Title: Mandatory training on learning disability and autism: code of practice consultation

IA No: 9596
RPC Reference No: RPC-DHSC-5273(1)
Lead department or agency: Department of Health and Social Care
Other departments or agencies: NHS England and Improvement; Health Education England; Skills for Care

Impact Assessment (IA)

Date: 26 June 2023
Stage: Consultation
Source of intervention: Domestic
Type of measure: Secondary legislation
Contact for enquiries: Ksenia Shagabutdinova

RPC Opinion: Informal: no rating provided

Summary: Intervention and Options

Cost of Preferred Option			
Total Net Present Social Value (in 2022 prices)	**Business Net Present Value** (in 2022 prices)	**Net direct cost to business per year** (in 2019 prices, 2020 base year)	**Business Impact Target Status** Non qualifying provision
- £443.3m	- £320.2m	£2.0m	

What is the problem under consideration? Why is government action or intervention necessary?

People with a learning disability and autistic people experience significant health inequalities and on average die earlier than the general population. Around half of these deaths are avoidable. Research with health and social care staff indicates that a lack of understanding and knowledge of learning disability and autism likely contributes to this. Over the past 15 years, key organisations have recommended mandatory training to improve the quality of care and reduce avoidable deaths. Despite consensus on the importance of such training, health and social care staff continue to report a lack of training opportunities. Without Government intervention, the issue will persist, and the health inequalities experienced by people with a learning disability and autistic people due to lack of staff understanding will not diminish.

What are the policy objectives of the action or intervention and the intended effects?

The policy objective is to improve health and social care staff knowledge and skills to provide safe, compassionate and informed care to people with a learning disability and autistic people by ensuring that they receive relevant training. The code of practice objective is to set standards for training to ensure consistency and quality of such training regarding content, delivery, and monitoring and evaluation. The desired effects are that people with a learning disability and autistic people receive consistently high-quality care, resulting in lower health disparities, have better health outcomes and are less likely to die prematurely. Indicators of success will include monitoring outcomes through the Health and Care of People with Learning Disabilities dataset, 'Learning from lives and deaths – people with a learning disability and autistic people' (LeDeR) reports and independent evaluation of the recommended training package.

What policy options have been considered, including any alternatives to regulation? Please justify preferred option (further details in Evidence Base)

In 2019, following public consultation, the Government committed to developing and testing a standardised learning disability and autism training package, the Oliver McGowan Mandatory Training (OMMT), which has since been trialled and evaluated. The IA considers two options: (1) the roll out of the OMMT is optimised through full funding of direct costs for adult social care and public healthcare sectors, including a central support team, or (2) the roll-out of the OMMT is supported with some funding, but it does not cover the full direct costs for adult social care and public healthcare sectors or a central support team. The options are considered against Option 0 – 'business as usual', where providers continue with current training arrangements and the OMMT is not rolled out. DHSC cannot yet commit to an implementation plan while work on the operational delivery model and funding is ongoing. However, Option 1 is preferred as it has been assessed as most likely to deliver the intended impacts. The negative net present value of Option 1 reflects partial monetisation of benefits, notably missing benefits for autistic people due to lack of data on their health and care.

Will the policy be reviewed? It **will** be reviewed. **If applicable, set review date: 2028/29**

Is this measure likely to impact on international trade and investment?		No		
Are any of these organisations in scope?	**Micro** Yes	**Small** Yes	**Medium** Yes	**Large** Yes
What is the CO_2 equivalent change in greenhouse gas emissions? (Million tonnes CO_2 equivalent)		**Traded: N/A**	**Non-traded: N/A**	

I have read the Impact Assessment and I am satisfied that, given the available evidence, it represents a reasonable view of the likely costs, benefits and impact of the leading options.

Signed by the responsible SELECT SIGNATORY:  Date: 26/06/23

Summary: Analysis & Evidence

Policy Option 0

Description: This option represents the counterfactual, where business as usual continues, in other words, health and care providers continue with their current training arrangements and do not provide the OMMT.

FULL ECONOMIC ASSESSMENT

Price Base Year 2022	PV Base Year 2022	Time Period Years 10	Net Benefit (Present Value (PV)) (£m)		
			Low: n/a	**High:** n/a	**Best Estimate:** 0

COSTS (£m)	Total Transition (Constant Price)	Years	Average Annual (excl. Transition) (Constant Price)	Total Cost (Present Value)
Low	n/a	n/a	n/a	**n/a**
High	n/a		n/a	**n/a**
Best Estimate	n/a		0	**0**

Description and scale of key monetised costs by 'main affected groups'

Primary legislation introduced a requirement for mandatory training on learning disability and autism on 1 July 2022. While the code of practice on how such training should be provided is in development, service providers can rely on existing statutory guidance. Options 1 and 2 are compared against this status quo position, where the OMMT is not rolled out. Option 0 is only used as a counterfactual to calculate costs arising because of the OMMT, it does not reflect a viable policy position. Because issuing a code of practice is specified in law, in practice, there is no option to continue with 'business as usual' with regards to issuing statutory guidance.

Other key non-monetised costs by 'main affected groups'

N/A

BENEFITS (£m)	Total Transition (Constant Price)	Years	Average Annual (excl. Transition) (Constant Price)	Total Benefit (Present Value)
Low	n/a	n/a	n/a	**n/a**
High	n/a		n/a	**n/a**
Best Estimate	n/a		0	**0**

Description and scale of key monetised benefits by 'main affected groups'

Primary legislation introduced a requirement for mandatory training on learning disability and autism on 1 July 2022. While the code of practice on how such training should be provided is in development, service providers can rely on existing statutory guidance. Options 1 and 2 are compared against this status quo position, where the OMMT is not rolled out. Option 0 is only used as a counterfactual to calculate benefits arising because of the OMMT, it does not reflect a viable policy position. Because issuing a code of practice is specified in law, in practice, there is no option to continue with 'business as usual' with regards to issuing statutory guidance.

Other key non-monetised benefits by 'main affected groups'

N/A

Key assumptions/sensitivities/risks	Discount rate (%)	N/A
N/A		

BUSINESS ASSESSMENT (Option 0)

Direct impact on business (Equivalent Annual) £m:			Score for Business Impact Target (qualifying provisions only) £m:
Costs: 0	**Benefits:** 0	**Net:** 0	N/A

Summary: Analysis & Evidence

Policy Option 1

Description: the roll out of the OMMT is optimised through full funding for the adult social care and public healthcare sectors, including a central support team.

FULL ECONOMIC ASSESSMENT

Price Base Year 2022	PV Base Year 2022	Time Period Years 10	Net Benefit (Present Value (PV)) (£m)		
			Low: - 919.0	High: 782.0	Best Estimate: - 443.3

COSTS (£m)	Total Transition (Constant Price)	Years	Average Annual (excl. Transition) (Constant Price)	Total Cost (Present Value)
Best-case scenario	n/a	n/a	60.4	**604.2**
Worst-case scenario	n/a		126.8	**1,268.3**
Best Estimate	n/a		125.2	**1,251.8**

Description and scale of key monetised costs by 'main affected groups'

The best estimate of costs (discounted in 2022 prices) includes:
(1) direct training and additional costs related to the delivery of training at £117.8m.
(2) opportunity costs to the NHS (£693.1m), private healthcare (£111.1m), public adult social care (£44.4m) and private adult social care (£164.1m).
The opportunity costs refer to the economic cost for the sector to undertake OMMT instead of other activities.

Other key non-monetised costs by 'main affected groups'

No other major costs identified at this stage.

BENEFITS (£m)	Total Transition (Constant Price)	Years	Average Annual (excl. Transition) (Constant Price)	Total Benefit (Present Value)
Best-case scenario	n/a	n/a	138.6	**1,386.3**
Worst-case scenario	n/a		34.9	**349.4**
Best Estimate	n/a		80.9	**808.5**

Description and scale of key monetised benefits by 'main affected groups'

Based on an evidence review of training outcomes in health and social care, we assumed that the OMMT can reduce the gap in health inequalities of people with a learning disability and autistic people compared to the general population by 6%. The best estimate of monetised benefits covers (discounted in 2022 prices):
(1) cost savings to the NHS from reduced mental health and emergency acute hospital admissions, prevention of non-type 1 diabetes and chronic constipation, and increased rate of cancer screening at £235.6m;
(2) societal value of reduced avoidable mortality, estimated through statistical life years gained, at £572.9m.
We also show a break-even analysis if the 6% impact assumption in the sensitivity analysis section.

Other key non-monetised benefits by 'main affected groups'

The key non-monetised benefits are related to the societal value of improved morbidity and management of conditions among people with a learning disability and autistic people, associated with improved routine support provided by health and care staff. Our analysis is only a partial monetisation of benefits, as we were not able to monetise benefits for autistic patients due to lack of data on their health and care, however, many of the identified benefits for patients with a learning disability also apply to autistic patients. We were only able to monetise a selection of NHS cost savings, notably missing savings from prevention of obesity and upper respiratory tract conditions, increased access to vaccination programmes and earlier identification of dental issues.

Key assumptions/sensitivities/risks	Discount rate	3.5%

All cost and benefits are discounted at 3.5%, except for the societal value derived from the increase in statistical life years, which is discounted at 1.5%. Key assumptions are that training will follow recommendations from the OMMT trial evaluation in terms of audience, content and delivery; that roll out will last 3 years; and that the policy can deliver a 6% reduction in avoidable mortality and hospital admissions. In particular, this 6% assumption is subject to high uncertainty. The assumptions are described in detail in later sections. Key risk is that the OMMT is not rolled out to all staff.

BUSINESS ASSESSMENT (Option 1)

Direct impact on business (Equivalent Annual) (in 2019 prices, 2020 base year) £m:			Score for Business Impact Target (qualifying provisions only) £m:
Costs: 2.0	**Benefits:** 0	**Net: 2.0**	Not applicable

Summary: Analysis & Evidence

Policy Option 2

Description: the roll-out of the OMMT is supported with some funding, but it does not cover the full costs for the adult social care and public healthcare sectors, and it does not cover a central support team.

FULL ECONOMIC ASSESSMENT

Price Base Year 2022	PV Base Year 2022	Time Period Years 10	Net Benefit (Present Value (PV)) (£m)		
			Low: - 451.3	**High: 662.8**	**Best Estimate: - 244.3**

COSTS (£m)	**Total Transition** (Constant Price)	Years	**Average Annual** (excl. Transition) (Constant Price)	**Total Cost** (Present Value)
Best-case scenario	n/a	n/a	48.4	**484.4**
Worst-case scenario	n/a		68.4	**683.9**
Best Estimate	n/a		84.8	**848.0**

Description and scale of key monetised costs by 'main affected groups'

The best estimate of monetised costs (discounted in 2022 prices) includes:
(1) direct training and additional costs related to the delivery of training at £77.7m.
(2) opportunity costs to the NHS (£431.2m), private healthcare (£111.1m), public adult social care (£29.4m) and private adult social care (£108.9m).
The opportunity costs refer to the economic cost for the sector to undertake OMMT instead of other activities.

Other key non-monetised costs by 'main affected groups'

No other major costs identified at this stage.

BENEFITS (£m)	**Total Transition** (Constant Price)	Years	**Average Annual** (excl. Transition) (Constant Price)	**Total Benefit** (Present Value)
Best-case scenario	n/a	n/a	114.7	**1,147.2**
Worst-case scenario	n/a		23.3	**232.6**
Best Estimate	n/a		60.4	**603.6**

Description and scale of key monetised benefits by 'main affected groups'

Based on an evidence review of training outcomes in health and social care, we assumed that the OMMT can reduce the gap in health inequalities of people with a learning disability and autistic people compared to the general population by 6%. The best estimate of monetised benefits covers (discounted in 2022 prices):
(1) cost savings to the NHS from reduced mental health and emergency acute hospital admissions, prevention of non-type 1 diabetes and chronic constipation, and increased rate of cancer screening at £175.2m.
(2) societal value of reduced avoidable mortality, estimated through statistical life years gained, at £428.5m.
We also show a break-even analysis if the 6% impact assumption in the sensitivity analysis section.

Other key non-monetised benefits by 'main affected groups'

The key non-monetised benefits are related to the societal value of improved morbidity and management of conditions among people with a learning disability and autistic people, associated with improved routine support provided by health and care staff. Our analysis is only a partial monetisation of benefits, as we were not able to monetise benefits for autistic patients due to lack of data on their health and care, however, many of the identified benefits for patients with a learning disability also apply to autistic patients. We were only able to monetise a selection of NHS cost savings, notably missing savings from prevention of obesity and upper respiratory tract conditions, increased access to vaccination programmes and earlier identification of dental issues.

Key assumptions/sensitivities/risks	**Discount rate**	3.5%

All cost and benefits are discounted at 3.5%, except for the societal value derived from the increase in statistical life years, which is discounted at 1.5%. Key assumptions are that training will follow recommendations from the OMMT trial evaluation in terms of audience, content and delivery; that roll out will last 5 years; and that the policy can deliver a 6% reduction in avoidable mortality and hospital admissions. In particular, this 6% assumption is subject to high uncertainty. The assumptions are described in detail in later sections. Key risk is that the OMMT is not rolled out to all staff.

BUSINESS ASSESSMENT (Option 2)

Direct impact on business (Equivalent Annual) (in 2019 prices, 2020 base year) £m:			**Score for Business Impact Target (qualifying provisions only) £m:**
Costs: 5.5	**Benefits:** 0	**Net: 5.5**	Not applicable

Contents

Problem under consideration and rationale for intervention

People with a learning disability and autistic people experience significant health inequalities

1. People with a learning disability and autistic people suffer premature mortality – the disparity between the median age at death for people with a learning disability and the general population is 23 years for males and 27 years for females[1], while autistic adults, on average, die 16 years earlier than non-autistic adults.[2]

2. A significant proportion of these deaths are avoidable. The Learning Disabilities Mortality Review (LeDeR) Programme annual reports in 2020 and 2021 found that, of all deaths among adults with learning disabilities that were reported to the programme, "overall avoidable medical causes were 54% in 2018, 52% in 2019, 50% in 2020 and 49% in 2021."[3,4] This included deaths that were preventable through public health and primary care interventions and those that were treatable by timely and effective health care. We also expect that this included deaths that were preventable through good social care, which enables people to appropriately engage with and in public health and primary care interventions.

Health inequalities are exacerbated by low understanding and knowledge of how to meet the needs of people with a learning disability and autistic people

3. Alongside premature deaths, we know that people with a learning disability and autistic people experience issues in accessing health care services[5], having their needs recognised[6] and having their views appropriately considered.[7] Evidence indicates that health and social care professionals who do not work in learning disability services are not comfortable working with people with a learning disability, because they do not know enough about them and have not had specialist training, leading to delays and difficulties in referrals to specialist services and delays in people with a learning disability accessing the right help at the right time.[8] This in turn leads to exacerbating health inequalities and increased risk of premature death.

4. Evidence suggests that communication with people with a learning disability is a major barrier to individuals accessing health and social care.[9] Patients with a learning disability often feel that healthcare professionals do not adapt their communication for someone with a learning disability and talk to the carer or parent instead of the individual. This often leads to individuals struggling to express their health concerns, missed or delayed diagnoses,[10] and not understanding medication dosage or possible side effects and

[1] The Learning Disabilities Mortality Review (LeDeR) Programme: Annual Report 2017. Accessed here.

[2] Hirvikoski, T., Mittendorfer-Rutz, E., Boman, M., Larsson, H., Lichtenstein, P. & Bolte, S. (2016). Premature mortality in autism spectrum disorder. *The British Journal of Psychiatry*, 208(3), p.232-238.

[3] The Learning Disabilities Mortality Review (LeDeR) Programme: Annual Report 2020. Accessed here.

[4] Learning from lives and deaths – people with a learning disability and autistic people: Annual report 2021. Accessed here.

[5] Emerson, E. & Baines, S. (2010). Health inequalities & people with learning disabilities in the UK: 2010

[6] Byrne, J.H., Lennox, N.G., & Ware, R.S. (2016). Systematic review and meta-analysis of primary healthcare interventions on health actions in people with intellectual disability. *Journal of Intellectual and Developmental Disability, 41*(1), 66-74.

[7] Griffith.G.M., Hutchinson, L., & Hasting, R.P. (2013). "I'm not a patient, I'm a person": the experiences of individuals with intellectual disabilities and challenging behaviour – a thematic synthesis of qualitative studies. *Clinical Psychology: Science and Practice, 20*(4), 469-488.

[8] Ee., J., Kroese, B.A., & Rose, J. (2021). A systematic review of the knowledge, attitudes and perceptions of health and social care professionals towards people with learning disabilities and mental health problems. *British Journal of Learning Disabilities*, 00, p.1-17.

[9] Afia et al (2013) Discrimination and Other Barriers to Accessing Health Care: Perspectives of Patients with Mild and Moderate Intellectual Disability and Their Carers. PLoS One, 8(8), e70855. Doi: 10.1371/journal.pone.0070855. Available here.

