Evaluation of the Oliver McGowan Mandatory Training in Learning Disabilities and Autism

An Interim Report

NDTi

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Acknowledgements:

Thank you to members of the evaluation team from My Life My Choice and bemix and to our Advisory Group.

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Introduction

Background

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 anti-psychotic 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. Oliver's parents, Paula and Tom McGowan believe his death could have been prevented if the doctors and nurses had been trained to understand how to make reasonable adjustments for him. An independent Learning Disability Mortality Review found that Oliver's death was avoidable.

The Learning Disabilities Mortality Review (LeDeR) 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.

Following Oliver's death, his mother 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 autism in their care. 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 5000 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'. In this, they announced funding to develop and test a learning disability and autism training package which can be rolled out widely. This is the Oliver McGowan Mandatory Training in Learning Disabilities and Autism programme.

Oliver McGowan Mandatory Training in Learning Disability and Autism

This 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 learning disabilities, provide improved services, reduce health inequality, and eliminate avoidable death.

The aim of this phase of the work is to trial a range of forms of training, evaluate it and produce a standardised training package suitable for roll out as mandatory training. This is being funded and overseen by Department of Health and Social Care, Health Education England (HEE) and Skills for Care. Trial and evaluation partners were appointed to co-produce, co-deliver and co-evaluate training. Every stage including consultation, planning, 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 tender was explicit that the Oliver McGowan Mandatory Training needed to be co-designed and co-delivered by autistic people, people with a learning disability, family carers and subject matter experts. 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. 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 range of health and social care staff. Each trial partner is a consortium of organisations and the leads are:

British Institute of Learning Disabilities (BILD)	Gloucestershire Health and Care NHS Foundation Trust	Royal Mencap Society/National Autistic Society	Pathways Associates Community Interest Company

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

This interim report summarises the progress made so far in the trial. It includes summarised analysis of the limited data collected so far. As of October 2021, sites are still delivering training and the evaluation team continues to collect data.

Evaluation

With coproduction at the heart of this evaluation, NDTi, in partnership with bemix and My Life My Choice, have built a delivery team to ensure the necessary breadth of knowledge, skills and experience required for the project. We are working together to design and deliver the evaluation. In this report we refer to this team of people as the evaluation team. The evaluation team is made up of people with evaluation expertise, expertise in workforce development, people who are autistic and others who have learning disabilities. We have others in the team who ensure people are supported to be fully involved to co-produce the evaluation throughout. We are supported by our Advisory group who use their personal and professional expertise to support, challenge and hold our delivery team to account. Members of this group include self-advocates, family carers, academics and other experts.

Evaluation questions

1. What works and for whom in learning disability and autism training? Taking into consideration different workplace settings, staff roles and geographical contexts:
    a. what type of training is the most effective in terms of improving staff understanding and confidence of learning disability and autism in the context of their day job?
    b. what type of training is the most effective in terms of training delivery methods in different workplace settings?
    c. to what extent is the training provided at the correct level for participating staff?

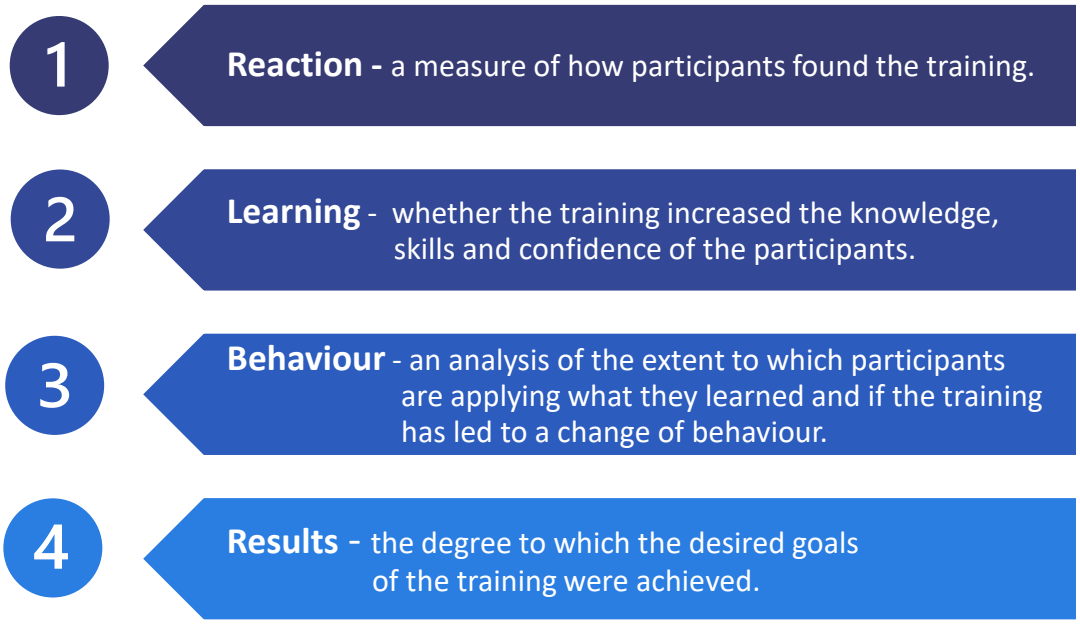
2. What are the estimated costs associated with the wider rollout of the mandatory training, including costs of different delivery methods, 'backfill', materials, and different levels of the workforce?

3. What are the potential challenges and barriers to rolling out the Oliver McGowan Mandatory Training across England? How might these be overcome based on learning from the trials?

4. Is there any evidence that learning disability and autism training delivered through the trial has led to an improvement in the delivery of care and support to people with learning disability and autism?

Evaluation method

Our approach to answering the evaluation questions is informed by the **Kirkpatrick Four-Level Training Evaluation Model**[1]. It helps to frame our analysis of the impact of the different training models. The Kirkpatrick Model considers learning at four levels:



In addition to this, we are also considering the impact of the training programme on Experts by Experience[2] who were involved in designing or delivering the packages. This could include increased confidence and skills or more practical benefits, such as paid employment.

We are using the following methods:

Benchmarking

We have mapped all the Trial Partner training against the specific capability training frameworks to show the capabilities the training covers.

Observation

All training delivered by Trial Partners will be observed at least once by our Expert by Experience evaluation team members. The evaluation team has developed a quality checklist to complete when observing the training.

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

[2] 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.

Pre-and post-user survey	Pre-and post-surveys have been designed and are sent to all participants who attend the training courses. The aim of these is to capture improvements in staff understanding of learning disability and autism and obtain feedback on the effectiveness of training delivery methods.
Follow-up survey	A short, online follow-up survey is sent to all training participants between two and three months after they have completed the training. This is to capture any longer-term impacts of the training and explore any changes in practice.
Semi-structured interviews	Telephone or online interviews are being conducted with a sample of training attendees between two and three months after the training is completed. These build 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. We are interviewing both health and social care staff working in a range of roles and settings and ensuring a mix of people who have varied levels of contact with autistic people or people with a learning disability in their day-to-day work roles and lives.
Focus group discussions	These will be conducted with people involved in the design and delivery of the trial training to capture their learning and views. Focus group discussions will enable people to share and compare experiences of designing and delivering the training and explore approaches to, and levels of, real co-production throughout the process.
Analysis of costs	We are collecting data from each Trial partner to enable us to estimate the costs of the training being rolled out nationally.

