autistic people have poorer physical and mental health compared with the general population and experience premature mortality (Doherty et al., 2022).

The Oliver McGowan Mandatory Training for all health and social care staff in England is a unique opportunity to make a difference to the lives of autistic people and people with a learning disability. The ambitious scale of this is a significant challenge, but it is also a strength of the programme, as it would mean that staff in all roles and at all levels receive this training. Moreover, some of the learning about approaches, such as reasonable adjustments and person-centred care, may also translate to better care and support in general, but particularly for other groups of people with cognitive impairment such as people with dementia.

Training at this scale will necessitate the employment of large numbers of trainers with lived experience. Data from the Office for National Statistics showed that, in 2021, autistic people and people with a learning disability had lower employment rates than disabled people with "other impairment types". Opportunities for paid employment, learning new skills and acquiring career experience for autistic people and people with a learning disability would be an additional positive outcome of this programme.

However, the training will only be delivered effectively if trainers are equipped with the necessary skills and ongoing support. Additionally, without buy-in at senior levels and a commitment to making wider changes in workplace settings this training could fail to have the positive impact it should. We believe that this would be a wasted opportunity and we urge consideration of the wider work that could be done to build upon the momentum created by this trial and bring about positive change.

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