[10] The Learning Disabilities Mortality Review (LeDeR) Programme: Annual Report 2021. Accessed here

management of them. Therefore, better communication skills among healthcare and social care professionals could help people with a learning disability explain the health problem they are experiencing and receive more timely intervention, leading to reduced health inequalities and avoidable death.

5. People with a learning disability often experience diagnostic overshadowing[11] and poor care within NHS settings, with evidence indicating that this is partly due to a lack of understanding and insufficient learning disability training for staff.[12,13] 50% of health care professionals surveyed by Mencap reported a lack of knowledge around learning disability; 42% reported that a lack of continuing professional development might be contributing to avoidable deaths; and 26% reported that negative attitudes towards people with a learning disability might be a contributing factor in avoidable deaths.[14]

6. Evidence indicates that greater knowledge of and more time spent with autistic people is associated with more positive attitudes towards autistic people.[15,16] Further, a training programme designed for parents of autistic children found their knowledge and skills increased and led to reduced anxiety in the children.[17] Therefore, increased knowledge of learning disability and autism among health and social care staff might enable more positive attitudes and respect towards people with a learning disability and autistic people, and in turn potentially reduce health inequalities and avoidable deaths.

Existing provision of training to staff on meeting the needs of people with a learning disability and autistic people is not consistent or effective

7. While training on learning disability and autism is available, provision and uptake is low among health and social care staff and organisations. In 2018, Mencap reported 52% and 38% hospital trusts provided content related to learning disabilities in their induction for clinical and non-clinical staff, respectively.[18] The same report highlighted that whilst many trusts provided specialist learning disability training to staff, this was largely optional and offered to only some groups in some cases. In general practice, professionals have indicated they need to provide good care to people with a learning disability and autistic people but there is no mandatory training around this in primary healthcare; 64% of GPs reported they received less than a day's training on how to meet the needs of people with a learning disability and 60% said additional training is necessary.[19]

8. In 2019, Health Education England published the Core Capabilities Framework for Supporting People with a Learning Disability[20] and the Core Capabilities Framework for

[11] *Diagnostic overshadowing is when an individual's symptoms are mis-attributed to their learning disability or autism, and so not investigated or treated further.*

[12] Mencap (2007). Death by indifference. Following up the Treat me Right! report. Accessed here.

[13] Disability Rights Commission (2006). Equal treatment: closing the gap. A formal investigation into physical health inequalities experienced by people with learning disabilities and/or mental health problems. Accessed here.

[14] Mencap (2004). Treat me right! Better healthcare for people with a learning disability. Accessed here.

[15] Sasson, N.J., & Morrison, K.E. (2017). First impressions of adults with autism improve diagnostic disclosure and increased autism knowledge of peers. *Autism*, 23(1), p. 50-59

[16] Shand, A.J., Close, S.A.D., & Shah, P. (2020). Greater autism knowledge and contact with autistic people are independently associated with favourable attitudes towards autistic people. *Experimental Results*, 1, E46

[17] M Pillay, B Alderson, B Wright, C Williams, & B Urwin. (2010). Autism Spectrum Conditions--enhancing Nurture and Development (ASCEND): an evaluation of intervention support groups for parents. *Clinical Child Psychology and Psychiatry,* 16(1), p.5-20

[18] Mencap (2018). Treat me well. Simple adjustments make a big difference. A campaign to transform how the NHS treats people with a learning disability. Accessed here.

[19] Dimensions (2018). #MyGPandMe: making primary care fair. Accessed here.

[20] Health Education England (2019). Core Capabilities Framework for Supporting People with a Learning Disability. Accessed here.

Supporting Autistic People[21] to set out the essential capabilities necessary for health and social care staff. The purpose of these frameworks was to help organisations identify the capabilities needed and plan and commission appropriate staff training to meet those. The frameworks were linked to Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014,[22] which specified that staff must receive appropriate training to carry out their duties. However, there was no specific regulatory requirement to demonstrate use of or compliance with the frameworks.

9. Despite the publication of the core capabilities frameworks, a lack of consistency and quality of training has remained an issue cited among health and social care staff in training for the same and other vulnerabilities. For instance, the CQC's 'State of Health Care and Adult Social Care in England 2019/2020' report indicated that mental health training in the context of learning disability services, which is not mandated, varied across trusts, and training did not always consistently provide staff or services with the understanding, level of awareness or practical knowledge to effectively embed learning into practice.[23]

10. In 2019, *'Right to be heard'*, the Government consultation on learning disability and autism training received broad support from individuals and organisations that more effective training was required. Moreover, 97% of respondents to the consultation agreed with mandating the training through legal means.[24]

Rationale for Government intervention

11. When healthcare and social care professionals are not able to recognise the unique needs, preferences, and care requirements of people with a learning disability and autistic people, this creates information asymmetry which leads to inappropriate and uncompassionate care or lack of care, with the potential to cause undue harm and avoidable deaths. The rationale for intervention is to reduce the information asymmetry allowing health and social care staff to treat and care compassionately and appropriately, resulting in better health and societal outcomes for people with a learning disability and autistic people, their carers, friends and families.

12. Over the past 15 years, multiple key stakeholder organisations, such as Mencap, the Confidential Inquiry into Premature Deaths of People with Learning Disabilities, the Healthcare for All Independent Inquiry and the LeDeR Programme have recommended mandatory training on learning disability for health and social care staff to improve the quality of care and reduce avoidable deaths. Despite consensus on the importance and likely effectiveness of such training, health and social care staff continue to report a lack of knowledge and a lack of training opportunities. Without Government intervention, the issue will persist, and the health inequalities experienced by people with a learning disability and autistic people will not diminish. Not only does this negatively impact the physical and emotional wellbeing of people with a learning disability and autistic people themselves, but also their families, friends, and carers for whom such issues have substantial emotional impacts.

[21] Health Education England (2019). Core Capabilities Framework for Supporting Autistic People. Accessed here.

[22] Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Accessed here.

[23] Care Quality Commission (2020). The state of health and social care in England 2019/20. Accessed here.

[24] Department of Health and Social Care (2019). 'Right to be heard': the Government's response to the consultation on learning disability and autism training for health and care staff. Accessed here.

Level of analysis used in the impact assessment

13. The introduction of a new mandatory requirement to complete training on learning disability and autism in the Health and Care Act 2022 has the potential to greatly impact the care and support received by autistic people, people with a learning disability and their family and carers. We determined the level of impact of the legislation, on the aggregate England level, to be high, in accordance with the Regulatory Policy Committee's proportionality guidance for departments and regulators.

14. The code of practice, accompanying the new mandatory requirement, must specify how training should be delivered to staff by service providers. Its purpose is to ensure that all staff receive standardised, high-quality training, which can facilitate the change in knowledge and skills that is needed to reduce health inequalities experienced by people with a learning disability and autistic people.

15. The Government has developed a training package, the 'Oliver McGowan Mandatory Training on Learning Disability and Autism', which is the recommended and preferred package to support service providers to meet the legislative requirement. However, we do not know how health and care organisations will roll-out this package to their employees or what level of Government funding will be available to support the roll-out. The impact assessment (IA) is, therefore, limited by assumptions about the operational delivery model for the OMMT. In addition, we started with a premise that everyone would do the OMMT, but in reality, that number may be less than 100% of health and care staff, if organisations do not choose the Government recommended package.

16. To inform our assumptions and analysis, including testing whether the assumptions appeared reasonable, we relied on the following sources:

    - the evaluation of the Oliver McGowan Mandatory Training Trial on Learning Disability and Autism;[25]
    - discussions with NHS England, Health Education England, Skills for Care and NHS Resolution;
    - a rapid evidence review of 22 studies on the effectiveness of training on changing health and social care staff knowledge, skills and behaviour, noting that this was limited and represents an under-researched area (the review process undertaken for the available literature is included in the Annex figure 1);
    - the Health and Care of People with Learning Disabilities Experimental statistics, which reports on the key differences in healthcare between people with a learning disability and those without, and various data sources from a search for unit costs of NHS services and treatments (e.g., Greater Manchester Combined Authority Unit Cost Database and academic articles);
    - other publicly available data relevant to assumptions regarding training provision.

17. Our approach considered a range of possible costs in detail and drew on broad related evidence to gauge the likely scale of benefits. To account for a high level of uncertainty, we conducted sensitivity tests and provided high and low estimates within this document.

18. A substantial limitation to our approach in monetising the benefits of rolling out the Oliver McGowan Mandatory Training on Learning Disability and Autism is that benefits have only

[25] National Development Team for Inclusion (2022). Evaluation of the Oliver McGowan Mandatory Training Trial in Learning Disability and Autism. Accessed here.

been monetised related to reducing health inequalities among people with a learning disability and not among autistic people due to a lack of data on the health and care of autistic people.

Description of policy development

The Oliver McGowan Mandatory Training on Learning Disability and Autism

19. In 2016, Oliver McGowan, an autistic teenager who was admitted to hospital with seizures, was prescribed antipsychotic medication and died. Oliver was intolerant to this medication and his parents believe his death could have been prevented. Oliver's parents campaigned to introduce mandatory training on learning disability and autism for healthcare and social care professionals.

20. In 2018, the Government made a commitment to consult on the introduction of mandatory training on learning disability in its response to the second annual LeDeR report (2017). The report made a specific recommendation to introduce mandatory training, as evidence from local LeDeR reviews identified the need for staff to have a greater awareness of the health needs of people with a learning disability.

21. On 13 February 2019, the Department for Health and Social Care (DHSC) published a consultation paper: *'Learning disability and autism training for health and care staff'*.[26] The consultation covered proposals for:

    - the content of training,
    - assessing the level of training required by staff,
    - the delivery of training, including by people with a learning disability or autistic people,
    - how to mandate training, and
    - how to monitor and evaluate its impact.

22. The ten-week public consultation closed on 26 April 2019 and DHSC received over 5,000 responses from a broad range of organisations and individuals. Through the consultation DHSC received wide support for the introduction of mandatory training in recognition that this would improve health and wellbeing outcomes and ensure that people with a learning disability and autistic people would have a better experience of health and social care services.

23. On 5 November 2019, DHSC published its response to the consultation on mandatory learning disability and autism training for health and care staff called *'Right to be heard'*.[27] It set out a commitment to work with Health Education England (HEE) and Skills for Care (SfC) to develop and trial a standardised training package, backed by a £1.4 million investment from the Government. The training package was named after Oliver McGowan (The Oliver McGowan Mandatory Training)[28] in recognition of his story, his mother and father's tireless campaigning for better training for staff, and to remember him and others whose lives were tragically cut short.

24. The National Development Team for inclusion (NDTi), in partnership with My Life My Choice and Bemix, were commissioned to be the evaluation partner for the trial, which

[26] DHSC (2019). Learning disability and autism training for health and care staff. Accessed here.

[27] DHSC (2019). 'Right to be heard': The Government's response to the consultation on learning disability and autism training for health and care staff. Accessed here.

[28] Oliver McGowan's story and the campaign in his name.

from this point in the document will be referred to as the Oliver McGowan Mandatory Training (OMMT) trial. The evaluation of this trial was published in June 2022,[29] and the report and its findings have been used to inform this IA.

Trial and evaluation of the Oliver McGowan Mandatory Training

25. Three different training packages were trialled and evaluated. Each had two components:

- tier 1 training, designed for those who require a general awareness of autistic people and/or people with a learning disability; and
- tier 2 training, designed for those provide care and/or support for autistic people and people with a learning disability, but rely on others for complex management.

26. While the OMMT trial experienced constraints due to pandemic restrictions, impacting the ability to collect as much data as anticipated, the evaluation report concluded that there was good evidence that the training had a positive impact on knowledge, skills, and confidence in working and communicating with people with a learning disability or autistic people. It also concluded there was some positive impact on behaviour change in supporting people with a learning disability and autistic people among those who took part in the trial.

27. The evaluation report recommended that tier 1 training take the form of a 1.5-hour e-learning module followed by a 1 hour online interactive webinar with two Experts by Experience (EbE),[30] and that the training trialled is ready to be used without further amends.

28. The report did not make recommendations on a specific tier 2 training package. Overall, all three training packages were well received in the trial. NDTi suggested that consideration should be given to taking the best elements of each of the three training packages to create a new one-day package, covering both learning disability and autism, and using the tier 1 e-learning module (without the online interactive webinar) as a pre-requisite for undertaking tier 2 training.

Legislation: mandatory training on learning disability and autism

29. As of 1 July 2022, new regulations came in under the Health and Care Act 2022[31] for service providers that perform Care Quality Commission (CQC)-regulated activities,[32] to ensure their staff receive training on learning disability and autism, appropriate to their role. This builds on the existing requirement set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014[33] that such staff should be provided with the training necessary to enable them to perform their duties.

30. CQC have one set of regulations that apply to all service providers, ensuring consistency and alignment with the legislation throughout. Regulated activities are detailed in Schedule 1 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014,[34] where each regulated activity is described and examples of services that are likely to carry out

[29] National Development Team for Inclusion (2022). Evaluation of the Oliver McGowan Mandatory Training Trial in Learning Disability and Autism. Accessed here.

[30] An Expert by Experience refers to an autistic individual, an individual with a learning disability or an individual who is autistic and has a learning disability. Please note that the term Expert by Experience is used in this IA in place of the term Expert with Lived Experience, which is the term used in the code of practice.

[31] Part 6, Section 181 of the Health and Care Act 2022. Accessed here.

[32] CQC (2022). Scope of registration: regulated activities. Accessed here.

[33] Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Accessed here.

[34] Schedule 1 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Accessed here.

these activities are provided. Where we refer to “workforce” throughout this document, we are referring to those working under the scope of this definition.

31. Children’s social care is outside of the scope of CQC regulated activities.

32. The legislation also specifies that the Secretary of State must issue a code of practice about compliance with the new requirement. The code must make provision about various aspects of training, such as its content, delivery method, accreditation and procurement, and monitoring and evaluation of the impact of training.

33. While the code of practice is in development and before it is published, existing regulations remain in force. This means that CQC will judge compliance with the new legal requirement based on existing statutory guidance and will only refer to the code of practice, after it has been consulted on, laid in parliament and published.

Policy objective

34. The main policy objective is to improve health and social care staff skills and knowledge to provide safe, compassionate and informed care to people with a learning disability and autistic people by ensuring that they receive relevant training on learning disability and autism.

35. The objective of the code of practice is to set standards for how such training should be provided to ensure it is effective in delivering the main policy objective; in other words, that the training undertaken increases staff skills and knowledge, and that it equips staff with the right learning that can be used to consistently improve the quality of care.

36. The desired effect of the intervention is that people with a learning disability and autistic people receive consistently high-quality care, have better health outcomes, and are less likely to die from avoidable causes of death.

37. We are looking at ways to make the main objective specific, measurable, attainable, relevant and time-based (SMART) by understanding how we can record who does the training, identifying initial funding streams, focusing on developing a sustainable future delivery model, and estimating a realistic timeframe to ensure as many people as possible receive the training.

38. We expect there will be several indicators of success from monitoring training records and feedback, to using ongoing data collection programmes and commissioning an independent evaluation of the OMMT roll-out, subject to funding and approval. With regards to monitoring training records, the draft code of practice specifies that health and care organisations should use their staff record management systems to record their staff’s training completion and that they are expected to make such data available to the relevant monitoring body (e.g., their integrated care board) and for the purposes of an independent evaluation. With regards to OMMT feedback, the draft code specifies that organisations are expected to ask staff to complete standardised feedback surveys, which can be made available to DHSC and its delivery partners or for the purposes of an independent evaluation of the OMMT. Outcomes can also be monitored through ongoing data collection programmes, such as through the findings of annual LeDeR reports, which from 2023 will include deaths among autistic people, and through the annual Health and Care of People with Learning Disabilities experimental statistics.

Description of options considered in the IA

Option 0 – business as usual

39. The primary legislation introducing mandatory training on learning disability and autism came into force on 1 July 2022 (paragraph 29). While the code of practice on how such training should be provided by healthcare and adult social care employers is being developed and before it is published, service providers can rely on existing statutory guidance, which is very high-level (paragraph 33). All options considered in this IA are compared against this status quo position where the OMMT is not rolled out.

40. The costs should be interpreted as costs incurred in providing the OMMT package instead of the existing learning disability and autism training arrangements continuing into the future. The benefits should be interpreted as benefits accruing as a result of staff receiving the OMMT package, which has been designed, trialled and evaluated to target the skills, knowledge and behavioural changes that are necessary to reduce health inequalities experienced by people with a learning disability and autistic people.

41. Option 0 is only used as a counterfactual to calculate costs and benefits arising because of the OMMT, it does not reflect a viable policy position. Because issuing a code of practice is specified in law (paragraph 32), in practice, there is no option to continue with 'business as usual' with regards to issuing a statutory instrument.