Evaluation progress

All stages of the evaluation work are underway. In this report we summarise initial analysis of the data to assess whether the trial and evaluation is working.

The journey so far

The Oliver McGowan Mandatory Training trial began in August 2020. The first three months were planned to be the set up and design phase for the following activity to take place:

- **Set up of local partnerships** – whilst each partnership is different, all comprise multiple local organisations, self-advocacy groups (autism focused and learning disability focused), training and health and care partners.

- **Training co-design by each trial partner** - every group had committed to fully co-producing and co-delivering all their training, with experts by experience and user led groups locally.

- **Setting up learning management systems** or bookings processes for learners to be able to book on, and progress across tiers.

- **Evaluation team set up** - the evaluation group also comprises 2 separate delivery and advisory groups, each with a range of experts by experience and other experts. These groups formed in autumn 2020.

- **Design of evaluation tools** such as a benchmarking process and pre-and-post learning questionnaires.

- **Gaining ethical approval for the evaluation methods**. All research and evaluation has to adhere to strict ethical protocol to ensure the safety and wellbeing of all participants, so the ethics application process is key to being able to begin the evaluation.

- The establishment of the governance processes surrounding the trials, including **contract monitoring and the set-up of the Operational Delivery Group (ODG)** to implement the trials. These are over seen by the Strategic Oversight Group that was established at the outset of the project and oversaw the procurement processes. Each of these different groups includes a range of experts by experience, subject matter experts, funders, commissioners and programme managers.

The four different trial partners had described their proposed training approaches in their bid submissions and together offered a range of different approaches. Some were planning a mix of e-learning and face-to-face, others all face-to-face. Some were planning to have single training sessions for Tier 1 and Tier 2, and others envisaged a modular approach where learners select different subjects at different times. Some were planning to co-create and make films with experts by experiences either sharing their own stories, or acting out scenarios.

Despite COVID-19 being in full swing when the trials began there were many unforeseen circumstances that led to an agreement for the trial to be extended. All trial partners and evaluation partners agreed contract extensions over the course of the winter of 2020-21.

A number of factors led to some of the original plans for training designs needing to be adapted before they were signed off as ready to start the trial with training participants.

These included:

- Modular approaches were deemed to be too complex to be rolled out on a practical basis, as it would be difficult to determine if learners had completed the required Tier 2 relevant to their individual job role.
- A decision not to use pre-existing e-learning after some feedback from experts by experience in the Operational Delivery Group; this led one trial partner having to co-design their own local e-learning package. Others had already planned to do that, so not everyone was impacted.
- One trial partner received early feedback from local clinical teams who were agreed participants in the trials, that they needed the Tier 1 timings to be shorter to accommodate learners' time being scheduled more easily around their working hours.
- In January 2021, it was clarified that the Tier 2 training did not have to cover every capability in the 2 capability frameworks, and priority needed to be given to a range of aspects of learning relating to issues identified in LeDeR and beyond. This led to the design of some of the training being updated.
- The Quality checking panel gave feedback to a number of trial partners leading to some changes to the content of their training.
- A number of trial partners planned to make films as part of the learning materials. One group working with a film making group with actors who have learning disabilities, were particularly delayed, as the set locations in healthcare settings could not be used for many months due to COVID-19.
- The film of Paula McGowan telling Oliver's story was re-filmed and reduced in length early 2021 and ready for trial partners to use in all their training from March 2021. Trial partners adapted their training plans to schedule time for the film to be viewed and discussed with participants in every course.

- For those trial partners who planned only on using face-to-face delivery for both tiers, training could not begin before social distancing measures allowed for training to be run in real settings. Others adapted their methods to use a range of online live interactive sessions, and hybrid methods of delivery.

Training trials actually began in a staggered way, with different trial partners being ready to start delivery of their different sets of Tier 1 and Tier 2 training at different times.

Two trial partners began to pilot some early versions of their Tier 1 training in December 2020. However, these were paused when the Quality Checking Panel reviewed their training in February 2021. One of those underwent small adaptations, and continued, and another required wider changes and was put on hold for adaptations. Some of the data collected at this point was able to be used in the evaluation, as the minor amendments needed do not impact of the validity of the evaluation. Feedback obtained from the pre-trial pilot packages that were not suitable for the trial was analysed separately and made available to the trial partners and commissioners to inform ongoing development. That training and feedback does not inform the final evaluation.

The main trials of the training began as follows:

- **The BILD Partnership** Tier 1 was piloted from December 2020, with a pause for amendments in February and then continued from May 2021. BILD Tier 2 training began in August 2021.
- **The Gloucestershire** partnership began training for both Tiers in May 2021.
- **The Mencap and NAS** trial partner group began both Tier 1 and Tier 2 training in August 2021.
- In August 2021 the **Pathways** led partnership involvement ended due to the impact of COVID in the Northwest.

This evaluation is based on the data which has been collected throughout the trials process, through a range of tools as described in our method section.

Table 1 presents a comparative summary of the design and delivery across the different trial partners.

Table 1. A comparative summary of the design and delivery across the different trial partners

Aspects of training	Tiers	BILD	Gloucester	Mencap (Learning disabilities)	Mencap (autism)
Delivery methods Summary	T1	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.	Face-to-face or online but interactive. Co-led by two trainers at least one of whom is autistic.
	T2	E-learning followed by face to face, grouped in 4 separate topics. These can be done all in one day face-to-face, or over 4 separate online interactive courses again with 2 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 4 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/ LD separate or mixed	T1	Separate Autism and Learning disability courses.	Autism and learning disability	Learning disability only*	Autism only*
	T2	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

Aspects of training	Tiers	BILD	Gloucester	Mencap (Learning disabilities)	Mencap (autism)
Involvement of people with lived experience in training delivery	T1	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 learning disabilities and family carers.	Yes Face-to-face sessions include someone with lived experience for part of the session.	Yes Online interactive session cofacilitated by 2 trainers, one or both with lived experience.
	T2	Yes Interactive online or face to face sessions cofacilitated by trainers with lived experience.	Yes 2 trainers cofacilitate throughout who have lived experience as an autistic person, someone 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 cofacilitated by 2 trainers, either both or one with lived experience.
Involvement of people with lived experience in training materials.	T1	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 codesigned and acted by people with learning disabilities part of the training.	Films of people sharing personal experiences part of the training
	T2	E-learning includes additional people's stories.	Films of people sharing their personal experiences throughout training.	Films codesigned and acted by people with learning disabilities	Films of people sharing personal experiences part of the training
Use of e-learning (non-interactive online learning)	T1	Yes- e-learning precedes face to face workshops.	Yes- e-learning precedes tutorial.	No	No
	T2	Yes- e-learning in 4 topics precede face to face or interactive live online learning sessions.	No	No	No