Options 1 and 2: Introducing the OMMT for CQC regulated health and social care staff

42. The OMMT is the Government recommended and preferred package to support providers to meet the legislative requirement for providing mandatory training on learning disability and autism. Options in this IA assume that the OMMT tier 1 and tier 2 packages will be rolled out to all CQC regulated health and social care staff. We are not making provisions for use of alternative training packages in the current IA, please see section 'details of alternative options considered' below.

43. To deliver the OMMT, health and care organisations may either become an accredited provider by training staff within their organisation (or network) to deliver the OMMT packages in-house or source an accredited provider. We expect that some level of Government funding will be provided to help health and care organisations roll out the recommended OMMT packages and to facilitate flexible in-house delivery, wherever feasible. The IA considers two options for the OMMT with variations in funding and modelling for the roll-out and uptake of the training. The funding is related to covering the costs of delivering the OMMT sessions and does not cover opportunity costs of staff taking the training. The options consider how such variations in funding might affect implementation and roll-out, and subsequently how variations in implementation and roll-out influence associated costs and expected benefits. Without funding and support, we assume that health and care providers will be less likely to take up the OMMT.

44. As a starting point, we considered what an optimal roll-out of the OMMT would look like and how much financial cost it is associated with. An optimal roll-out is one that most closely reflects the capabilities frameworks for supporting people with a learning disability and autistic people (see paragraph 8). Such roll-out is one that completes in 3 years; where training refreshes happen every 3 years; where all staff take either the full tier 1 package or the full tier 2 package, in line with the intended staff roles for each tier as per the OMMT trial (see paragraph 24); and where as many organisations as feasible are supported to deliver the OMMT in-house.

45. We assume that full funding is needed to ensure such optimal roll-out. Specifically, Government funding needs to cover all financial costs associated with the optimal roll-out for the adult social care and public healthcare sectors and to fund a central support team, which can lead on governance, communications, and monitoring of progress. This is the basis of Option 1.

    Option 1 – the roll out of the OMMT is optimised through full funding for the adult social care and public healthcare sectors, including a central support team.

46. The decisions about the level of funding to accompany the roll-out of the OMMT, how such funding can be distributed and what it can be used on are in development. We, therefore, considered a second option where a generally lower level of funding is made available, compared to option 1. In this case, we assumed roll-out will deviate from optimal in the following ways: it will take 5 years to train everyone; some staff groups, for whom tier 1 was intended, may not complete the full tier 1 package; some staff groups, for whom tier 2 was intended, may complete the tier 1 package instead of the tier 2 package; fewer organisations may opt to become accredited providers of the OMMT to deliver in-house. These variations formed the basis of Option 2.

    Option 2 – the roll-out of the OMMT is supported with some funding, but it does not cover the full costs for the adult social care and public healthcare sectors, and it does not cover a central support team.

Details of alternative options considered

47. As mentioned in paragraph 42, this IA did not make provisions for organisations choosing alternative training packages on learning disability and autism (as opposed to the OMMT). However, some organisations may already have or be able to develop packages that meet the training standards specified in the draft code of practice. Any such alternative packages would need to meet the same standards as those used in the development of the OMMT package and would be expected to deliver the same level of impact – we also assume that they would incur similar costs.

48. We also considered roll-out of the OMMT to staff who perform activities outside the scope of CQC regulations. There are constraints with this proposal as the same set of enforcement powers that allow the CQC to protect the public and hold registered providers and managers to account cannot be applied to the non-regulated sector. It must also be taken into account that regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 already requires registered providers to ensure their staff have training appropriate to their role, this statutory requirement does not encompass non-regulated staff.

49. Further scoping is required to deduce what existing enforcement levers could be utilised to ensure uptake and accountability for the training in the non-regulated health and social care sector. Consideration has been given to utilising NHS contracts or local authority commissioner contracts.

50. We have also considered alternative ways of ensuring the provision of training, such as weaving the OMMT into existing training offers such as the Care Certificate, vocational training and to apprenticeships. For all the aforementioned options, further scoping is required for a full assessment of the feasibility and sustainability of this approach.

Preferred option with description of implementation plan

51. The draft code of practice provides some details of the implementation plan for the OMMT, which are summarized under specific headings below.

Who will undertake each tier of the OMMT

52. The following definitions are used to describe the intended staff groups or roles for tier 1 and tier 2 of the OMMT:

    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.

The OMMT content

53. The OMMT is based on the capabilities and learning outcomes described in the Capabilities Frameworks for Supporting People with a Learning Disability[35] and the Capabilities Framework for Supporting Autistic People.[36]

54. Tier 1 minimum content includes:

- 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 of own attitudes and behaviour.

55. Tier 2 minimum content includes 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 they are in health, including 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 to ASK – LISTEN – DO.
- Learning from LeDeR.

[35] Health Education England (2019). Core Capabilities Framework for Supporting People with a Learning Disability. Accessed here.

[36] Health Education England (2019). Core Capabilities Framework for Supporting Autistic People. Accessed here.

- Annual health checks.

The OMMT delivery method

56. Tier 1 is delivered via a 1.5-hour e-learning module that training participants can do in their own time and a subsequent 1-hour live interactive webinar with two EbEs and a co-trainer. There is capacity for 30 training participants per each webinar.

57. Tier 2 is delivered via a 1.5-hour e-learning module that training participants can do in their own time and a subsequent 1-day face-to-face session (7.5 hours) with two EbEs and a co-trainer. There is capacity for 30 training participants per each session.

The OMMT training frequency / refresh

58. Staff are expected to undertake the OMMT at least every 3 years and earlier if a member of staff requires it. This may be, for instance, if a staff member's role and/or responsibilities change or to address an identified learning need.

59. For the purposes of this IA, we assumed that staff will re-take the full tier package intended for their role every 3 years. However, it is possible that dedicated refresh packages may be delivered over time, which may be shorter in duration than the original package or cover different content. We will consider this possibility during the code of practice consultation process and will reflect it, if applicable, in the final stage IA.

The OMMT accreditation and procurement

60. The draft code of practice specifies that organisations or individuals delivering the OMMT must undergo a quality assurance process to become an accredited provider. Health and social care employers can choose either to become an accredited provider by training staff within their own organisation or networks to deliver the OMMT or can source training from a list of accredited providers. We refer to the two options as in-house delivery and procured delivery, respectively.

61. The remaining details of the implementation plan are under development. DHSC is working with statutory bodies (NHS England and Health Education England) and Skills for Care to develop an operational delivery model for the OMMT and the IA is informing this work. Once the delivery model is decided, we will update assumptions underpinning the options in the IA, specify DHSC/NHSE funding requirements under each and consider the affordability of each option. These will be presented in the final stage IA, accompanying the publication of the code of practice.

62. DHSC cannot commit to an implementation plan while the work on the operational delivery model and funding requirements is ongoing. However, if judged solely on the net present value of the options presented in the IA, option 2 represents the preferred option.

63. The enforcement body for the legal training requirement is the CQC. Existing CQC enforcement policy will be applied in any determination of a breach of regulation and in considering appropriate regulatory action. The CQC will act with due proportionality and consider all relevant circumstances on a case-by-case basis, with respect to the new requirement, including providers' application of CQC statutory guidance, which will remain in place until the code of practice is published.

Costs of Options 1 and 2

64. Most of the cost inputs are shared across options 1 and 2 – these are presented first. The two options differ in terms of three key inputs:

- the length of roll-out, where option 1 assumes a 3-year roll-out and option 2 assumes a 5-year roll-out,
- the expected number of staff who complete each tier of the OMMT, where option 1 assumes everyone either completes the full tier 1 or the full tier 2, as intended for their staff group, and option 2 assumes that some staff complete the e-learning module instead of the full tier 1 package intended for their group and that some staff complete the tier 1 package instead of the tier 2 package intended for their group (details in paragraphs 115 and 132),
- the expected number of staff who receive training in-house, where option 1 assumes that as many staff as possible receive training in-house and option 2 assumes that fewer staff receive training in-house (details in paragraphs 121 and 136).

The difference in assumed outcome for option 2 is driven by differences in decisions by providers due to financial incentives. As option 2 does not cover all financial costs associated with the optimal roll-out of the OMMT, we assume this would influence how service providers interpret the code of practice and decide which members of staff need each component of the OMMT package.

The three above-mentioned cost inputs are presented separately for each option.

65. We assumed that all those eligible, where relevant for each option, will receive the training. However, in practice it is possible that some staff will not need the training. For example, doctors and nurses who specialise in the care of people with a learning disability and autistic people are less likely to need tier 1 or tier 2 OMMT training, as they are already equipped with appropriate and extensive knowledge and skills. However, this cohort represents 0.9% of the clinical nursing population and 0.1% of the qualified doctor population so will likely have a minimal impact on cost estimations.[37] This will become clearer following consultation and will be reflected in the final stage IA.

66. We use a 10-year appraisal period across both options.

Cost of a tier 1 session

67. The OMMT tier 1 package includes a 1.5-hour e-learning module and a 1-hour webinar. The e-learning module is already rolled out – it is hosted on the eLearning for healthcare platform.[38] The module is open to the public and free to anyone; therefore, there are no further costs associated with delivering the e-learning to health and care staff.

68. The 1-hour webinar could be run using a platform such as Microsoft Teams or Zoom. It is anticipated that this software would already be available and so there would be no extra cost involved. The webinars will be facilitated by two EbEs, where one is a person with a learning disability and one is an autistic person, and a co-facilitator. Each webinar will have 30 participants. Based on conversations with HEE, we assume that the facilitators will work as part of a wider training team, which will also include a team leader and an administrative assistant, each working at 0.2 and 0.5 full time equivalent (FTE) on the OMMT, respectively. On this basis, for each webinar we account for 0.2 hours of a team leader's time and 0.5 hours of administrative assistant's time.

69. Prior to the webinar, participants submit questions for the facilitators, who then meet to discuss the questions and structure the session. Based on conversations with HEE, we

[37] NHS (2022) NHS Workforce Statistics – October 2022. Accessed here

[38] Elearning: The Oliver McGowan Mandatory Training on Learning Disability and Autism. Accessed here.

assume that such preparation increases the time the facilitators spend on each webinar from 1 hour to 1.67 hours (or 1 hour 40 min).

70. We assume that all members of the training team will need to spend time on non-delivery activities, such as performance management and professional development, as well as sick absences. We, therefore, allow 20% headroom for their working hours.

71. To calculate the cost of each webinar delivered in-house, we multiply the involvement of each team member in terms of hours by their cost per hour, which is defined as their salary including oncosts and overheads (see table 1). To calculate the cost of each webinar delivered in-house per participant, we divide that figure by 30, arriving at £6.58 per participant (in 2022/23 prices).

Table 1. Tier 1 webinar delivery team salary description, annual salary and cost per hour in 2022/23 prices

	Agenda for Change pay scale[39]	**Annual salary**	**Cost per hour, incl. oncosts and overheads[40]**
Team Leader	Band 7, intermediate step point	£43,806	£48.46
Administrative assistant	Band 4, intermediate step point	£26,282	£29.07
Expert with lived experience	Band 5, intermediate step point	£29,180	£53.79
Co-facilitator	Band 6, intermediate step point	£35,572	£65.58

72. If the webinar is procured, we need to reflect the costs in market prices by applying an indirect tax correction[41] - the cost of a procured tier 1 webinar per participant becomes £7.83 (in 2022/23 prices).

Cost of a tier 2 session

73. Those who are required to complete the OMMT tier 2 will also complete the e-learning module. We do not anticipate any additional costs involved with this component. They will then attend a full day (7.5 hours) face-to-face session with two EbEs, where a person with a learning disability will be present for one half of the session and an autistic person will be present for the other half of the session, and a co-trainer. Each session will have 30 participants. As with tier 1, we assume that the trainers will work as part of a wider team which will also include a team leader and an administrative assistant, each working at 0.2 and 0.5 FTE on the OMMT, respectively. On this basis, for each session we account for 1.5 hours of a team leader's time and 3.75 hours of administrative assistant's time.

74. Based on conversations with HEE, we assume that there will be some preparation ahead of each session, which will increase the time the trainers spend on a session from 7.5 hours to 8.3 hours (or 8 hours 20 min).

75. We assume that all members of the training team will need to spend time on non-delivery activities, such as performance management and professional development, as well as sick absences. We, therefore, allow 20% headroom for their working hours.

76. To calculate the cost of each session delivered in-house, we multiply the involvement of each team member in terms of hours by their cost per hour, which is defined as their

[39] NHS (2022). Agenda for Change – pay rates 2022/23. Accessed here.
[40] To calculate the cost per hour, we assume 1,338 working hours per annum and apply 48% uplift for oncosts and overheads on guidance from NHSE.
[41] Department for Transport (2022). TAG Unit A1.1 Cost-Benefit Analysis, p.13. Accessed here.

salary including oncosts and overheads (see table 1). To calculate the cost of each session delivered in-house per participant, we divide that figure by 30, arriving at £25.95 per participant (in 2022/23 prices).

77. Some of the face-to-face sessions may need to be delivered at hired venues when organisations do not have the right space on-site. Costs from the NDTi evaluation suggest that venue hire for 30 participants will cost £250 per day. Some staff may also need to travel to attend the face-to-face session. We allow a travel cost at £20 per person per day (transportation costs are likely to be greater for those with accessibility needs, for example, where a taxi is needed as opposed to private or public transport). There will be regional variation in these costs. When adding in venue and travel, the cost of a tier 2 session delivered in-house arrives at £54.29 (in 2022/23 prices).

78. If the tier 2 face-to-face session is procured, we need to reflect the costs in market prices by applying an indirect tax correction[42] - the cost of a procured session per participant arrives at £30.88 (in 2022/23 prices). When adding in venue and travel, the cost of a procured tier 2 session arrives at £59.22 (in 2022/23 prices).

79. HEE advised that most healthcare staff (75%) will not need a venue as they are likely to have venue space on-site, suggesting that costs for 25% of staff should include venue and travel. This is a potential opportunity cost in the early phases of implementation, but HEE indicated that this is likely to be absorbed into the new ways of working (for example, fewer rooms in use due to more frequent working from home practices). SfC advised that most training among the smaller adult social care organisations will need an off-site venue. Larger adult social care organisations may be able to become accredited providers of the OMMT and deliver in-house, so for in-house delivery we assume that costs for 25% of staff should include venue and travel, in line with healthcare. Smaller adult social care organisations may be more likely to procure training, so we assume, where training is procured, costs for 75% of adult social care staff will need to factor in venue and travel.

Cost of refresher sessions

80. The draft code of practice states that staff are expected to take the OMMT at least every 3 years – based on this, we assume that the cost of refresher sessions will be the same as the cost of the tier 1 and tier 2 sessions during the initial roll-out. However, it is possible that shorter refresher sessions may be developed, for example, such that staff who attend the full day face-to-face session, may subsequently attend a shorter refresher session three years later. We have included this possibility in our sensitivity analysis to illustrate what effect it would have on the costs of each option.

Costs related to in-house delivery of the OMMT tiers 1 and 2

81. To become accredited providers of the OMMT, organisations will need to recruit EbEs and co-trainers to deliver sessions in-house. These trainers will need to learn the specifics of the OMMT packages via dedicated ‘train the trainer’ sessions prepared by HEE. We also expect that EbEs will require some support into employment, for example, related to softer skills for the workplace, such as time management and communication skills. The associated costs are presented in this section under specific headings.

<u>Cost of recruiting EbEs and co-trainers</u>

82. First, we consider the fixed cost of recruitment, related to the preparation of job advert and application materials and publicising the job advert. HEE have prepared trainer job descriptions and we assume that organisations will make use of these descriptions. We

[42] Department for Transport (2022). TAG Unit A1.1 Cost-Benefit Analysis, p.13. Accessed here.

assume that a recruitment manager (Band 6,[43] £56.36 per hour, including oncosts and overheads, in 2022/23 prices) will spend 15 hours preparing the recruitment process. We assume that publicising the job advert will cost £5,000. Together, this arrives at a fixed cost of c.£5,845 (in 2022/23 prices) per each year of recruitment.

83. Based on stakeholder engagement, we assume that a HR manager (Band 6,[44] £56.35 per hour, including oncosts and overheads, in 2022/23 prices) will work with the recruitment manager on the following co-trainer recruitment process:

- everyone who applies will ask a query, and it takes 10 minutes for the HR manager to answer each query
- it will take 10 minutes each for the HR and recruitment managers to moderate each application form
- 33% of those who apply will be offered an interview (i.e., for every 9 people that apply, 3 go on to interview); the cost per applicant who does not progress to interview is thus calculated to be £28.18
- the interview will take 1 hour and 15 minutes (including administration) each for the HR and recruitment managers
- 33% of interviewees will be successful (i.e., for every 3 candidates that interview, 1 is offered the role)
- it will take 10 minutes for the HR manager to notify each unsuccessful applicant of the outcome; the cost per applicant who is unsuccessful at interview is calculated to be £178.47
- it will take 3 hours of the HR manager's time in administration to appoint each successful candidate; the cost per successful applicant is calculated to be £338.15

84. This comes out at c.£874 in recruitment costs per co-trainer recruited (inclusive of the cost for each unsuccessful applicant at application and interview stages).