Aspects of training	Tiers	BILD	Gloucester	Mencap (Learning disabilities)	Mencap (autism)
Face to Face (In a room in person)	T1	No (But some online interactive)	No (But some online interactive)	Yes	Yes (OR online interactive)
	T2	Yes	Yes	Yes	Yes
Online interactive (live but run on teams or zoom)	T1	Yes	Yes	No	Yes
	T2	Yes	In hybrid session	No	No
Hybrid delivery (live workshop in room which is livestreamed for online participants)	T1	No	No	No	No
	T2	No	Yes	No	No
Length of learning time	T1	6 hours	2 hours	3.5 hours	3.5 hours
	T2	1 day	1 day	1 day	1 day
T1 incorporated into T2	T1	NA	NA	NA	NA
	T2	No - participants have to do both T1 and then T2	Yes	Yes	Yes
Numbers of participants	T1	10-15 per tutorial	Approx. 50 per tutorial.	Up to 25 (in non-covid times)	Up to 25 (in non-covid times)
	T2	10-15 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)

Benchmarking and quality assurance

As part of the development of the training, which is being trialled now, two processes took place before it was confirmed that trial training could begin. The first of these was a short benchmarking process carried out by NDTi, and the second a more intense quality checking process carried out by HEE, Skills for Care and a number of experts by experience who formed a quality checking panel.

NDTi as evaluation partners had a role in checking training plans and materials once they had been codesigned. In its evaluation role it is important that NDTi remain impartial and not judge the merit of training, particularly on the basis only of materials, before seeing the actual delivery and getting feedback from participants. The evaluation methodology has been designed to ascertain the quality and impact of the training, based on its impact on learners and all involved.

This checking therefore involved benchmarking session plans and learning materials against the two Core Capability Frameworks to ensure that they were covering the required content[3]. Approximately half a day of time for checking was allocated to each trial site. As soon as trial partners finished their design of one course (e.g., Tier 1 Autism training) this was sent to NDTi.

The benchmarking process changed over the course of the development phase. Initially checking was carried out against the full capability frameworks. This involves 25 Capability areas across 5 domains for the learning disability framework, and 19 capability areas across 5 domains for the autism framework. Using a spreadsheet which mapped both capability frameworks, training materials were checked to ensure they covered the relevant capabilities sufficiently.

In January 2021 HEE wrote to trial partners clarifying the need to prioritise core content, recognising that it would not be feasible to cover the entire set of the Tier 2 capabilities. This letter highlighted the need to deliver key learning objectives whilst maintaining quality delivery, and trial partners should show where they were including practical aspects such as learning from LeDeR, STOMP, Ask, Listen, Do and other important learning from Oliver's story. The benchmarking process was slightly adapted - highlighting against capabilities where this content was relevant.

[3] Capabilities Framework for Supporting People with a Learning Disability Capabilities Framework for Supporting Autistic People.

Each check was followed by feedback to the trial partner that the training either fully covered the required capabilities, or that there was content missing, or content that was excessive or out of line for the audience. Examples of feedback included:

- asking trial partners to reflect on the relevance of content that sits outside of the role of those in health or care settings
- suggesting that case examples should be workplace specific
- pointing out that there was no content on involving people's families
- highlighting that the topic of communication was covered but was about sharing information with people and missing listening and understanding people
- commenting on the level of in-depth detail of content in e-learning and reflecting it may be at a T3 level

On the whole, the trial partners responded explaining any missing content that would be covered in delivery (e.g., the focus of a film) or made some small changes to address the feedback. The benchmarking took place at each point at which a training course had been designed, between November 2020 and July 2021 as training development progressed.

In addition to this check of training content or benchmarking, a quality assurance process was designed by HEE and Skills for Care. This process was longer and more in depth, whereby all learning materials and lesson plans were reviewed in detail by a panel of 12 people, who work across the operational delivery of the Oliver McGowan Mandatory Training trials. The panel first came together to review Pathways and BILD tier 1 training in February 2021. This group comprised 2 autistic people, 2 people with a learning disability, 3 family members including Paula McGowan, 2 people each from Skills for Care, HEE and DHSC and 1 person from NHSE. They reviewed materials separately, or with support, and then came together to discuss as a panel, following which feedback was sent to the trial partner. This process was carried out as often as the panel decided was necessary before signing of the training to formally comprise part of the trials. The aspects on which the quality decisions were based were framed around any content in the materials that could be unsafe, inaccurate or offensive. Thus, this check went beyond a general content check to the way in which training materials, scripts and lesson plans were worded or portrayed.

Following these two checking processes trial training was ready to begin at different times between April and August 2021.

Focus group with delivery site leads

In June 2021 a focus group was conducted with the leads responsible for design and delivery of the trial training in each site, to capture their learning and views so far. While the focus group discussion covered a wide range of learning and reflections on the process and journey of delivery, several key points emerged of relevance to Evaluation Question 3:

What are the potential challenges and barriers to rolling out the Oliver McGowan Mandatory Training across England? How might these be overcome based on learning from the trials?

The points raised here will be useful to consider in planning the rolling out of training across England and are themes that will be explored in further focus groups with those overseeing and delivering the training.

Balancing innovation and learning outcomes – some participants felt that some of the innovative and creative methods of delivery initially planned had been restricted by the requirement to cover so many learning outcomes, with some concerns that the training could become limited to a list of factual information to cover. As the plans to roll out the training move forwards it will be important to consider the balance between delivering engaging training and covering crucial information.

Developing positive partnerships – one of the positives identified by participants that has been key to the successful delivery of the training has been some of the partnerships developed:

- partnerships between the organisations delivering the training
- partnerships with people with a learning disability, autistic people, and families
- partnerships with organisations the sites are delivering the training to.

It will be important to learn more about what it is that works to enable and sustain these positive relationships in order to harness and replicate them more widely.

Working in co-production – At times, those involved in codesign of training, have found it difficult when other groups, also co-run, have asked them to make changes in their designs. The Oliver McGowan Mandatory Training Trial has a number of groups working in different roles:

- The Delivery Trial Partnerships
- The Evaluation Team and their Advisory Group
- The Operational Delivery Group (ODG)
- The Strategic Oversight Group (SOG)
- The Quality Assurance Panel

Each of these groups involves a number of experts by experience (autistic people, people with learning disabilities and family members) as well as clinical, social care, and training professionals. There has been huge learning that will be reflected on in more depth in the final evaluation, about equally involving experts by experience at every level of a huge development programme.

Engaging training participants – participants described some challenges around engaging particular groups of professionals with the training, with some professionals feeling that they do not need it and others not being released for training due to current pressures in their work settings. This is something that would clearly create a challenge to further rolling out the training and consideration will need to be given as to how and where mandatory training may be built into different professional roles and CPD processes.

Pre-and post-training surveys

The evaluation team designed one survey to be sent to all participants prior to their training and one to be completed immediately after the training. These were informed by relevant literature (Marriott and Harflett, 2020)[4] and by conversations with the funders about the data analysis required. Site leads and HEE/SfC/Paula McGowan and other members of the Operational Delivery Group (ODG) were asked to comment on the content to ensure the surveys would be appropriate across all sites.

Pre-training survey

The pre-training survey collects some demographic data as well as information about people's job roles, work setting and how often they interact with autistic people/people with a learning disability in, and outside of, work.

Baseline data was collected on a series of statements relating to their knowledge, skills and communication with autistic people and people with a learning disability. They were asked to respond to the following statements using a 5-point Likert scale from strongly agree to strongly disagree, with an option of not applicable:

- I have the knowledge that I need to work with autistic people/people with a learning disability in my job[5]
- I have the skills that I need to work with autistic people/people with a learning disability in my job
- I feel confident when I am working with autistic people/people with a learning disability in my job
- I feel confident that I can communicate with an autistic person/person with a learning disability
- I have an important role to play in meeting the general health needs of autistic people/people with a learning disability
- Autistic people/people with a learning disability face significant challenges in healthcare settings

[4] Marriott, A & Harflett, N. (2020) *A review of the current evidence on the effectiveness of LD training programmes for NHS Trust staff.*

[5] These statements were asked separately in relation to autistic people and people with a learning disability.

As the same baseline data was collected across all training sites, we have presented analysis of this data for all respondents, irrespective of the training they went on to complete. This analysis provides us with some demographic information about the cohort of people being trained. However, it should be noted that this is limited to the people who take part in the surveys and full participant data is required to be collected directly by trial partners.

Post-training survey

We asked all respondents about the training they had completed and if this was optional for them or not.

We also asked the extent to which they agreed/disagreed with the same six statements about knowledge/skills/confidence after the training and their reflections on any changes in their answers. For those who completed both surveys it is possible to compare responses. Where we present this data, all responses have been converted to percentages as we have a different number of respondents from each trial partner and not all respondents completed both pre-and-post training surveys.

Most of the questions in the post-training survey focused on immediate reflections on the training in relation to:

- the training being pitched at the right level
- the pace and amount of content
- if it was a good use of time
- if the trainer had the skills needed to deliver the training
- whether the overall training was good

Participants were asked to rate their responses on a 5-point Likert scale from "strongly agree" to "strongly disagree", with an option of not applicable. We present all 6 responses in the relevant graphs, but in text when we refer to the percentage of people agreeing, this includes the "strongly agree" and "agree" responses. The same also applies to any discussion regarding the percentage of people disagreeing, which includes the "disagree" and "strongly disagree" responses.

We also asked how the mode of delivery and the activities used suited their learning style. Participants were asked to rate how well it worked for them on a 5-point Likert scale from "it didn't work for me" to "it worked very well for me", with an option of not applicable. Again, any references to percentages of people who said it worked for them includes responses of "worked very well for me" and "worked quite well for me". For responses where a mode of delivery or activity did

not work for them, this includes responses of “it didn’t work very well for me” and “it did not work well for me”.

To explore the impact of the training, participants were asked to respond to the following three statements using a 5-point Likert scale from strongly agree to strongly disagree, with an option of not applicable:

- The training has given me new learning about learning disabilities/autism
- The training has made me more aware of the needs of autistic people/people with a learning disability in healthcare settings
- The training has given me ideas for things I can do to better support autistic people/people with a learning disability in my own work

Finally, participants were asked two free text questions:

- What was the one thing about the training that stood out for you?
- Is there anything that could have been done better?

We have pre-and-post responses for all sites for Tier 1 training and the data collected so far is reflected upon in this report. We have collected some data regarding Tier 2 training but the number of responses we have is too small a proportion of the anticipated final data set to be able to report robustly at this time. Full data sets will be analysed and presented in the final report where we will present further analysis exploring the impact of job role/tier/sector/choice of doing the training on the responses people gave.

Pre-survey data for all respondents

There are a total of **2126** pre-survey responses from across all sites. This is based on the data received being cleansed and the removal of

- incomplete data
- multiple responses from the same respondents
- respondents who said they worked in multiple Tiers.

The number of responses to some questions are more than 2126 due to respondents being able to provide multiple answers to these questions, whilst the responses to other questions are lower than 2126 due to not all respondents being asked some questions or responses not being received. Where the number of responses differs to the total (2126) "N= "is provided in the graphs/text.

Demographics

We asked respondents to provide some basic demographic information for us. Figure 1 presents the spread of age ranges and figure 2 presents how people identified in terms of gender. In relation to age we have a good spread, and this is broadly representative of the age breakdown of the NHS workforce and what we know of age distribution of the adult social care workforce. Over 80% of our respondents identified as women which again is broadly representative of the gender split in the NHS and social care workforces, where 77% and 82% respectively of the workforce identify as women.

Figure 1. Age of respondents

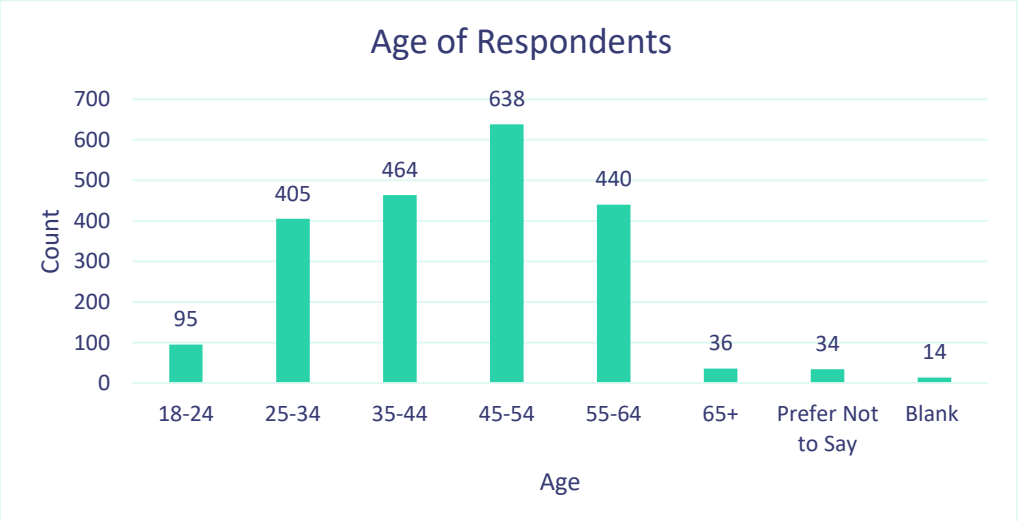
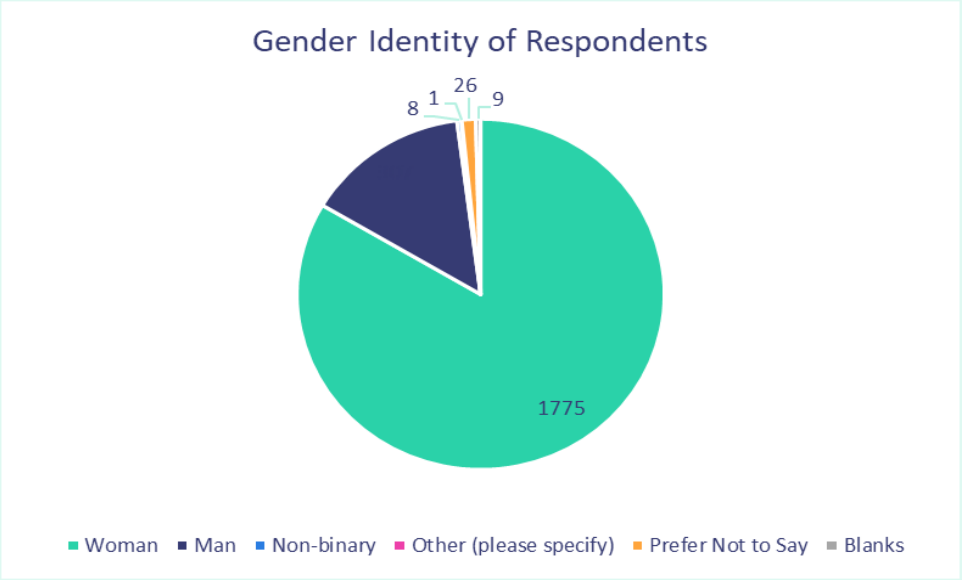