85. Based on stakeholder engagement, we assume that an adjusted process will be required for the recruitment of EbEs, such that:

- everyone who applies will ask a query, and it takes 10 minutes for the HR manager to answer each query
- it will take 20 minutes each for the HR and recruitment managers to moderate each application form
- 33% of those who apply will progress to an assessment stage (i.e., for every 9 people that apply, 3 go on to be assessed further); the cost per applicant who does not progress to interview is thus calculated to be £46.97
- the assessment stage will run for 6 EbEs as a group and consist of a group task lasting 90 minutes and individual presentations lasting 10 minutes each, and will require 10 minutes for clarification questions and 60 minutes for scoring, amounting to 3.7 hours each for the HR and recruitment managers
- 33% of candidates will be successful at the assessment stage (i.e., for every 3 candidates who are assessed, 1 is offered the role)

[43] We used the Personal Social Services Research Unit report to obtain the staff cost per hour. Accessed here.
[44] We used the Personal Social Services Research Unit report to obtain the staff cost per hour. Accessed here.

- it will take 20 minutes for the HR manager to notify each unsuccessful applicant of the outcome and provide feedback; the cost per applicant who is unsuccessful at the assessment stage is calculated to be £134.63

- it will take 3 hours of the HR manager's time in administration to appoint each successful candidate; the cost per successful applicant is calculated to be £284.92

86. This comes out at c.£847 in recruitment costs per EbE recruited (inclusive of the cost for each unsuccessful applicant at application and interview stages).

Costs of 'train the trainer' sessions

87. This section was informed by the 'train the trainer' initiative developed by HEE, which began at the end of 2022. This initiative is based on a cascaded approach, where those people who have completed 'train the trainer' sessions will be able to go on and run their own 'train the trainer' sessions for others. In this way, HEE involvement is only required during the initial roll-out and the initiative then becomes self-sustaining.

88. We assume that a small national team will be needed to co-ordinate sessions, maintain a register of the OMMT trainers and co-ordinate peer review. This team will consist of a Project Lead (1 FTE at Agenda for Change[45] (AfC) Band 8a), Manager (1 FTE at AfC Band 7), EbEs (2.5 FTE at AfC Band 5) and administrative assistants (1 FTE at AfC Band 4 and 1 FTE at AfC Band 3). The annual cost of this team, inclusive of oncosts and overheads, arrives at £317,817.

89. We assume that a 'train the trainer' session to prepare EbEs and co-trainers to deliver the OMMT tier 1 webinars will last 4 hours, will be run by a Lead trainer (AfC Band 6) and a facilitator (AfC Band 5) and will accommodate 21 participants (or 7 'trios' who go on to deliver the webinars together). This arrives at a cost of £13.64 per participant (in 2022/23 prices).

90. We assume that a 'train the trainer' session to prepare co-trainers to deliver the OMMT tier 2 face-to-face sessions will last 2 days (or 16 hours), will be run by a Lead trainer (AfC Band 6) and a facilitator (AfC Band 5) and will accommodate 15 participants. This arrives at a cost of £76.40 per co-trainer (in 2022/23 prices).

91. We assume that a 'train the trainer' session to prepare EbEs to deliver the OMMT tier 2 face-to-face sessions will last 3 days (or 24 hours), will be run by a Lead trainer (AfC Band 6) and a facilitator (AfC Band 5) and will accommodate 8 participants. This arrives at a cost of £214.87 per EbE (in 2022/23 prices).

92. Based on conversations with HEE, we assume that these sessions will be delivered across regions in convenient locations for participants and we have not included venue hire, travel, or accommodation costs. It may be that this assumption does not apply to all and, if necessary, we will update the assumption for the final stage IA, when more details of the operational delivery will be available.

Cost of supporting EbEs into employment

93. HEE published guidance on 'Involving people with a learning disability and autistic people in delivering the Oliver McGowan Mandatory Training on Learning Disability and Autism'[46]

[45] NHS (2022). Agenda for Change – pay rates 2022/23. Accessed here.

[46] HEE (2022). Involving people with a learning disability and autistic people in delivering the Oliver McGowan Mandatory Training on Learning Disability and Autism. Accessed here.

and a report by NDTi based on the OMMT trial on 'Learning about involvement of experts by experience in design and delivery of training.'[47] It is expected that EbEs will require support when starting employment, which may be offered in the form of formal learning or on-the-job coaching or co-working.

94. For the purposes of this IA, we assume that employers who become accredited providers of the OMMT will wish to arrange dedicated sessions to support EbEs with softer workplace skills. We assume that over their first year of employment, EbEs will attend 14 such sessions, each lasting 3.5 hours. We assume that each session will be delivered by a Lead trainer (AfC Band 6) and will accommodate 8 participants. This arrives at a cost of £241 per EbE.

Yearly changes to the size of the healthcare and social care workforce: growth and turnover

95. To estimate how many members of staff need to take part in training for the roll out to complete in 'X' years, we cannot simply divide the size of the total workforce by 'X' for two reasons: (1) the workforce is expanding over time and (2) each year there is staff turnover. Due to turnover, each year some of the trained staff leave their posts and people coming in as their replacements need to be trained. In the paragraphs below we state how we obtained the growth and turnover figures for each staff group. These inputs were shared across both options.

Public healthcare workforce

96. For NHS Hospital and Community Health Services (HCHS) staff, we used the NHS Workforce Statistics – August 2022.[48] We split staff groups into those doing tier 1 ('support to clinical staff', 'NHS infrastructure support' and 'other staff or those with unknown classification') and those doing tier 2 ('professionally qualitied clinical staff'). We then calculated the average annual workforce growth rates for the past 10 years. This was 3.0% for staff doing the OMMT tier 1 and 2.1% for staff doing the OMMT tier 2.

97. We applied these average annual growth rates to each of the years in the 10-year appraisal period for NHS HCHS staff. We are aware that there are commitments in expanding the medical workforce in the NHS Long Term Plan (LTP), including increasing international recruitment and increasing nursing and medical school places. However, we have not accounted for these commitments as our calculation already includes the recent increases in staff numbers due to the response to COVID-19, which we have assumed will be absorbed in the LTP projections.

98. We used the NHS Workforce Statistics – August 2022[45] to find out the numbers of joiners and leavers from August 2021 to August 2022. In absence of regularly published statistics on the source of recruitment for NHS workforce, we used HCHS joiners by source of recruitment data from March 2020 to March 2021.[49] From these two data sources, we estimated that c.209,600 staff members left their post between August 2021 and August 2022, of which 82,300 left for another post within healthcare or social are and 127,300 left the healthcare and social care sectors altogether. This means that 9.2% of NHS HCHS staff who had been employed at the start of September 2021 left the combined health and core workforce by August 2022 (the leavers rate). We applied the same rate to each year of the appraisal period.

[47] NDTi (2022). The Oliver McGowan Mandatory Training evaluation: Learning about involvement of experts by experience in design and delivery of training. Accessed here.
[48] NHS Digital (2022). NHS Workforce Statistics – August 2022. Accessed here.
[49] NHS Digital (2022). Joiners by source of recruitment and staff group, March 2020 to March 2021. Accessed here.

99. For General Practice, we used the General Practice Workforce Statistics – November 2022.[50] We split the staff groups into those doing tier 1 ('all admin/non-clinical') and those doing tier 2 ('all GPs', 'all nurses', 'all direct patient care'). These statistics contain data from 2016 to 2022, meaning that we could only calculate average annual growth rates over the past 7 years. These were 1.1% for staff doing the OMMT tier 1 and 2.2% for staff doing the OMMT tier 2. We applied these rates to each of the 10 years in the appraisal period for GP staff.

100. We could not find data on staff turnover or source of recruitment for General Practice. Instead, we applied the 9.2% leavers rate to each year of the appraisal period.

101. For NHS dentist workforce, we used a combination of the NHS Dental Statistics for England, 2021-22, Annual Report[51] and monthly General Dental Council (GDC) registration reports to June of each year.[52] We assumed that all dentists and dental care professionals (DCPs) will require the OMMT tier 2 package. The average annual workforce growth rate was calculated for both groups combined over the past 10 years at 0.7%, and this rate was applied to each year of the appraisal period.

102. We could not find data on staff turnover or source of recruitment for dentists and DCPs. Instead, we applied the 9.2% leavers rate for each year of the appraisal period.

Independent healthcare workforce

103. There is a lack of published data on the size and trends of the independent HCHS workforce. Based on conversations with the Independent Healthcare Providers Network, we estimated the size of the workforce to be 215,000. We assumed that proportionately the same number of staff will do tier 1 and tier 2 packages as in the NHS HCHS workforce. We also applied the same growth rates and leavers rate as for NHS HCHS workforce.

104. For independent dentist workforce, we used the monthly GDC registration reports for the past 5 years and subtracted the estimated figures for NHS dentists and DCPs (see paragraph 101). We estimated the average annual growth rate at 4.6%. We also applied the 9.2% leavers rate calculated for NHS HCHS staff. These are crude calculations to give a sense of scale for the purposes of splitting costs between the public sector and businesses; however, we acknowledge that dentists and DCPs can perform both NHS and independent services, and these cannot be easily split.

Public and independent adult social care workforce

105. For adult social care (ASC) workforce, we used SfC ASC Workforce Statistical Appendix 2021/22.[53] The data does not split public and independent or regulated and non-regulated workforce over time, and instead we calculated the average annual growth rate over the past 10 years for the total ASC workforce at 0.9%. We applied this rate to each year of the 10-year appraisal period.

106. For regulated workforce, we found that 32% of staff had left their role in the previous year and that, among joiners, 62% were recruited from within ASC. Based on these figures, we estimated an annual leavers rate at 12.4% (32%*(100-62%)), meaning that we estimate that 12.4% of people who are employed at the start of the year will leave their post and

[50] NHS Digital (2022). General Practice Workforce Statistics, 30 November 2022. Accessed here.

[51] NHS Digital (2022). NHS Dental Statistics for England, 2021-22, Annual Report. Accessed here.

[52] General Dental Council. Registration reports. Accessed here.

[53] Skills for Care (2021). Adult Social Care Workforce Estimates (table 4.9). Accessed here.

ASC altogether by the end of the year. We applied the same rate for public and independent workforce to each year of the appraisal period.

Mean annual earnings for healthcare and social care staff groups

107. In healthcare and social care there will be an opportunity cost as staff undertake the OMMT in place of other activities, including providing services to patients. While all regulated service providers must comply with the existing requirement set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014[54] that staff should be provided with the training necessary to enable them to perform their duties and, therefore, must make allowance for staff to take time for training, we do not know to which extent the OMMT packages can come under such existing allowances. Where they exceed the allocated training time, this represents an economic cost under both policy options. The opportunity cost is calculated based on the time needed to complete the training and the corresponding earnings staff would otherwise earn for the duration of the training.

Public healthcare workforce

108. To calculate working hours for public healthcare staff, we used the Agenda for Change Terms and Conditions of Service Handbook.[55] We assumed that staff work 37.5 hours per week and take 37 days or 7.4 weeks of annual leave (inclusive of public holidays).

109. For NHS HCHS staff, we used NHS Staff Earnings Estimates, June 2022.[56] For those doing the OMMT tier 1 we estimated mean pay per hour of £15.32 and for those doing the OMMT tier 2 we estimated mean pay per hour of £27.75 (both in 2022/23 prices).

110. For General Practice, we used GP Earnings and Expenses Estimates 2020/21[57] for GPs and estimates from NHS HCHS for similar roles in General Practice (e.g., nurses, admin staff). For those doing the OMMT tier 1 we estimated mean pay per hour of £15.32 and for those doing the OMMT tier 2 we estimated mean pay per hour of £43.77 (in 2022/23 prices).

111. For NHS dental workforce, we used Dental Earnings and Expenses Estimates 2020/21[58] for dentists and estimates from NHS HCHS for DCPs. The mean pay per hour was estimated at £34.05 in 2022/23 prices.

Independent healthcare workforce

112. For independent HCHS workforce, we calculated that their earnings would have a 34% margin above the weighted average earnings for those working for the NHS. This is based on the comparison of the estimated average NHS and independent healthcare salaries from two websites.[59,60] We estimated the mean pay per hour of £20.52 for those doing the OMMT tier 1 and of £37.17 for those doing the OMMT tier 2 (both in 2022/23 prices).

113. There is no data available on the earning of the independent dental workforce; moreover, the earnings reported for NHS dental workforce can also contain earnings from providing independent services. For these reasons, we assumed the mean pay per hour for

[54] Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Accessed here.

[55] NHS Terms and Conditions of Service Handbook (2002). Accessed here.

[56] NHS Digital (2022). NHS Staff Earnings Estimates, June 2022. Accessed here.

[57] NHS Digital (2022). GP Earnings and Expenses Estimates, 2020/21. Accessed here.

[58] NHS Digital (2022). Dental Earnings and Expenses Estimates, 2020/21. Accessed here.

[59] Payscale. Average salary for the National Health Service (NHS) employees in United Kingdom.

[60] Totaljobs. What is the average salary for Private Healthcare jobs?

independent dental workforce is the same as the estimated mean pay per hour for NHS dental workforce, at £34.05 in 2022/23 prices.

Public and independent adult social care workforce

114. For ASC, we used SfC ASC Workforce Statistical Appendix 2021/22.[61] The mean pay per hour for public ASC workforce was estimated at £15.87 in 2022/23 prices and the mean pay per hour for independent ASC workforce was estimated at £10.86 per hour. Based on conversations with SfC, we assumed that there is no difference in pay between staff who will be doing the OMMT tier 1 and those who will be doing the OMMT tier 2.

Option 1: monetised costs

Size of health and adult social care workforce receiving tier 1 or tier 2

115. Table 2 below summarises our estimates of the size of each staff group who are expected to take the OMMT tier 1 and tier 2 packages at the start of training roll-out in 2023/24. For ASC, the available workforce statistics do not provide data by staff role and we relied on guidance from SfC that 63% of all ASC staff will require the OMMT tier 1 and 37% will require the OMMT tier 2. The figures are based on headcount statistics (or registrants' numbers in the case of independent dentists and DCPs) in healthcare and on filled posts in ASC. (For data sources, please see refer to the earlier section 'Yearly changes to the size of the healthcare and social care workforce: growth and turnover'.)

116. Overall, we calculated that, to the nearest million, 1.6 million health and care staff will require the OMMT tier 1 and 1.5 million will require the OMMT tier 2, totalling to approximately 3.1 million workers.

Table 2. Estimated size of health and adult social care staff groups in 2023/24, split by tier 1 and tier 2 participants under Option 1 (headcount or filled posts, rounded to the nearest thousand, and proportion).

Staff group	Tier	Headcount / Filled posts	Proportion
NHS HCHS	Tier 1	685,000	48%
	Tier 2	733,000	52%
	Total	**1,418,000**	**100%**
General Practice	Tier 1	102,000	53%
	Tier 2	94,000	48%
	Total	**195,000**	**100%**
NHS dentists and DCPs	Tier 1	0	0%
	Tier 2	69,000	100%
	Total	69,000	**100%**
Independent HCHS	Tier 1	106,000	48%
	Tier 2	114,000	52%
	Total	**220,000**	**100%**
Independent dentists and DCPs	Tier 1	0	0%
	Tier 2	25,000	100%
	Total	25,000	**100%**
Public CQC-regulated ASC	Tier 1	113,000	63%
	Tier 2	67,000	37%

[61] Skills for Care (2021). Adult Social Care Workforce Estimates (table 4.9). Accessed here.

	Total	**181,000**	**100%**
Independent CQC-regulated ASC	Tier 1	612,000	63%
	Tier 2	360,000	37%
	Total	**972,000**	**100%**
Total combined workforce	Tier 1	1,619,000	53%
	Tier 2	1,462,000	47%
	Total	**3,082,000**	**100%**

Number of health and adult social care staff to receive the OMMT in each year

117. To calculate the number of staff that need to receive the OMMT in each year for a 3-year roll-out period, we accounted for annual workforce growth rates for each staff group and annual leavers' rates, as specified in the earlier section 'Yearly changes to the size of the healthcare and social care workforce: growth and turnover'. Below, we explain the approach to our calculations.

118. First, we calculated the expected workforce size in each year accounting for growth. Second, to calculate the number of staff that need to be trained in each year, we looked at how many of the staff already trained will remain each year (sizing the number of those who train and stay employed in the health and adult social care sectors) and how this accumulates over the 3 years. Specifically, we did this by:

    for year one

    - specifying a percentage of staff to be trained and calculating the number of staff to receive training,
    - then applying the leavers' rate to those trained in the year to calculate how many have been trained and are retained.

    from year two onwards

    - specifying a percentage of staff to be trained in each year and calculating the number of staff to receive training in each year,
    - then applying the leavers' rate to those trained in the year to calculate how many have been trained and retained, and
    - applying the leavers' rate to everyone who was trained and retained in the previous year, as some of those members of staff will also leave in the following year,
    - adding the number of staff trained and retained across all years to arrive at a cumulative total of trained and retained staff.

    Using this method, we were able to find the percentage of staff that need to be trained each year so that all staff that remain employed in the health and care sectors at the end of year 3 are trained. Where possible, we set the percentage to be the same in each year to even the roll-out.

119. These percentages were different across staff groups due to different growth and leavers' rates, they ranged from 36% to 39% of staff to be trained each year to reach the maximum number of trained and retained staff at the end of the 3-year roll-out period. Note that it is not possible to reach 100% of staff in any given year, because there will still be turnover in the final year of the roll-out, meaning that some people who receive training that year will still leave and will be replaced by joiners who are new to the healthcare and adult social care sectors and, therefore, who have not had the OMMT. The maximum cumulative

proportion of trained and retained staff is '100% - leavers' rate', which is 91% for healthcare and 88% for ASC.

120. From year 4 onwards, we estimate the workforce size by accounting for annual growth and we calculate the number of staff who require training refreshers and the number of new members of staff, who are either filling newly created posts as the workforce expands or filling existing posts but are recruited from outside the healthcare or ASC settings. Specifically, we do this by:

- taking the number of staff who were trained and retained 3 years ago (e.g., in year one for year 4 calculations) and applying the annual leavers' rate for each year between first training and the refresh session to estimate how many are still employed in the health and social care sector and, therefore, need a refresher,
- finding the number of joiners to train by subtracting the cumulative number of staff trained and retained in previous years (e.g., after three years for year 4 calculation) from the estimated workforce size in the following year to arrive at the number of untrained staff (while following the same methodology as described in paragraph 118 to continue estimating the cumulative number of staff trained and retained).

Table 3 below shows the number of staff that should receive training for each year of the appraisal period under Option 1.

Table 3. Number of staff to receive training each year under Option 1 (rounded and expressed in thousands).

Staff group	23/24	24/25	25/26	26/27	27/28	28/29	29/30	30/31	31/32	32/33
NHS HCHS – T1	260	268	269	284	293	296	258	266	270	239
NHS HCHS – T2	279	284	276	295	301	296	263	269	265	239
GP – T1	38	38	39	39	40	40	34	35	35	31
GP – T2	36	35	36	38	38	39	34	34	35	31
NHS dentists and DCPs – T2	26	26	26	26	26	27	23	23	23	20
Independent HCHS – T1	40	42	42	44	45	46	40	41	42	37
Independent HCHS – T2	43	44	43	46	47	46	41	42	41	37
Independent dentists and DCPs – T2	10	11	11	11	12	12	11	11	12	10
Public ASC – T1	44	45	42	45	45	44	38	39	38	34
Public ASC – T2	26	26	25	26	27	26	23	23	22	20
Independent ASC – T1	239	241	229	243	245	238	208	210	204	182
Independent ASC – T2	140	141	134	143	144	140	122	123	120	107

Cost of providing training sessions under Option 1

121. Option 1 represents an optimal roll-out of the OMMT, with dedicated Government funding to aid the roll-out, where as many organisations as feasible become accredited providers of the OMMT to deliver training sessions in-house. Based on conversations with HEE, we assumed that the vast majority of public healthcare workforce (90%) would be able to receive training in-house. We have not consulted with independent healthcare providers;

as they would not receive Government funding under this option and to avoid making assumptions that would lower the costs to business estimations, we assumed that 100% of the independent healthcare workforce would receive procured training from a third party. For ASC, we relied on the *'State of the adult social care sector and workforce in England: 2022'*[62] report from SfC, which showed that about half of ASC workforce are employed by small-to-medium enterprises (SMEs) with fewer than 250 members of staff and about half are employed by large independent organisations. It is likely to be less feasible for SMEs to deliver the OMMT in-house. We, therefore, assumed that even with funding only 50% of independent ASC workforce (i.e., those working in large organisations) would be able to receive the OMMT in-house and that 100% of public ASC workforce would receive procured training from a third party.

122. To calculate the cost of training sessions for all staff groups in each year of the appraisal period, we multiplied the number of staff to receive training each year by the cost of tier 1 and tier 2 sessions, while adding venue hire and travel where applicable, as described in sections: 'cost of a tier 1 session', 'cost of a tier 2 session' and 'cost of refresher sessions'. These costs are shown in table 4 below.

Table 4. Cost of training sessions per year under Option 1 (in £millions in 2022/23 prices, discounted).

Staff group	23/24	24/25	25/26	26/27	27/28	28/29	29/30	30/31	31/32	32/33
NHS HCHS – T1	1.7	1.7	1.7	1.7	1.7	1.7	1.4	1.4	1.4	1.1
NHS HCHS – T2	9.4	9.2	8.6	8.9	8.8	8.3	7.2	7.1	6.8	5.9
GP – T1	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.1	2.1
GP – T2	1.2	1.1	1.1	1.1	1.1	1.1	0.9	0.9	0.9	0.8
NHS dentists and DCPs – T2	0.9	0.8	0.8	0.8	0.8	0.8	0.7	0.6	0.6	0.5
Independent HCHS – T1	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.2	0.2
Independent HCHS – T2	1.6	1.6	1.5	1.6	1.5	1.5	1.3	1.2	1.2	1.0
Independent dentists and DCPs – T2	0.4	0.4	0.4	0.4	0.4	0.4	0.3	0.3	0.3	0.3
Public ASC – T1	0.3	0.3	0.3	0.3	0.3	0.3	0.2	0.2	0.2	0.2
Public ASC – T2	1.4	1.3	1.2	1.2	1.2	1.1	1.0	0.9	0.9	0.8
Independent ASC – T1	1.7	1.7	1.5	1.6	1.5	1.5	1.3	1.1	1.1	0.9
Independent ASC – T2	6.0	5.9	5.4	5.5	5.4	5.0	4.2	4.1	3.9	3.3
Total workforce	**25.1**	**24.7**	**23.1**	**23.7**	**23.3**	**22.1**	**18.8**	**18.5**	**17.7**	**15.2**

Cost of a central support team

123. Based on advice from HEE, we assumed that the central team would consist of a Programme Lead (0.5FTE, AfC Band 8b), a Programme Manager and a Stakeholder Manager (both at 1FTE, AfC Band 8a), a Project Manager (1FTE, AfC Band 6), EbEs (1FTE, AfC Band 5) and an Administrative Assistant (1FTE, AfC Band 4). We applied

[62] Skills for Care (2022). State of the adult social care sector and workforce in England: 2022. Accessed here.

oncosts and overheads at 48% to the intermediate step points of the AfC bands. This resulted in a cost of £319,929 per year in 2022/23 prices.

124. The team would support the roll-out of the OMMT across both public healthcare and all ASC workforce, providing governance, communications and support with monitoring the roll-out. The assumption is that a new team would need to be recruited solely for the purpose of delivering the OMMT, an alternative could be that existing posts are used to resource the delivery, which would not be associated with additional costs but would be associated with opportunity costs.

Costs related to in-house delivery of the OMMT tiers 1 and 2 under Option 1

125. After estimating the proportion of workforce in each staff group who could feasibly receive the OMMT packages in-house under Option 1 (see paragraph 121), we calculated the number of EbEs and co-trainers needed for this option. This is based on the number of people that should be trained, divided by the number of working hours an EbE and co-trainer have in a year to deliver sessions and accounting for a 10% leavers' rate (i.e., assuming that 10% of recruited EbEs or co-trainers would stop delivering the OMMT each year). To estimate the number of hours an EbE or co-trainer would spend on delivering sessions, we assumed that EbEs, on average, would work at 0.5 FTE and co-trainers would work at 1 FTE, we allowed for 20% headroom (e.g., to account for sickness, professional development, and other such activities) and we accounted for the session preparation time (please see paragraph 68 for tier 1 and 73 for tier 2). Table 5 shows the number of EbEs and co-trainers that need to be recruited each year to deliver the OMMT in-house sessions under Option 1.

Table 5. Number of EbEs and co-trainers to recruit for delivering the OMMT in-house under Option 1.

	23/24	24/25	25/26	26/27	27/28	28/29	29/30	30/31	31/32	32/33
EbEs	200	23	16	32	25	19	-	18	18	-
Co-trainers	87	10	7	14	11	8	-	8	8	-

126. After calculating the number of EbEs and co-trainers needed to be recruited in each year, we multiplied them by the costs of recruitment, 'train the trainer' sessions and employment support sessions (see section 'Costs related to in-house delivery of the OMMT tiers 1 and 2'). The total costs are shown in table 6.

Table 6. Breakdown of costs related to the in-house delivery of OMMT under Option 1 (in £ thousands, 2022/23 prices, discounted).

	23/24	24/25	25/26	26/27	27/28	28/29	29/30	30/31	31/32	32/33
Recruitment	252	33	23	41	31	25	-	22	21	-
Support into employment	48	5	4	7	5	4	-	3	3	-
'Train the trainer'	356	311	299	6	4	3	-	3	2	-

Opportunity costs under Option 1

127. To calculate the opportunity cost of undertaking the OMMT, we multiplied the number of staff in each staff group that would take either tier 1 or tier 2 by the hours they would

spend on training and their mean annual earnings, as derived in the section 'Mean annual earnings for healthcare and social care staff groups'. It is not clear how much of the OMMT tier 1 and tier 2 packages can be absorbed under existing contractual allowances for training time. Based on conversations with HEE and SfC, we assumed that the 1.5-hour e-learning element would be absorbed by healthcare staff Continuing Professional Development (CPD) across all settings but that none of the OMMT would be absorbed in such provision for ASC. The opportunity costs are presented in table 7 below.

128. In our sensitivity analysis, we vary this assumption under worst-case and best-case scenarios to demonstrate how it affects the estimated economic costs of the options and we provide break-even analysis to demonstrate how much of the OMMT needs to be absorbed in CPD/headroom for the policy net present value to be zero.

Table 7. Opportunity costs per year for each staff groups under Option 1 (in £millions in 2022/23 prices, discounted).

Staff group	23/24	24/25	25/26	26/27	27/28	28/29	29/30	30/31	31/32	32/33
NHS HCHS	62.0	61.1	57.4	59.2	58.4	55.7	47.8	47.2	45.1	39.2
GP	12.3	11.8	11.6	11.8	11.4	11.2	9.5	9.2	9.1	7.8
NHS dentists and DCPs	6.6	6.4	6.2	6.0	5.9	5.7	4.8	4.6	4.5	3.8
Independent HCHS	12.9	12.7	11.9	12.4	12.2	11.6	10.0	9.8	9.4	8.2
Independent dentists and DCPs	2.6	2.6	2.6	2.6	2.7	2.7	2.2	2.3	2.2	1.9
Public ASC	5.5	5.3	4.9	5.0	4.9	4.6	3.9	3.8	3.5	3.0
Independent ASC	20.2	19.7	18.0	18.6	18.1	16.9	14.3	13.9	13.1	11.3
Total workforce	**122.0**	**119.7**	**112.7**	**115.6**	**113.5**	**108.4**	**92.4**	**90.8**	**86.9**	**75.2**

Summary of all costs under Option 1

129. In summary, we estimate that Option 1 will cost £1,265.1m expressed in 2022/23 prices and discounted for future years of the 10-year roll out period. Table 8 below present a summary of all costs under this option.

Table 8. Summary of total costs for Option 1 (in £millions in 2022/23 prices, discounted).

	23/24	24/25	25/26	26/27	27/28	28/29	29/30	30/31	31/32	32/33	Total
Training sessions	25.1	24.7	23.1	23.7	23.3	22.1	18.8	18.5	17.7	15.2	212.2
Central support team	0.3	0.3	0.3	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.9
In-house delivery costs	0.7	0.4	0.3	0.1	0.0	0.0	-	0.0	0.0	-	1.5
Opportunity costs	122.0	119.7	112.7	115.6	113.5	108.4	92.4	90.8	86.9	75.2	1,037.1
Total	**148.1**	**145.0**	**136.4**	**149.3**	**136.8**	**130.5**	**111.3**	**109.3**	**104.6**	**90.4**	**1,251.8**

Opportunity cost of DHSC/NHSE funding under Option 1

130. Option 1 shows the optimal OMMT roll-out and assumes that funding will be provided to public healthcare and all ASC organisations to support the roll-out period, i.e., it will be provided for 3 years. Under this assumption, DHSC/NHSE will require £75.2m (in 2022/23 prices, discounted) to cover the costs of the training sessions, the central support team, and the in-house delivery route. There is an associated opportunity cost such that funding could be spent on other DHSC/NHSE programmes and in turn lead to further health impacts in the NHS or the wider health and social care system. To quantify this into Quality Adjusted Life Years (QALYs), we divided the cost by £15,000 (the cost per QALY in impact assessments). Therefore, the opportunity cost of funding Option 1 is estimated to be 5,188 QALYs, or a societal value of £363.2 million (the societal value of a QALY is valued at £70,000).

Summary of NHS cost impacts under Option 1 (preferred DHSC measure)

131. Option 1 is associated with the total costs of £808.4m for public healthcare, which cover training sessions and opportunity costs across NHS HCHS, GP and NHS dentists and DCPs over the 10-year appraisal period (in 2022/23 prices, discounted). These costs can be converted to foregoing 53,894 QALYs (valued at £15,000) or £3,772.6m in societal value (where each QALY is valued at £70,000).

Option 2: monetised costs

Size of health and adult social care workforce receiving tier 1 or tier 2

132. Under Option 2, we assume that the funding provided by DHSC/NHSE would not cover all financial costs associated with the optimal roll-out of the OMMT and there would not be a central support team for the roll-out. Consequently, we assume that this would influence how service providers interpret the code of practice and decide which members of staff need which component of the OMMT packages. In the central (best estimate) scenario we assume that 20% of the public healthcare and total ASC workforce who would have taken the OMMT tier 2 under optimal roll-out would do the OMMT tier 1 instead and 20% of the same workforce who would have taken the full OMMT tier 1 under optimal roll-out would do just the e-learning component instead. This assumption is highly uncertain – we will seek views to substantiate it during the consultation process and we will reflect an updated position in the final stage IA. In the meantime, we included variations to this assumption in our sensitivity analysis under best-case and worst-case scenarios.

133. For independent healthcare workforce, we did not introduce any similar assumptions and instead assumed that all staff members would either take the full tier 1 or the full tier 2 packages, as intended for their role.

134. Table 9 below shows the estimated size of staff groups taking each training component in 2023/24 (please refer to paragraph 115 for details of calculations).

Table 9. Estimated size of health and adult social care staff groups in 2023/24, split by e-learning only, tier 1 and tier 2 participants under Option 2 (headcount or filled posts, rounded to the nearest thousand, and proportion).

Staff group	Tier	Headcount / Filled posts	Proportion
NHS HCHS	E-learning only	285,000	20%
	Tier 1	683,000	48%
	Tier 2	451,000	32%
	Total	**1,418,000**	**100%**
General Practice	E-learning only	39,000	20%

	Tier 1	103,000	53%
	Tier 2	55,000	28%
	Total	**196,000**	**100%**
NHS dentists and DCPs	E-learning only	0	0%
	Tier 1	14,000	20%
	Tier 2	56,000	80%
	Total	**70,000**	**100%**
Independent HCHS	Tier 1	106,000	48%
	Tier 2	114,000	52%
	Total	**220,000**	**100%**
Independent dentists and DCPs	Tier 1	0	0%
	Tier 2	26,000	100%
	Total	**26,000**	**100%**
Public CQC-regulated ASC	E-learning only	36,000	20%
	Tier 1	113,000	63%
	Tier 2	31,000	17%
	Total	**180,000**	**100%**
Independent CQC-regulated ASC	E-learning only	194,000	20%
	Tier 1	612,000	63%
	Tier 2	165,000	17%
	Total	**972,000**	**100%**
Total combined workforce	E-learning only	554,000	18%
	Tier 1	1,632,000	53%
	Tier 2	898,000	29%
	Total	**3,082,000**	**100%**

Number of health and adult social care staff to receive the OMMT in each year

135. Under Option 2, we assumed the roll-out would take 5 years to complete, however, refreshers would need to be provided at least every 3 years to staff member who had already taken the training in line with the code of practice. To calculate the numbers of staff in each group that would receive each component of the OMMT, we followed the methodology described for Option 1 with the 5-year roll-out parameter (paragraphs 117-120). These figures are shown in table 10 below.

Table 10. Number of staff to receive training each year under Option 2 (rounded and expressed in thousands).