Figure 2. Gender Identity of Respondents

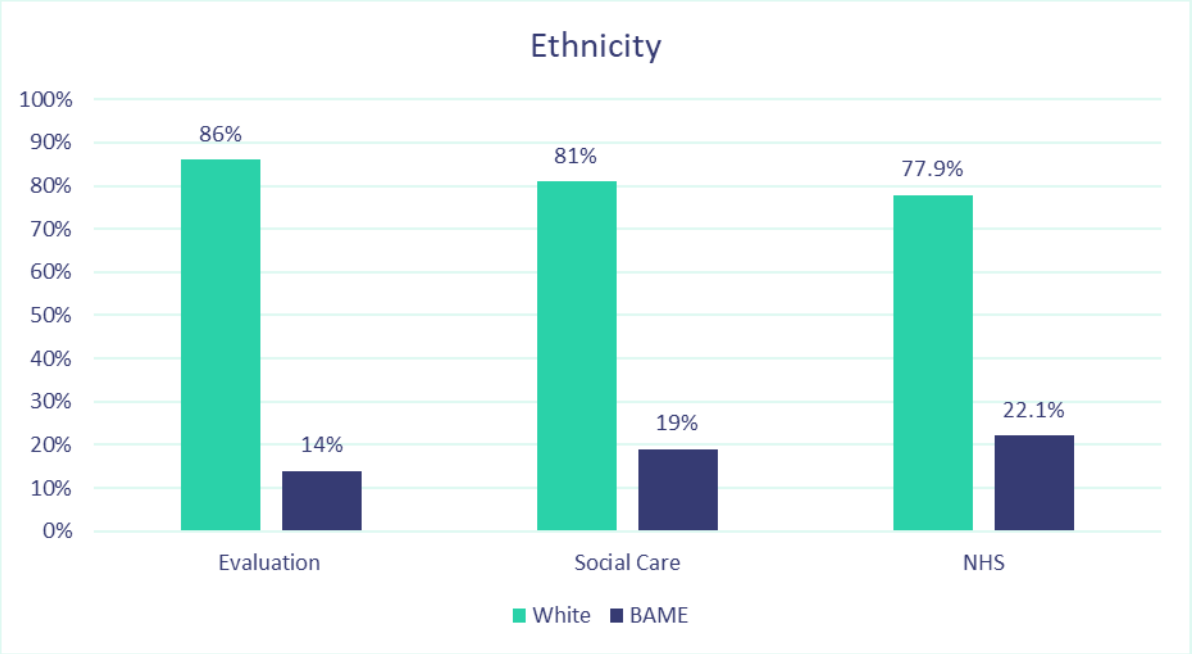


The ethnicity data (Table 3) shows that 14% of respondents identified as being of an ethnicity that was black, Asian, mixed, or minority ethnic (BAME), Figure 3 compares our ethnicity data with that from the Social Care and NHS workforces. Our sample is a little under-representative in terms of BAME respondents.

Table 3: Ethnicity of respondents

Ethnicity	Count
African	38
Any other Asian background	19
Any other Black / African / Caribbean background	13
Any other Mixed / Multiple ethnic background	18
Any other White background	76
Arab	3
Bangladeshi	8
Caribbean	12
Chinese	4
Indian	56
Pakistani	24
White and Asian	12
White and Black African	12
White and Black Caribbean	9
White English / Welsh / Scottish / Northern Irish / British	1737
White Irish	26
Other (please specify)	13
Prefer not to say	37
Blanks	9

Figure 3. Comparison of Ethnicity of evaluation respondents in comparison to NHS and Social Care Workforces



Most respondents (2,010) did not identify as having a disability, with a further 54 preferring not to say or leaving the question blank. However, 31 identified as being autistic, 30 as having a learning disability and one as being autistic and having a learning disability.

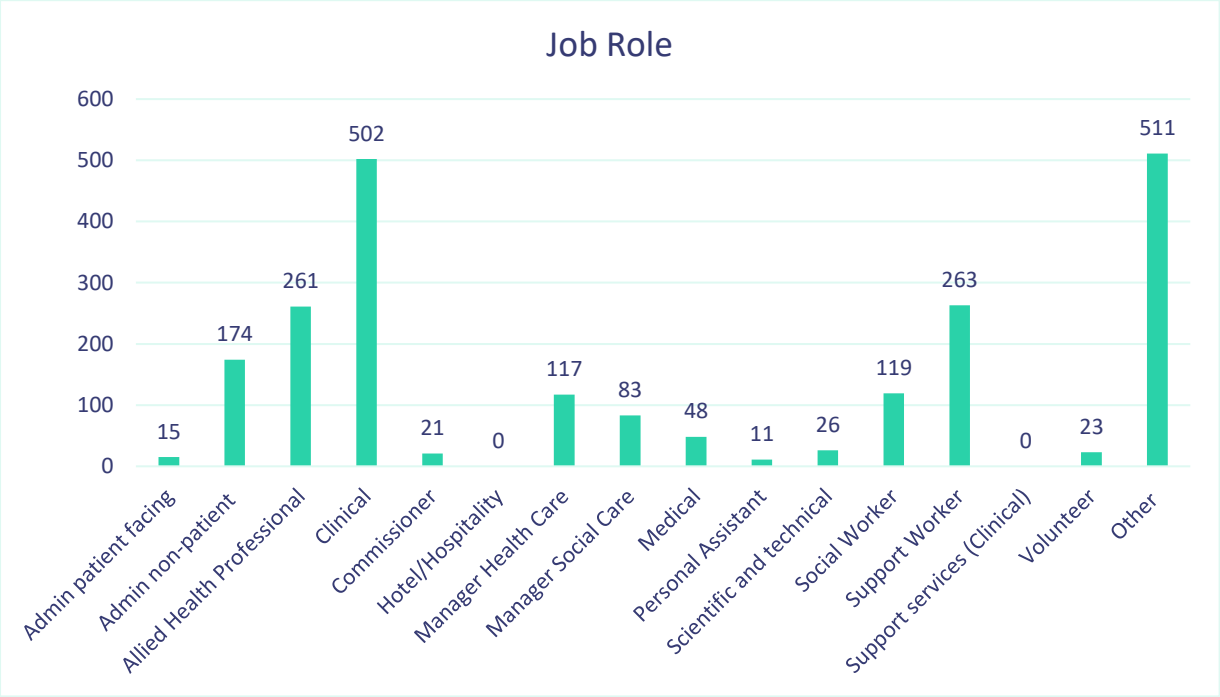
Roles

We asked a number of questions about people's roles (see Figure 4). The most common category selected was "Clinical" followed by "Support Workers" and "Allied Health Professionals". It is worth noting that almost a quarter of respondents did not fit into the categories given. The 'Other' roles respondents worked in included, but were not limited to:

- Activity Coordinators
- Benefits/Welfare Officers
- Community Workers
- Educators and Youth Workers
- Firemen/women
- Health Visitors
- LeDeR Reviewers

Whilst we think there is a need for people working in settings other than health and social care to have training around autism and learning disabilities, they are not the target audience of the Oliver McGowan Mandatory Training. When we have a full data set, we will analyse the data in relation to job role.

Figure 4. Job role



We asked which sector people worked in and the responses are presented in Table 4. This shows the respondents are from both health and social care settings. Again, there is a significant proportion of the respondents working in settings which are beyond the remit of the Oliver McGowan Mandatory Training.

The 'other' sectors respondents worked in included, but were not limited to:

- Administration
- Fire Service
- Local Government
- Library and Leisure Services
- Police and Youth Justice
- Research and Development
- Welfare and Benefits

Table 4: Sector worked in

Sector worked in	Count
Health - Primary Care	402
Health - Secondary Care	154
Residential Nursing - Tertiary Care	12
Social Care	583
Education	103
Charity	186
Other	751

N = 2192

We wanted to find out which Tier of learning staff considered themselves to work within according to the definitions given in the Capability frameworks[6]

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

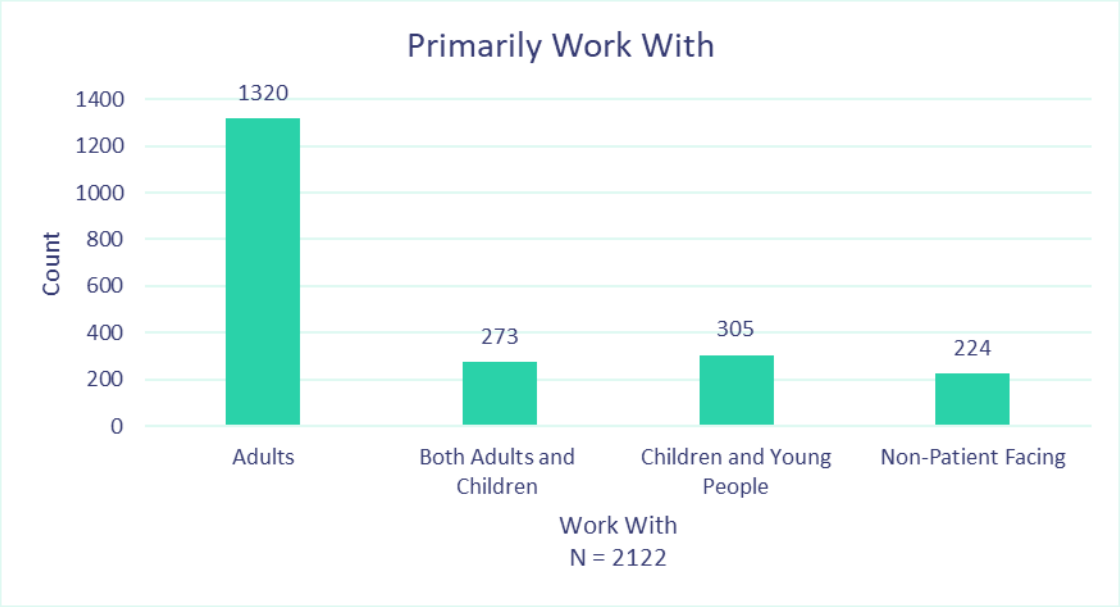
Tier 2 - In my role, I have responsibility for providing care and support for autistic people/people with a learning disability but would seek support from others for complex management or complex decision-making.

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.

The majority (51%) of the respondents considered themselves to be working in a Tier 1 role, 39% in a Tier 2 role and 11% in a Tier 3 role.

Overwhelmingly, respondents worked with adults (62%), with 14% working with children and 13% with both adults and children. (11% were in non-patient facing roles) (figure 5)

Figure 5. Primarily work with



There was a reasonably even split in terms of people's roles primarily relating to learning disability, physical health and mental health (See figure 6). Most respondents had been in their role for more than 5 years (see figure 7).

[6] These descriptions are taken from the Core Capabilities Framework for Supporting People with a Learning Disability (p.10) and Core Capabilities Framework for Supporting Autistic People (p.11).