Staff group	23/24	24/25	25/26	26/27	27/28	28/29	29/30	30/31	31/32	32/33
NHS HCHS – E-learning only	74	76	76	133	137	96	144	149	90	130
NHS HCHS – T1	178	183	181	320	330	230	347	358	215	312
NHS HCHS – T2	113	115	117	204	207	143	216	219	131	191
GP – E-learning only	10	10	10	17	17	12	17	18	10	15

GP – T1	26	26	26	45	45	31	46	47	28	40
GP – T2	14	14	14	25	25	18	26	27	16	23
NHS dentists and DCPs – T1	3	3	4	6	6	4	6	6	4	5
NHS dentists and DCPs – T2	14	14	14	24	24	16	24	24	14	21
Independent HCHS – T1	40	42	42	44	45	46	40	41	42	37
Independent HCHS – T2	43	44	43	46	47	46	41	42	41	37
Independent dentists and DCPs – T2	10	11	11	11	12	12	11	11	12	10
Public ASC – E-learning only	9	9	10	16	16	11	16	16	10	14
Public ASC – T1	29	30	30	50	50	36	51	52	31	43
Public ASC – T2	8	8	8	13	14	10	14	14	8	12
Independent ASC – E-learning only	51	51	51	86	87	61	88	89	54	74
Independent ASC – T1	159	161	162	270	273	193	277	279	170	234
Independent ASC – T2	43	43	44	73	74	52	75	75	46	63

Cost of providing training sessions under Option 2

136. As described in paragraph 121, based on input from HEE and SfC, we assumed that 90% of public healthcare and 50% of independent ASC workforce could receive the OMMT sessions in-house, as their employers would become accredited providers. In-house delivery is associated with a lower cost for the employers and is advantageous over the longer term, as once the training team is established, they can deliver both the initial roll-out and future refresher sessions, although it likely requires more effort in the shorter term than procuring training sessions. Elements of this approach have already started, as HEE began running initial 'train the trainer' sessions at the end of 2022. We, therefore, maintained the assumption that most NHS employers (90%) would wish to become accredited providers (even if lower levels of funding are offered). However, for independent ASC, we lowered the assumed proportion of workforce that would receive the OMMT sessions in-house to 30% to reflect the plausible influence of lower funding.

137. To calculate the cost of training sessions for all staff groups in each year of the appraisal period under Option 2, we multiplied the number of staff to receive training each year by the cost of tier 1 and tier 2 sessions, while adding venue hire and travel where applicable, as described in sections: 'cost of a tier 1 session', 'cost of a tier 2 session' and 'cost of refresher sessions'. These costs are shown in table 11 below.

Table 11. Cost of training sessions per year under Option 2 (in £thousands and £millions in 2022/23 prices, discounted).

Staff group	23/24	24/25	25/26	26/27	27/28	28/29	29/30	30/31	31/32	32/33

NHS HCHS – T1	1.2	1.1	1.1	1.9	1.9	1.3	1.9	1.9	1.1	1.6
NHS HCHS – T2	3.8	3.7	3.7	6.2	6.1	4.1	5.9	5.8	3.4	4.7
GP – T1	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.1
GP – T2	0.5	0.5	0.5	0.8	0.8	0.5	0.7	0.7	0.4	0.6
NHS dentists and DCPs – T2	0.5	0.5	0.4	0.7	0.7	0.5	0.7	0.7	0.3	0.6
Independent HCHS – T1 (£millions)	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.2	0.2
Independent HCHS – T2 (£millions)	1.6	1.6	1.5	1.6	1.5	1.5	1.3	1.2	1.2	1.0
Independent dentists and DCPs – T2 (£millions)	0.4	0.4	0.4	0.4	0.4	0.4	0.3	0.3	0.3	0.3
Public ASC – T1	0.2	0.2	0.2	0.4	0.3	0.2	0.3	0.3	0.2	0.2
Public ASC – T2	0.4	0.4	0.4	0.6	0.6	0.4	0.6	0.6	0.3	0.4
Independent ASC – T1 (£millions)	1.2	1.2	1.1	1.8	1.8	1.2	1.6	1.6	1.0	1.2
Independent ASC – T2 (£millions)	2.0	1.9	1.9	3.1	2.9	2.0	2.8	2.8	1.6	2.2
Total workforce	**12.3**	**12.1**	**11.8**	**18.0**	**17.6**	**12.6**	**16.7**	**16.3**	**10.3**	**13.2**

Costs related to in-house delivery of the OMMT tiers 1 and 2 under Option 2

138. After estimating the proportion of workforce in each staff group who might receive the OMMT packages in-house under Option 2 (see paragraphs 121 and 136), we calculated the number of EbEs and co-trainers needed for this option using the same methodology as described for Option 1 in paragraph 125. Table 12 shows the number of EbEs and co-trainers that need to be recruited each year to deliver the OMMT in-house sessions under Option 2.

Table 12. Number of EbEs and co-trainers to recruit for delivering the OMMT in-house under Option 2.

	23/24	**24/25**	**25/26**	**26/27**	**27/28**	**28/29**	**29/30**	**30/31**	**31/32**	**32/33**
EbEs	83	10	9	71	17	-	34	18	-	9
Co-trainers	34	4	4	29	7	-	14	7	-	4

139. After calculating the number of EbEs and co-trainers needed to be recruited in each year, we multiplied them by the costs of recruitment, ‘train the trainer’ sessions and employment support sessions (see section ‘Costs related to in-house delivery of the OMMT tiers 1 and 2’). The total costs are shown in table 13.

Table 13. Breakdown of costs related to the in-house delivery of OMMT under Option 2 (in £ thousands, 2022/23 prices, discounted).

	23/24	**24/25**	**25/26**	**26/27**	**27/28**	**28/29**	**29/30**	**30/31**	**31/32**	**32/33**
Recruitment	106	17	16	82	23	-	38	22	-	13
Support into employment	20	5	2	19	4	-	7	4	-	2

'Train the trainer'	332	309	298	297	279	-	5	2	-	1

Opportunity costs under Option 2

140. To calculate the opportunity cost of undertaking the OMMT, we multiplied the number of staff in each staff group that would take either just the e-learning, the full tier 1 or the full tier 2 by the hours they would spend on training and their mean annual earnings, as derived in the section 'Mean annual earnings for healthcare and social care staff groups'. It is not clear how much of the OMMT tier 1 and tier 2 packages can be absorbed under existing contractual allowances for training time. Based on conversations with HEE and SfC, we assumed that the 1.5-hour e-learning element would be absorbed by healthcare staff CPD across all settings but that none of the OMMT would be absorbed in such provision for ASC. The opportunity costs are presented in table 14 below.

141. In our sensitivity analysis, we vary this assumption under worst-case and best-case scenarios to demonstrate how it affects the estimated economic costs of the options and we provide break-even analysis to demonstrate how much of the OMMT needs to be absorbed in CPD/headroom for the policy net present value to be zero.

Table 14. Opportunity costs per year for each staff groups under Option 2 (in £millions in 2022/23 prices, discounted).

Staff group	23/24	24/25	25/26	26/27	27/28	28/29	29/30	30/31	31/32	32/33
NHS HCHS	26.2	25.9	25.4	42.8	42.0	28.1	40.8	40.1	23.2	32.7
GP	4.9	4.8	4.8	8.0	7.9	5.3	7.6	7.5	4.4	6.1
NHS dentists and DCPs	3.7	3.6	3.5	5.7	5.4	3.6	5.3	5.0	2.9	4.1
Independent HCHS	12.9	12.7	11.9	12.4	12.2	11.6	10.0	9.8	9.4	8.2
Independent dentists and DCPs	2.6	2.6	2.6	2.6	2.7	2.7	2.2	2.3	2.2	1.9
Public ASC	2.5	2.5	2.4	3.9	3.8	2.6	3.6	3.5	2.0	2.7
Independent ASC	9.3	9.1	8.9	14.3	13.9	9.6	13.2	12.9	7.6	10.1
Total workforce	**62.2**	**61.2**	**59.4**	**89.7**	**87.9**	**63.3**	**82.7**	**81.1**	**51.7**	**65.9**

Summary of all costs under Option 2

142. In summary, we estimate that Option 2 will cost £847.9 million expressed in 2022/23 prices and discounted for future years of the 10-year roll out period. Table 15 below presents a summary of all costs under this option.

Table 15. Summary of total costs for Option 2 (in £millions in 2022/23 prices, discounted).

	23/24	24/25	25/26	26/27	27/28	28/29	29/30	30/31	31/32	32/33	Total
Training sessions	12.3	12.1	11.8	18.0	17.6	12.6	16.7	16.3	10.3	13.2	140.9
In-house delivery costs	0.5	0.3	0.3	0.4	0.3	-	0.1	0.0	-	0.0	1.9
Opportunity costs	62.2	61.2	59.4	89.7	87.9	63.3	82.7	81.1	51.7	65.9	705.1

Total	**74.9**	**73.7**	**71.5**	**108.1**	**105.8**	**76.0**	**99.4**	**97.5**	**62.0**	**79.1**	**847.9**

Summary of NHS cost impacts under Option 2 (preferred DHSC measure)

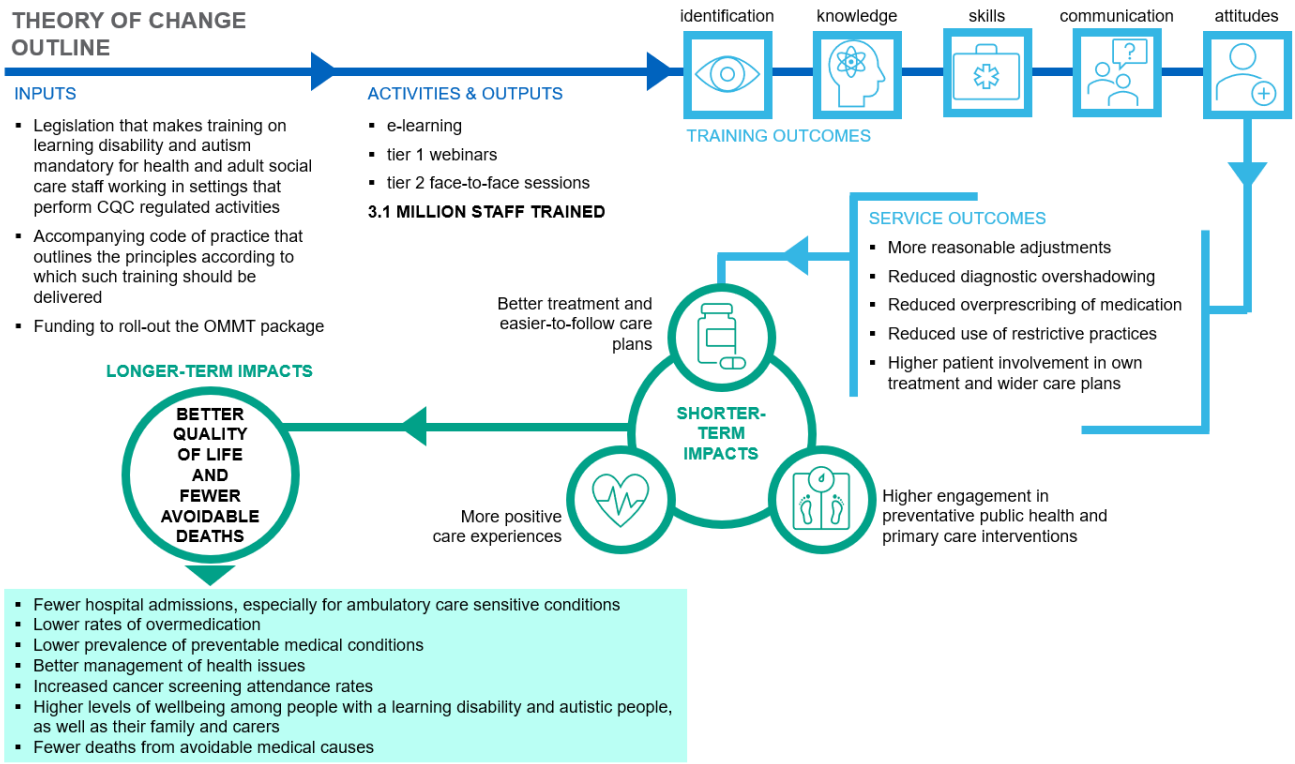
143. Option 2 is associated with the total costs of £507.0m for public healthcare, which cover training sessions and opportunity costs across NHS HCHS, GP and NHS dentists and DCPs over the 10-year appraisal period (in 2022/23 prices, discounted). These costs can be converted to foregoing 33,800 QALYs (valued at £15,000) or £2,366.0m in societal value (where each QALY is valued at £70,000).

Benefits of Options 1 and 2

Outline of the theory of change

144. To illustrate our approach to estimating the potential benefits of rolling out the OMMT under both options, we provide an outline of the theory of change for this intervention in figure 1 and summarised in text below. This is not intended to be comprehensive.

Figure 1. Theory of change outline for the Oliver McGowan Mandatory Training roll-out.



Inputs – legislation that makes training on learning disability and autism mandatory for health and adult social care staff working in settings that perform CQC regulated activities; accompanying code of practice that outlines how such training should be delivered; and expenditure on training.

Activities – training sessions and their components (i.e., completion of e-learning module, online webinar, face-to-face session).

Outputs – number of trained health and adult social care staff working in settings that perform CQC regulated activities.

Training outcomes – increased staff knowledge; increased ability to recognise patients with a learning disability and autistic patients; better skills in working with them; better ability to communicate in an accessible way; more positive attitudes.

Service outcomes – higher provision of reasonable adjustments; reduced diagnostic overshadowing; reduced overprescribing of medication; reduced use of restrictive practices; higher patient involvement in own treatment and wider care choices.

Shorter-term impacts – more positive experience of care provision; higher engagement in preventative public health and primary care interventions; more effective health care treatment and more adherence to treatment and care.

Longer-term impacts – reduced hospital admissions, especially for ambulatory care sensitive conditions;[63] lower rates of overmedication; reduced prevalence of preventable medical conditions; better management of morbidity rates; increased cancer screening attendance rates; higher levels of wellbeing among people with a learning disability and autistic people, as well as their family and carers; reduced mortality associated with avoidable medical causes of death.

Assessing the scale of outputs: number of staff trained over time

145. In calculating the monetised benefits, we account for the rising cumulative proportion of staff that receive training during the roll-out period. Table 16 below shows the percentage of trained staff in relation to the total workforce size across regulated health and adult social care. Option 1, the optimal roll-out, is associated with a higher level of monetised benefit than Option 2 due to the maximised proportion of the workforce having received training.

146. We assumed that the ratio between the number of staff trained and the amount of benefits realised remains the same across both options. In practice, it may be that under Option 2 health and social care employers will prioritise training for staff who have the highest chance of coming in contact with people with a learning disability and autistic people, and who therefore have the greatest potential to make changes to how care is provided to these people. In this case, the ratio of number of staff trained and amount of benefit realised would be greater for Option 2 than for Option 1. However, we have not modelled this possibility as we do not have any evidence to substantiate or quantify it.

Table 16. Proportion of trained staff across the appraisal period under Options 1 and 2.

	23/24	24/25	25/26	26/27	27/28	28/29	29/30	30/31	31/32	32/33
Option 1	34%	64%	90%	90%	90%	90%	90%	90%	90%	90%
Option 2	20%	37%	52%	64%	73%	73%	73%	73%	73%	73%

147. We also account for a decline in knowledge and skills after training. Based on wider literature, the average rate of such decline when out of practice is reported to be between 5% to 15%, and the decline is fastest at the beginning and fading over time.[64] The NDTi evaluation found that most participants stated that the gains in their knowledge and skills were maintained at the 2-3 months follow-up after completing training, although this is

[63] "Ambulatory care sensitive conditions (ACSCs) are those for which prevention or effective management in primary care should decrease the risk of acute hospitalisation and are widely used as an indicator of access to, and quality of, primary care." Hosking et al (2017) Preventable Emergency Hospital Admissions among Adults with Intellectual Disability: comparisons with the general population in England. *Annals of Family medicine.* Accessed here.

[64] Oates, J. (2014). *Skills fade: a review of the evidence that clinical and professional skills fade during time out of practice, and how skills fade may be measured or remediated.* General Medical Council. http://www.gmc-uk.org/about/research/26013.asp

based on self-reported data. We therefore assume the effect of OMMT will decline by 10% (as the midpoint of 5% to 15%) after the first year of roll-out, with this fading over time.

Assessing the scale of training outcomes

148. The NDTi evaluation of the OMMT trial provides a direct assessment of learning outcomes among training participants. The report states that for both tier 1 and tier 2 packages "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."[65] (NDTi report pages 38 and 69)

These improvements were maintained 2-3 months after the training, as measured through follow-up surveys.

149. The rapid evidence review of outcomes from previous training found that staff skills, knowledge and attitudes improved after training, with maintenance of the improvement continuing up to 1 year post-training.