Figure 6. Role primarily relates to

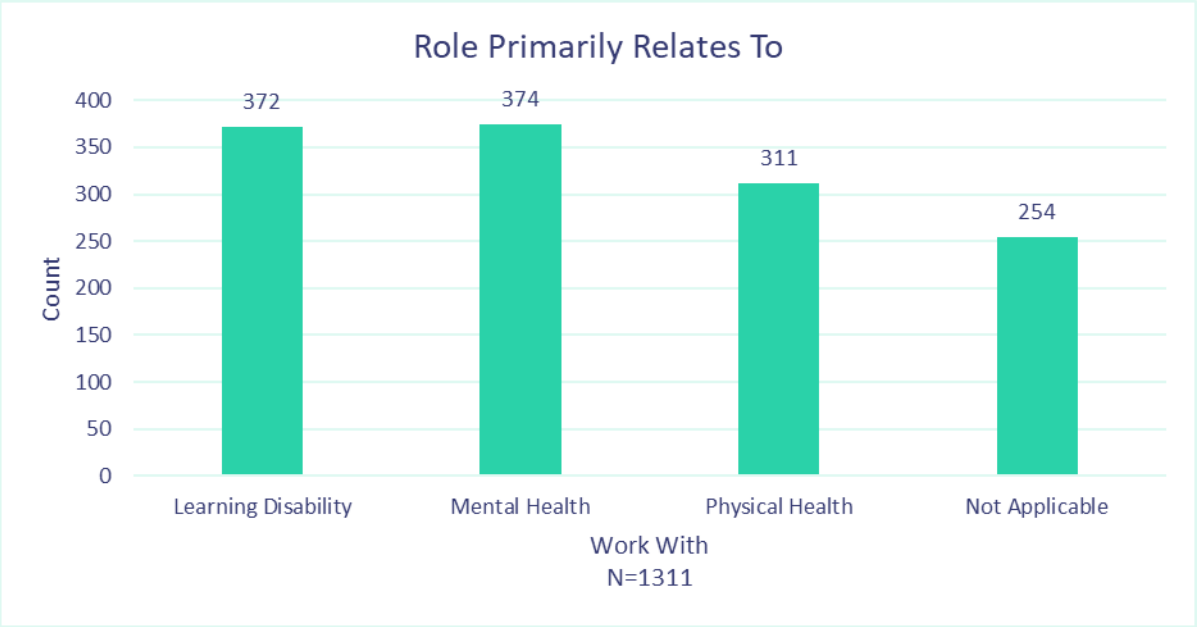
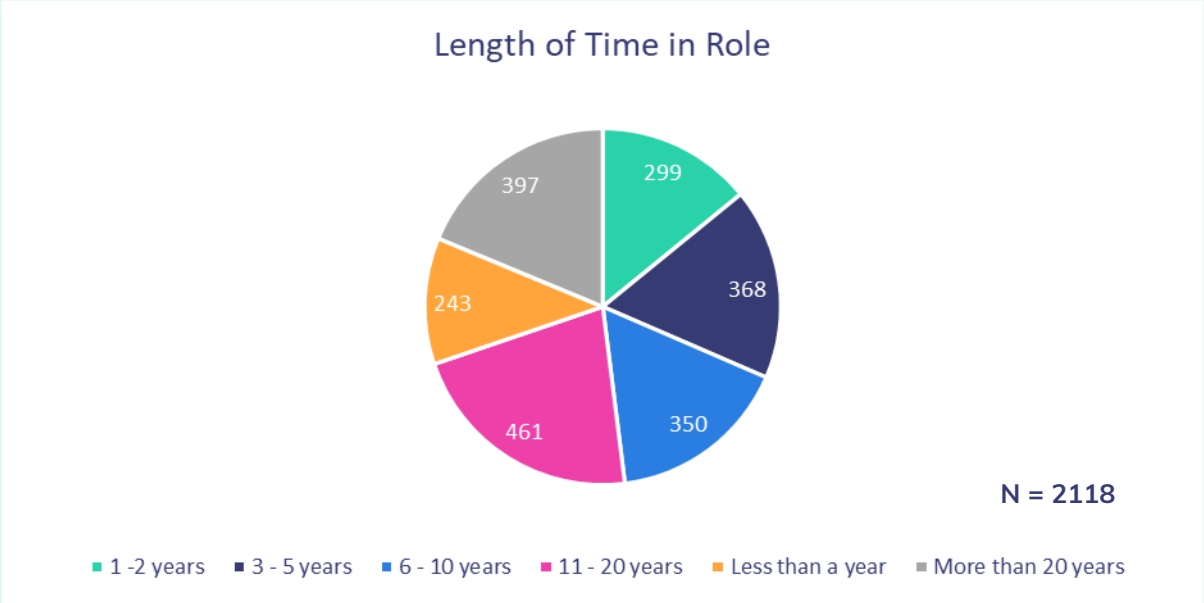


Figure 7. Length of time in role



Experience in relation to learning disability and autism

We wanted to know how often respondents think they interact with people with a learning disability/autistic people both within and outside of their work. Overall, our respondents were more likely to interact with both groups within their work than outside of work. As we would expect, staff identifying as Tier 2 and Tier 3 were more likely to report coming into contact with both people with a learning disability and autistic people in their work frequently/often than Tier 1 staff were.

When asked about previous training about autism or learning disability, 79% had received some learning disability training and 74% had received some autism training. It is interesting to note, that those that considered themselves needing Tier 1 and Tier 3 training were the most likely to have received 2 or more days training.

Figure 8. Previous training

We asked people to rate their level of agreement/disagreement with the following statements:

- I have the knowledge that I need to work with autistic people/people with a learning disability in my job
- I have the skills that I need to work with autistic people/people with a learning disability in my job

- I feel confident when I am working with autistic people/people with a learning disability in my job
- I feel confident that I can communicate with autistic people/people with a learning disability
- I have an important role to play in meeting the general health needs of autistic people/people with a learning disability
- Autistic people/people with a learning disability face significant challenges in healthcare settings

The patterns of response in terms of knowledge, skills and confidence were broadly similar in relation to autistic people and people with a learning disability, with just over half agreeing they had the necessary knowledge, skills and confidence. Respondents were more confident in their ability to communicate with autistic people (53%) and people with a learning disability (63%).

The responses clearly show that most people do agree they have an important role to play in meeting the general health needs of autistic people (71%) and people with a learning disability (72%). It is also evident that the respondents recognise the challenges autistic people (86%) and people with a learning disability face in healthcare settings (86%).

In responses to all the questions in this section, Tier 3 respondents were slightly more confident in their skills, knowledge, ability to communicate, and generally working with people with a learning disability and autistic people. They were also slightly more aware of their role in the health care of people with a learning disability and autistic people, as well as the challenges they face.

In our analysis of each site's data, we reflect on the changes to these responses immediately after training.

Discussion and Conclusions

The research questions being posed by the evaluation include:

1. What works for whom in learning disability and autism training, considering different workplace settings, staff roles and geographical contexts?
    a. What type of training is the most effective in terms of improving staff understanding and confidence of learning disability and autism in the context of their day job?
    b. What type of training is the most effective in terms of training delivery methods in different workplace settings?
    c. To what extent is the training provided at the correct level for participating staff?
2. What are the estimated costs associated with the wider rollout of the mandatory training, including costs of different delivery methods, 'backfill', materials, and different levels of the workforce?
3. What are the potential challenges and barriers to rolling out the Oliver McGowan Mandatory Training across England? How might these be overcome based on learning from the trials? Costs/ feasibility?
4. Is there any evidence that learning disability and autism training delivered through the trial has led to an improvement in the delivery of care and support to people with learning disability and autism?

The data we have collected so far enables us to partially address the first question for Tier 1 immediate learning only. We are unable to draw conclusions as data is still being collected but we are able to present some information about how this Tier 1 training is being received. Once data collection is complete, we will have this information for Tier 2 training as well and a broader picture of the impact on real longer-term learning from the follow-up surveys and interviews.

The discussion below is based on the data from the pre-and-post surveys received being cleansed and the removal of:

- incomplete data
- multiple responses from the same respondent.

The response rates from sites ranged from 35-80% of the number of people who have completed this training. We are looking for the sites to learn from each other to try to improve the lower evaluation response rates for the remainder of the training being delivered.

Overall, the training was perceived as high quality and a good use of people's time - with positive responses to all the training from approximately 90% or more of participants.

Fantastic training, easy to digest and really informative without being lengthy.

I thought the training was fantastic and very valuable, thanks so much to the team.

This was one of the most informative, useful and interesting training that I have received throughout my five years' service.

This is a really excellent training course.

Type of training

The delivery partners have taken a range of different approaches to training delivery have been taken (see table 1). These include e-learning, online interactive learning, face-to-face learning and hybrid situations, where face-to-face training is also live streamed to people joining online. There does not appear to be any significant preference between participants who have received different types. Those who have had learning at home options valued the flexibility and lack of travel.

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.

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.