- Knowledge increases were seen immediately post training in most studies, ranging from 11% to 71%.[66,67] Increases in knowledge were also maintained up to a year post-training.[73]
- Communication skills were reportedly improved, with 80% of participants using the skills learnt in practice up to 6 weeks post-training.[68]
- Confidence was regularly significantly increased post-training and was maintained over time. One study reported confidence increasing by 9% between immediate post-training assessment and 1 year follow up.[69]

[65] National Development Team for Inclusion (2022). Evaluation of the Oliver McGowan Mandatory Training Trial in Learning Disability and Autism. Accessed here.

[66] Ashworth Sarah, Tully Ruth J. Advances in Autism 2017;3(4): 240-249. Available here

[67] Nancarrow Thomas, Rencher Joshua, Wilcock Mike, Bonell Simon, Wolke Tony, Shankar Rohit. British Journal of Learning Disabilities 2019;47(3): 181-187. Available here

[68] Wilkinson, K., Gumm, R., Hambly, H., Logan, S., & Morris, C. (2021) Implementation of training to improve communication with disabled children on the ward: A feasibility study. Health Expectations, 24, 1438-1447. Accessed here: 10.1111/hex.13283

[69] Long, J., Butchart, M., Brown, M., Bain, J., McMillan, A., & Karatzias, T. Improving vision awareness in autism services: Evaluation of a dedicated education programme for support practitioners. Journal of Applied Research in Intellectual Disabilities, 31(2), e244-e252. Accessed here: 10.1111/jar.12330

- Attitudes towards people with a learning disability also changed after training, with significant increases in positive attitudes towards people with a learning disability post-training.[70,71]

Assessing the scale of service outcomes

150. The NDTi evaluation of the OMMT trial provides some evidence towards the possible service outcomes as a result of training, where the data is based on self-reported behaviour change among professionals. The report highlights that

    - 63-72% of tier 1 participants, who had come into contact with a person with a learning disability or an autistic person since the training, reported that they had done things differently to support them; and

    - 61-88% of tier 2 participants, who had come into contact with a person with a learning disability or an autistic person since the training, reported that they had done things differently to support them.

    These indicators for the effectiveness of training are further supported by qualitative evidence from interviews with training participants. Such evidence suggests training increased the provision of reasonable adjustments in some instances: "*I now regularly ask before my first visit if there are things they like or don't like so I can adapt my practice."*[72] (NDTi report page 75)

    In addition, the evaluation report shows that

    - 27-44% of tier 1 participants, who said that they could make changes to how things are done in their workplace, reported doing so after taking the training; and

    - 27-43% of tier 2 participants, who said that they could make changes to how things are done in their workplace, reported doing so after taking the training.

    Such evidence suggests that in some instances training can lead to organisational or culture change that can improve service provision, as supported in qualitative insights: "*Helped create a new pathway with more support for bowel cancer screening for people with a learning disability."*[73] (NDTi report page 76)

151. The rapid evidence review found evidence of improved service outcomes after training in healthcare environments. Some of the studies found:

    - Increased understanding and confidence around a subject led to immediate changes in the way an individual communicated with families and patients in clinical environments.[71,74]

[70] Nolan, A., & Hannah, E. (2019) Impact of training in Autism on inclusive practices. Advances in Autism, 5(2), 94-106. Accessed here: 10.1108/AIA-03-2018-0008

[71] Bailey A, Barr O, and Bunting B. (2001) Police attitudes toward people with intellectual disability: an evaluation of awareness training. Journal of Intellectual Disability Research; 45(4): 344-350. Accessible here: 10.1046/j.1365-2788.2001.00339.x

[72] National Development Team for Inclusion (2022). Evaluation of the Oliver McGowan Mandatory Training Trial in Learning Disability and Autism. Accessed here.

[73] National Development Team for Inclusion (2022). Evaluation of the Oliver McGowan Mandatory Training Trial in Learning Disability and Autism. Accessed here.

[74] Mugweni E, Lowenhoff C, Walker M, Jaswal S, Emrys-Jones A, Adams C, and Kendall S.(2020) The feasibility of a multi-professional training to improve how health care professionals deliver different news to families during pregnancy and at birth. Child Care Health Dev. 46: 506-512. Accessible here: https://doi.org/10.1111/cch.12758

- Increased discussion with patients using skills, understanding and knowledge obtained from the training, including higher rates of inclusivity when making medical decisions and planning treatment.[75]

- Training also led to changes in clinical environments, including reasonable adjustments to the waiting environment, documentation and adaption to remove the barriers people with a learning disability may face.[72]

Assessing the scale of change to shorter-term and longer-term impacts

152. The NDTi evaluation of the OMMT trial did not measure the impacts of training on health and social care provision or experiences of people with a learning disability or autistic people. To gauge the scale of potential shorter-term and longer-term impacts, we have drawn from broader related literature, noting that evidence on mandatory training specifically is very limited.

153. Out of 7,150 deaths reviewed from 2018 to 2020 through the LeDeR programme, among 1,054 (15%) there were reportedly problems with organisational systems and processes. Among 46 cases (0.65%) there were reportedly gaps in service provision, which included staff availability, training or skills (other than in specialist learning disability services), which may have contributed towards the person's death.[76] If the OMMT is fully capitalised and addresses the organisational system and process failures, it could potentially prevent these deaths, resulting in 16% reduction of avoidable deaths.

154. A cluster randomised controlled study of residents in care homes with dementia observed the change from an intervention, in which care home staff received training to increase social interaction.[77] It found that person-centred care training improved quality of life (effect size 0.2), as well as other important symptoms including agitation (effect size 0.2) and overall neuropsychiatric symptoms (effect size 0.3). These effect sizes are considered small. The study also found a statistically significant benefit in positive care interactions (20% increase; with medium effect size of 0.5).

155. A pilot study of Sensory Adapted Dental Environment (SADE) intervention aimed to reduce sensory-related distress and anxiety in autistic children facing dental treatment.[78] The study tailored the experience, using multisensory environments and sensory integration theories, with the treatment environment adapted. The study found that SADE reduced sensory-related distress and anxiety in autistic children when measuring behavioural distress (effect size 0.2), pain (effect size 0.6), and sensory discomfort (effect size 0.7). Further, the trial found that SADE increased the duration of dental cleaning, which could be associated with increased quality of dental treatment, (effect size 0.8). The effect sizes associated with reduced pain and discomfort and increased quality of treatment are considered large. These findings demonstrate the high potential effectiveness of reasonable adjustments.

[75] Carpenter J, Milne D, Lombardo C, and Dickinson C. (2007) Process and outcomes of training in psychosocial interventions in mental health: A stepwise approach to evaluation. Journal of Mental Health, 16(4), 505-520. Accessed here: 10.1080/09638230701482329

[76] University of Bristol (2020). The Learning Disabilities Mortality Review (LeDeR) Programme: Annual report. Accessed here.

[77] Ballard, C., et al. (2018). Impact of person-centred care training and person-centred activities on quality of life, agitation, and antipsychotic use in people with dementia living in nursing homes: A cluster-randomised controlled trial. PLoS medicine, 15(2), e1002500. https://doi.org/10.1371/journal.pmed.1002500

[78] Cermark, S.A., Duker, L.I.S., Williams, M.E., Dawson, M.E., Lane, C.J., & Polido, J.C. (2015). Sensory adapted dental environments to enhance oral care for children with autism spectrum disorders: a randomised controlled pilot study. *Journal of Autism and Developmental Disorders*, 45, p.2876-2888.

156. A study has found that treatments which incorporate positive behaviour support (PBS) in intellectual disability services in England, as recommended by NICE, would increase quality adjusted life years by 0.175 in 36 months, when compared to treatment as usual.[79]

157. A study following participants who attended a one-year postgraduate course in psychological interventions found that their patients post-intervention had fewer psychiatric symptoms, improved life skills and were more likely to be involved in their own care planning, diagnosis, treatment and medication (increases seen between 13% and 78%) when compared to patients of a comparator group who hadn't attended training.[76]

158. A study of Identification and Referral to Improve Safety (IRIS) intervention training for GPs to help them refer women affected by domestic violence and abuse on the right pathway found that referrals to domestic violence and abuse workers from GPs were 30 times higher than before training had occurred in these boroughs. This was also compared to a comparator borough that showed no change. These findings show that training can help professionals identify problems easier and earlier.[80]

159. A study assessing the impact of health visitors attending training on post-natal depression found that the interventions for mothers presenting with a high postnatal depression score decreased their depressive symptomatology significantly. Six months post-intervention training, the number of high postnatal depressions scores had decreased by 8%.[81]

160. A long-term study measuring the outcomes of Sexual Health in Practice (SHIP) training for GPs on HIV testing rates found that, for each GP trained, HIV testing rates increased by 16%. Six months post-training, the 16% increase remained the same and GP practices reported a 17% increase in positive HIV tests.[82]

161. Table 17 below summarised the range of impact estimates found in the evidence review. Based on this review and the results from the OMMT trial evaluation, to monetise the potential benefits of the OMMT, we assumed that it could have a small impact of improving health and wellbeing outcomes by 6% when the benefits are fully realised (the benefits are at their highest when the highest number of staff are fully trained and the fade in knowledge and skills is minimised). The 6% is conceptualised as follows: we find the number of people with a learning disability who experience a health inequality and assume that the OMMT can reduce this by 6%. For example, if 100 people with a learning disability suffer from a preventable health condition, we assume that the OMMT can reduce the number of people with a learning disability who suffer from this condition by 6 (100*6%). Due to uncertainty around this figure, we included an increase and decrease to this impact factor of 50% in our sensitivity testing (see paragraph 236).

162. A substantial limitation to our assumption that the OMMT can deliver a 6% difference in short-term and longer-term impacts is that we are applying the same scale of change independent of outcome type. This is because we did not have sufficient evidence to generate more nuanced estimate for different outcome types (e.g., engagement with public health interventions vs. reducing overall avoidable mortality). Based on the limited findings presented in table 17, we also could not produce separate estimates of the range of

[79] Hunter, R. et al. (2020). Staff training in positive behaviour support for behaviour that challenges in people with intellectual disability: Cost-utility analysis of a cluster randomised controlled trial. *BJPsych Open, 6(2), E15.* Accessed here.

[80] Sohal A, Feder G, Boomla K et al. (2020) Improving the healthcare response to domestic violence and abuse in UK primary care: interrupted time series evaluation of a system-level training and support programme. *BMC Med, 18: 48.* Accessed here.

[81] Elliott S, Gerrard J, Ashton C, and Cox J. Training health visitors to reduce levels of depression after childbirth: An evaluation. Journal of Mental Health 2001; 10(6), 613-625. Accessed here.

[82] Pillay K, Gardner M, Gould A, Otiti S, Mullineux J, Barnighausen T, and Matthews, P. Long term effect of primary health care training on HIV testing: A quasi-experimental evaluation of the Sexual Health in Practice (SHIP) intervention. PLOS ONE 2018; 13(8): e0199891. Accessed here.

uncertainty around the assumption for each monetised benefit. We have therefore tested the same range across all monetised benefits in our sensitivity testing, from 3% in worst-case scenario to 9% in best-case scenario (see paragraph 236).

Table 17. Summary of studies from the rapid evidence review which measured impact of training on service users.

Size of impact	Number of studies	Description of evaluation study	Range of estimates against outcomes
No impact	2	• Positive Behaviour Support training for health staff working with adults with learning disability and/or autistic adults and challenging behaviour.[83] Method: cluster randomised trial. Sample size: small, 113 patients. Follow-up period: 12 months.	• Outcome measure: Aberrant Behaviour Checklist total score. Estimate: no significant effect of training found.
		• Oral health training programme for adult social care staff working with elderly care home residents.[84] Method: cross-sectional study. Sample size: small, 213 residents. Follow-up period: 12 months.	• Outcome measure: oral health examination. Estimate: no significant effect of training found.
Small impact	1	• Training in postnatal depression counselling for health staff. [85] Method: cross-sectional study. Sample size: small, 64 health visitors. Follow-up period: 6 months.	• Outcome measure: Edinburgh Postnatal Depression Scale. Estimate: significant 8% decrease in high depression scores.
Medium impact	4	• Self-help parent training programme for children with ADHD.[86] Method: randomised control trial. Sample size: small, 43 children. Follow-up period: 6 weeks.	• Outcome measures: parental account of children's symptoms (PACs) and DuPaul ADHD rating scale. Estimate: significant decrease in PACS (Cohen's d = 0.73) and significant decrease in number of children meeting clinical concern level on ADHD rating scale (45% of children had a reduced concern level).
		• Postgraduate training in psychosocial interventions for mental health staff.[87] Method: cross-sectional study. Sample size: small, 129 service users. Follow-up period: 6 months.	• Outcome measures: standardised measures of mental health and Life Skills Profile questionnaire. Estimate: mental health patients had fewer psychiatric symptoms (t = -3.74) and improved self-reported life skills (t = -7.43).

[83] Strydom A., Bosco A., Vickerstaff V., Hunter R., Hassiotis A. (2020) Clinical and cost effectiveness of staff training in the delivery of Positive Behaviour Support (PBS) for adults with intellectual disabilities, autism spectrum disorder and challenging behaviour - randomised trial. *BMC Psychiatry, 20*, p.1-13. Accessed here.

[84] Simons D, Baker P, Jones B, Kidd E. (2000) An evaluation of an oral health training programme for carers of the elderly in residential homes. *British Dental Journal, 188(04)*, p.206-210. Accessed here.

[85] Elliott S, Gerrard J, Ashton C, & Cox J. (2001) Training health visitors to reduce levels of depression after childbirth: An evaluation. *Journal of Mental Health, 10(6),* p.613-625. Accessed here.

[86] Daley D, O'Brien M. (2013) A small-scale randomized controlled trial of the self-help version of the New Forest Parent Training Programme for children with ADHD symptoms. *European Child and Adolescent Psychiatry, 22*, p.543-552. Accessed here.

[87] Carpenter J, Milne D, Lombardo C, Dickinson C. (2007) Process and outcomes of training in psychosocial interventions in mental health: A stepwise approach to evaluation. *Journal of Mental Health, 16(4)*, p.505-520. Accessed here.

	• Take-home naloxone distribution and training on opiate overdose knowledge for opiate users.[88] Method: repeated-measure study. Sample size: medium, 525 participants. Follow-up period: 12 months.	• Outcome measure: overdose occurrence. Estimate: significant 32% reduction.
	• Domestic violence and abuse (DVA) training for general practice staff.[89] Method: observational time-series study. Sample size: large, 144 general practices. Follow-up period: 5 years.	• Outcome measure: daily number of referrals received by DVA workers per 1,000 women registered in a general practice. Estimate: significant increase in referrals (Incidence Risk Ratio = 30.24)
	• Sexual Health in Practice training for general practitioners.[90] Method: quasi-experimental time series. Sample size: medium, 52 general practices. Follow-up period: 8 years.	• Outcome measure: HIV testing rate. Estimate: significant 16% increase in HIV testing rates for every GP trained.

Overview of overall benefits of the OMMT

163. As explained in the theory of change outline (paragraph 144 and figure 1), the longer-term impacts of the OMMT are better quality of life and fewer avoidable deaths among people with a learning disability and autistic people. These can be expressed in terms of the societal value of reduced morbidity, better management of conditions and reduced mortality. There are also potentially benefits to the NHS in terms of cost savings, which can be realised when health conditions are prevented or diagnosed sooner, thereby reducing the need for more expensive and extensive treatment. We describe these two types of benefits under sub-headings below and explain where our assumption of 6% reduction in the health inequality applies (see paragraph 161).

Societal value of reduced morbidity, better management of conditions and reduced mortality among people with a learning disability and autistic people

164. The Health and Care of People with Learning Disabilities is an annual publication reporting on the differences in health between people with and without a learning disability.[91] Data is collected from participating GP surgeries (56% of the GP surgeries in England) for different indicators looking at the prevalence of certain conditions, such as obesity and dementia, and participation in public health interventions, such as health checks and cancer screening. Based on this and other evidence, we know that people with a learning disability are more likely to suffer from preventable health conditions than the general population.[92]

[88] Bennet T, Holloway K. (2012) The impact of take-home naloxone distribution and training on opiate overdose knowledge and response: An evaluation of the THN Project in Wales. *Drugs: education, prevention and policy, 19(4),* p.320-328. Accessed here.

[89] Sohal A, Feder G, Boomla K et al. (2020) Improving the healthcare response to domestic violence and abuse in UK primary care: interrupted time series evaluation of a system-level training and support programme. *BMC Med, 18: 48.* Accessed here.

[90] Pillay K, Gardner M, Gould A, Otiti S, Mullineux J, Barnighausen T, and Matthews, P. (2018) Long term effect of primary health care training on HIV testing: A quasi-experimental evaluation of the Sexual Health in Practice (SHIP) intervention. *PLOS ONE; 13(8): e0199891.* Accessed here.

[91] NHS Digital. The Health and Care of People with Learning Disabilities 2021-22. Accessed here.

[92] Office for Health Improvement and Disparities. Learning Disability Profiles. Accessed here.

165. Examples of these conditions include respiratory diseases, obesity, non-type-1 diabetes, chronic constipation, and dental issues.