I liked that you could do it bit by bit as it was easier to fit into my schedule.

However, it was felt that some of the trainers needed to practice their technical skills:

It would make sense for the trainer to perform a practice run to ensure they make the best use of the time that the trainees/participants have when attending.

There was evidence that although online training was still valuable, some people would prefer the opportunity to receive face-to-face training:

Due to current restrictions the training worked well, however, I think long term it would benefit from taught face-to-face where it could be more interactive.

Excellent training, really valuable learning experience, would love to have attended a face-to-face workshop with these trainers.

Those who have learned face-to-face appreciated the direct interaction with trainers:

Face-to-face was essential as it gave time to explore people's experience.

At this point we do not have enough data to establish whether there is a difference of preference between people in different job roles.

Learning Activities that make a difference to learners

Every different training course has been developed to include multiple learning activities. Some courses are predominantly e-learning based, and others cover everything in virtual or real classroom sessions. The way in which people with lived experience are included varies from their presence in films to having them lead or support the training.

Taking into account the variation across partners, there is overwhelming support from participants for learning to be delivered by autistic people and those with learning disabilities.

The expert with experience is an essential element to have first-hand knowledge at training as it makes it more personal and engaging.

I really valued having people with a learning disability as an integral part of the training.

The team's training was fantastic. The lady with autism [sic] was really helpful giving examples and the lady running the training worked very well as a team and was very knowledgeable.

Having the training run by experts by experience had a massive impact on my learning as the key messages really hit home.

Good mix of expert by experience, parents and professionals. Powerful life experiences shared by those affected.

Excellent training... as a nurse, this training will go a long way to reframe approaches to supporting people with individual needs. It was inspirational and thought provoking, hearing first-hand experiences and what would be helpful was very powerful.

Second to this, people's preference for their learning style includes the videos featuring people with lived experience.

The videos were insightful and I felt I learnt more from the videos than the general discussion.

Found the online package very good - much better than most training I have done online due to the videos and examples of people with lived experience.

On the occasions in the learning disabilities training when no expert by experience has been directly involved in delivering training, the videos featuring them were the highest rated activity.

Although group quizzes did not work well, individual quizzes were valued as a way to consolidate learning:

I do not learn from sitting and watching programs, I need a little quiz at the end to ensure I know what has been asked.

Comments from respondents suggest that group discussions worked better in face-to-face settings:

I feel due to online learning not everyone was as forthcoming with discussion points.

It was good to have a chance to discuss questions raised throughout the training in small groups as we all came from very different backgrounds and had valuable experiences to share with each other.

It was evident that attendees appreciated the range of activities within the training sessions:

It was a good mix of video, presentation and discussion.

It was a good mix of media, presentation, group thoughts and experience.

Some of the delivery partners provide written information, such as a handbook. Where this happened, 66-87% of respondents said this worked well:

The handbook will be an excellent resource to use and share with others.

Where there wasn't written information provided there were some comments suggesting that this would have been appreciated:

Information on available resources to support autistic people.

Overall, the responses and comments from participants suggest that it is hearing people's real-life experiences and listening to Oliver's story that is having a big impact on their own perceptions and driving a realisation about the stark reality of the poor experiences of people with a learning disability and autistic people.

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.

One of the best training sessions I have attended - detailed, thought provoking, skills based. I was so shocked to hear Oliver's story it will have a marked impact on my teaching practitioners and personal support of people's rights in future.

Impact of learning - Pre and Post changes in knowledge and skills

To establish the impact on learners of attending the training, pre- and post-learning surveys asked participants about their knowledge, awareness, confidence and skills. Post training surveys also asked people about what new learning they had gained.

Turning first to new learning, across the sites:

- 68-93% of respondents reported they had new learning about people with a learning disability and autistic people following the training.
- 70-96% of people said they had gained new ideas to use in their work
- 74-95% said that the training had made them more aware of the needs of people with a learning disability and autistic people

Following this excellent training I feel I have learnt much more that I can reflect on and use these skills in my job.

I thought that I had quite a good understanding of autism, but I have realised I actually do not. I will put my updated learning into my everyday work situations and outside of work.

Many participants mentioned that it was "the involvement of an individual with lived experience on the training team" that was helpful and gave them an insight they might not otherwise have gained:

I was unaware of the deep complexities of autism and how sight, sounds and actions that are mostly normal, and I can cope with, had such a profound impact on autistic people.

There appears to be a slightly higher self-reported rating for new learning around autism. This may reflect that this is an area people have previously known less about. This is a positive indicator for the need to offer this training more widely and for it to be carried out and led by autistic people.

This new learning has been generated only through Tier 1 at this point for all partners, suggesting that even this level of learning can be impactful to a wide range of learners. There were slight variations in learning between different trial partners which need to be further explored, to see if this is linked to delivery styles or methods, or the roles of people who undertook the training. This will be explored in the final report.

We asked people to rate themselves on knowledge, skills and confidence before they did the training. Then we asked them to rate their knowledge skills and confidence immediately after the training. The rate of change shows how big an increase there was between the before and after training scores that people gave themselves. From this we could see that across the trial partners there were changes in knowledge and skills from 20-50%.

Certainly have gained knowledge and understanding that will help in my giving support to someone either with a learning disability or autism.

I have more knowledge. The training has given me a greater insight into the needs of the individual, the importance to ask not assume.

I feel I have some specific strategies to help me support people with a learning disability that I have the skills to implement.

Participants' perceived levels of confidence in supporting people and communicating with them also increased, but by slightly less than the increases in levels of knowledge and skills. The increases in confidence ranged from 20-37%, with rises in confidence around communicating being slightly lower across all trial partners.

I feel more confident in making sure my communication and approach when supporting someone with a learning disability / an autistic person is fair and keeps them at the centre.

The talk from the mother about professionals listening to the people that know someone the best even though they may not have the qualifications of the doctors or other people involved with their care.

It is heartening to see that people have gained confidence and knowledge and skills in what they need to do. In the follow up surveys and interviews, we will be gathering more evidence about what they have been able to change in their practice and their workplace. This will ultimately help us to assess if the training is effective in meeting its aims.

Coproduction and involvement of people with lived experience

All the trial partners developed the training in partnerships with people with lived experience, from the content to the materials of the training. The impact of learning directly from people, and their stories presented in films has been reflected on above. There is already strong evidence at this point that this will be an essential element of any mandatory training going forward. There have been some difficulties in enabling this to happen across all trial partners, including ensuring people can be fairly remunerated, whilst recognising that some people cannot work full time and will remain dependent on benefits. In the final stages of evaluation, we will be hearing from people who have lived experience who have been involved in the design and delivering of the training to gather more learning about this.

Conclusion

Broadly speaking, the Tier 1 training from all the sites has been well received across all the modes of delivery. There is strong evidence that the involvement of people with lived experience is central to people's positive experiences of the training. We find it encouraging that there are early signs that the Tier 1 training alone is making a difference to people's knowledge, skills and confidence. The real impact of this training will be known when we complete the follow-up surveys and interviews and can explore if people have been able to put this into practice.