    1. In 2016, a study of 343 GP practices in England found that deaths caused by respiratory diseases were nearly 7 times more common in adults with a learning disability than without.[93] In particular, pneumonia and aspiration pneumonia as underlying causes of death were 10 times more common. Adults with a learning disability are also more likely to be admitted to hospital for a respiratory condition.[94] Admissions were more frequent, of a longer duration and had a higher likelihood of re-occurrence, in particular, influenza and pneumonia.

    2. In 2021/22, 25% of people with a learning disability were clinically obese, compared to 8% of people without.[95]

    3. In 2021/22, 7% of people with a learning disability had non-type 1 diabetes, compared to 5% of people without.[87]

    4. In 2021/22, 13% of people with a learning disability had chronic constipation, compared to 1% in the general population.[87]

    5. People with a learning disability are at an increased risk of tooth decay, gum disease and edentulism (complete tooth loss). This is likely due to a decreased understanding of good oral health and its importance, and poorer access to dental services and preventative dentistry. All these conditions are preventable with good oral hygiene practices and regular oral health checks.[96]

166. In some instances, these conditions may be preventable or they may be managed to reduce detrimental effects to health, wellbeing and participation in daily activities. The OMMT is intended to help health and care professionals to provide better support with these conditions, resulting in either lower morbidity or lesser effects of morbidity on health and wellbeing. The assumed 6% reduction in the health inequality (paragraph 161) would apply to all, such that we would expect the number of people who suffer from these preventable conditions to reduce by 6%.

167. The Health and Care of People with Learning Disabilities 2021/22 dataset[97] also tracks the rate of medication prescriptions, which are used to manage behaviour that challenges among people with a learning disability and autistic people. We know that overmedication is an issue:

    1. 12% of people with a learning disability were prescribed antidepressants without an active diagnosis of depression, compared to 4% in the general population without a learning disability.

[93] Hosking, F.J., Carey, I.M., Shah, S.M., Harris, T., DeWilde S., Beighton, C. & Cook, D.G. (2016). Mortality Among Adults with Intellectual Disability in England: Comparisons with the General Population*. American Journal of Public Health, 106(8)*: p. 1483-1490. Accessed here.

[94] Chang, C-K., Chen, C-Y., Broadbent, M., Stewart, R., & O'Hara, J. (2017). Hospital admissions for respiratory system diseases in adults with intellectual disabilities in Southeast London: a register-based cohort study. *BMJ Open, 7(3)*. Accessed here.

[95] NHS Digital (2021). Health and Care of People with Learning Disabilities: Experimental Statistics 2020 to 2021. Accessed here.

[96] Office for Health Improvement and Disparities. Learning Disability Profiles. Accessed here.

[97] NHS Digital. The Health and Care of People with Learning Disabilities 2021-22. Accessed here.

2. 9% of people with a learning disability were prescribed antipsychotics without an active diagnosis of severe mental illness, compared to 0.5% in the general population without a learning disability.

3. 5% of people with a learning disability were prescribed epilepsy drugs without an active diagnosis of epilepsy, compared 2% in the general population without a learning disability.

168. There are two national NHSE programmes targeting over-medication among children and young people: Stopping The Over-Medication of children and young People with a learning disability, autism or both (STOMP) and Supporting Treatment and Appropriate Medication in Paediatrics (STAMP). We expect that the OMMT will raise awareness of these programmes among health professionals and support efforts in reducing the rates of medication prescription for behaviour that challenges. However, we do not assume that the 6% reduction in the health inequality (paragraph 161) would apply here, because the effect of the OMMT is indirect through raising awareness of other programmes.

169. Another health and care issue that affects people with a learning disability and autistic people is the use of restraint and restrictive practices in hospitals. In 2020, CQC published a report providing evidence of such practices[98] and recommending that "there must be renewed attempts to reduce restrictive practice by all health and social care providers […]." NHSE are committed to reducing inappropriate restrictive practice and we expect that the OMMT will raise awareness of this commitment. Through emphasising the use of reasonable adjustments, hospital passports, effective communication and person-centred care, the OMMT should help health and care professionals better plan for instances when people with a learning disability and autistic people may experience stress, thus avoiding the use of inappropriate restraint. However, we do not assume that the 6% reduction in the health inequality (paragraph 161) would apply here, because, as with STOMP/STAMP, the effect of the OMMT is indirect.

170. From 2018 to 2020, the average rate of deaths from avoidable medical causes among people with a learning disability was 647 people per 100,000,[99] about 3 times higher than the general population (average of 221 avoidable deaths per 100,000 population in 2018 and 2019). Applying the avoidable death rate to the population of people with a learning disability, this suggests that there are around 1,827 deaths from avoidable medical causes among people with a learning disability each year. The assumed 6% reduction in the health inequality (paragraph 161) would apply to all deaths of avoidable medical causes.

171. We monetised the societal value of avoidable mortality in the next section ('monetised benefits of Options 1 and 2'). We were not able to monetise the societal value of reduced morbidity or better management of conditions among people with a learning disability and autistic people due to lack of available data. There is likely a high societal value to this, as better health means a person could increase their participation in society, including social and economic activities. There is also a high value related to better experience of health and care provision, where individuals feel treated with respect and compassion. We intend to seek further inputs on addressing this gap in our analysis during the code of practice consultation.

NHS cost savings

172. The purpose of the OMMT is to improve how people with a learning disability and autistic people receive routine health and social care support. There are substantial cost savings

[98] Care Quality Commission (2020). Out of sight – who cares? Restraint, segregation and seclusion review. Accessed here.

[99] University of Bristol (2020). The Learning Disabilities Mortality Review (LeDeR) Programme: Annual report. Accessed here.

that could be realised through the roll-out of the OMMT, most notably, from preventing an escalation of health needs among people with a learning disability and autistic people.

173. This covers acute hospital admissions and re-admissions, where such admissions could be prevented through better access and experience of primary healthcare interventions and better support in engaging with preventative and public health interventions. Increased rates of flu vaccination in people with a learning disability, for example, could decrease hospitalisation due to flu and pneumonia from the infection, especially for people with a comorbid condition such as asthma.

174. Other examples stem from better management of health disparities (as described in paragraph 164). Obesity is a particular health issue that could be de-escalated. With better access to healthcare services, especially primary care and annual health checks, obesity could be prevented by improving access to weight loss programmes. By preventing obesity, further health conditions, such as type 2 diabetes and hypertension, could be prevented. De-escalation of upper respiratory conditions, with people with a learning disability able to communicate their concerns with a healthcare professional and access primary healthcare sooner, could lead to earlier detection of developing conditions and, therefore, earlier treatment.

175. The cost savings could extend to dental services as adaptions to dental surgeries and better experiences during appointments could increase dental appointment attendance, leading to earlier identification and intervention for oral problems, as well as a better understanding of general oral health, preventing conditions from occurring.

176. We assume that the 6% reduction in the health inequality (paragraph 161) due to the OMMT would apply to all of the above, and as a result NHS activity will also be reduced. We present a selection of examples, where we could monetise such NHS cost savings in the next section.

177. Diagnostic overshadowing occurs when a person's symptoms of physical illness are mis-attributed to their learning disability or neurodiversity. We note that the OMMT aims to reduce diagnostic overshadowing, which could be associated with more NHS activity as more conditions are diagnosed and given due treatment. However, we assume that the reduction in diagnostic overshadowing would allow health needs to be addressed sooner and prevent escalation. For example, undiagnosed constipation may result in the development of a chronic condition and the need for continuous laxative prescription. If it is diagnosed earlier, it may be managed with simpler lifestyle changes. Therefore, we assume any increases in NHS activity due to less diagnostic overshadowing would be offset by a decrease in more expensive and extensive treatment, had the condition been allowed to escalate.

Monetised benefits of Options 1 and 2

178. In this section, we present a selection of benefits, which we were able to monetise given available data. It is intended to give some scale to the benefits of the OMMT but does not represent the full spectrum of policy benefits.

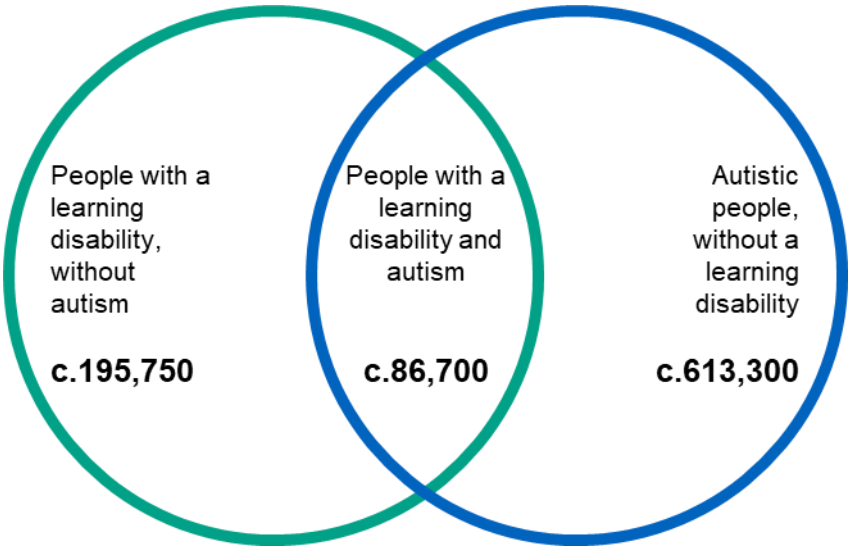
179. We were unable to monetise the benefits of the OMMT for autistic people due to lack of data on the health and care of autistic people. This is a substantial limitation and represents a large underestimation of the policy benefits. To give an idea of the scale of such underestimation, we considered the relative sizes of the populations of people with a learning disability and of autistic people. Figure 2 below illustrates this.

180. Using the Health and Care of People with Learning Disabilities Experimental Statistics, 2021-22,[100] we estimate that there are 282,450 people with a learning disability in England (i.e., 0.5% prevalence in the population). The statistics also tell us that 30.7% of people with a learning disability have been diagnosed with autism, meaning that there are c. 86,700 people with a learning disability who are also autistic. According to the National Autistic Society,[101] there are 700,000 autistic adults and children in England. This suggests that there are c.613,300 autistic people without a learning disability.

181. Our benefits estimations are based on the population of people with a learning disability (including those who are also autistic) based on the GP Learning Disability Registers. There are over twice as many autistic people without a learning disability, who will benefit from the OMMT but who have not been represented in our benefits monetisation.

182. It is worth noting that the GP Learning Disability Registers may be underrepresenting the true number of people with a learning disability in the population. We recognise that Mencap use a different prevalence estimate,[102] however, given that we do not have the health and care data of the population missing from the registers, we did not account for this underrepresentation in our monetisation methodology.

Figure 2. Estimated sizes of the populations of people with a learning disability and autistic people.



183. The following sections under dedicated sub-headings explain how we monetised some of the impacts of the OMMT. For all, we used a ten-year appraisal period from the point of implementation, because we think this will give a reasonable period to assess arising benefits, following Green Book guidance.[103]

Reduction in the prevalence of preventable health conditions

184. The OMMT aims to reduce the prevalence of preventable health conditions by improving accessibility and experiences with primary care for people with a learning disability. By providing the right support, people will be more likely to access primary care at an earlier stage of illness and can lead to symptoms of preventable conditions being identified earlier and treated before the onset of the condition.

[100] NHS England. Health and Care of People with Learning Disabilities 2021-22. Accessed here.

[101] National Autistic Society. What is autism. Accessed here.

[102] Mencap. Research and statistics. Accessed here.

[103] HM Treasury (2022). The Green Book: appraisal and evaluation in central government. Access here.

185. We identified which of the conditions measured in the Health and Care of People with Learning Disabilities data set were preventable and had a higher prevalence than in the population without a learning disability (a health inequality). We then assessed whether the savings to the NHS from the prevention of these conditions could be costed, from which we identified chronic constipation and non-type 1 diabetes.[104]

186. For chronic constipation, the annual cost of treatment was calculated in two parts:

1. Firstly, we calculated the cost of laxative prescriptions per year for each person with a learning disability and chronic constipation.

    - To calculate the number of people with chronic constipation, the population of England from March 2021 (56,490,048[105]) was multiplied by the percentage of the general population with chronic constipation (1.3%) to equal 723,073. As 0.5% of the population has a learning disability[87], the population in England with a learning disability is 282,450. This was multiplied by 13% (the proportion of people with a learning disability and chronic constipation)[87] to reach 36,719.

    - To find the number of prescriptions for all people with a learning disability and chronic constipation, 36,179 was divided by the number of people in the whole population with chronic constipation (723,073) to find the proportion of people with a learning disability in the chronic constipation population (5%).

    - The cost of laxatives prescriptions to the NHS in the 12 months between November 2021 and December 2022 was £114,267,550.[106]

    - £114,267,550 was multiplied by 5% to give the average cost of annual laxative prescriptions for all people with a learning disability and chronic constipation (£5,802,649).

    - We divided £5,802,649 by the number of people with chronic constipation and a learning disability to find the cost of laxative prescriptions per year per person with a learning disability and chronic constipation (£158.03).

2. Secondly, we calculated the cost of GP appointments per year per person with a learning disability and chronic constipation by multiplying the cost of one GP appointment (£33.87)[107] by the average number of GP appointments attended per year by someone with a learning disability and chronic constipation.

    - By multiplying the number of GP appointments each week for people with constipation (218,000)[108] by the prevalence of people with a learning disability in the chronic constipation population (5%) we found that 11,070 GP appointments each week were for people with a learning disability and chronic constipation.

[104] Non-type 1 diabetes can include type 2 diabetes as well as several other types including gestational diabetes. Type 2 is preventable and controllable through lifestyle and diet changes and medication. The other (rarer) types are less preventable and there is lack of data to be able to monetise them. As they equal around 1% of overall diabetes cases, it is assumed there will not be a large impact from the prevention of them.

[105] ONS. Census 2021. Accessed here

[106] Open prescribing. Analysis of laxative prescriptions between November 2021 and December 2022. Accessed here.

[107] PSSRU. Unit costs of health and social care 2021. Accessed here.

[108] Bowel Interest Group. The Cost of Constipation 2019. Accessed here.

- To find a year's worth of appointments, we multiplied 11,070 by 52 to make 575,656. This was then divided by the number of people with both a learning disability and chronic constipation (36,719) to reach 16 appointments per year.

- To find the annual cost of appointments per person, £33.87 x 16 = £531.04.

3. The annual cost was the cost of laxative prescriptions plus the cost of GP appointments per person with a learning disability and chronic constipation each year, which made £689.07.

187. We multiplied the number of people with a learning disability and chronic constipation (36,719) by the expected reduction of 6%, which resulted in an estimated 2,203 fewer people with chronic constipation after the OMMT roll-out.

188. To find the cost savings to the NHS associated with the prevention of chronic constipation, £689.07 x 2,203 (decrease in number of people with chronic constipation) = £1,518,091.

189. For non-type 1 diabetes, we calculated the annual cost by finding the estimated lifetime cost of treatment and dividing this by the estimated lifetime of the condition in years. This was calculated from three different sources from academic articles and averaged to find an estimated cost per year.

190. To estimate lifetime costs for all sources, the average life expectancy of 66.5 for people with a learning disability[109] was decreased by 1.7 years[110] (to 64.8) to account for type 2 diabetes lowered life expectancy. The average age of someone with type 2 diabetes was 50. This was subtracted from 64.8 to find an average lifetime of 15 years of type 2 diabetes.

1. Firstly, the annual cost of diabetes (£8.8 billion in 2017/18[111]) was uplifted by GDP inflators to 2022/23 prices and divided by the number of people with type 2 diabetes (3,368,115) in 2021/22[112] to find an annual cost to the NHS per person of £3,030. This was multiplied by 15 years to find an average lifetime cost of £45,455.

2. A study of health care resources and costs for people with type 2 diabetes found annual costs per person to be £2,446 after GDP uplift to 2022/23 prices[113]. This was multiplied by 15 years to find an average lifetime cost of £36,692.

3. Thirdly, a study of lifetime costs-effectiveness based on the EXSCEL trial found that it costs the NHS an average of £56,564 per person with type 2 diabetes across their lifetime[114].

[109] NHS Digital. The Health and Care of people with Learning disabilities: Experimental statistics 2018-19. Accessed here.

[110] Heald, A., Stedman, M., Davies, M., Livingstone, M., Alshames, R., Lunt, M., Rayman, G., & Gadsby, R. (2020) Estimating life years lost to diabetes: outcomes from analysis of National Diabetes Audit and Office of National Statistics data. Cardiovascular Endocrinology & Metabolism, 9(4), 183-185. Accessed here.

[111] Hex, N., Bartlett, C., Wright D., Taylor, M., & Varley, D. (2012) Estimating the current and future costs of Type 1 and Type 2 diabetes in the UK, including direct health costs and indirect societal and productivity costs. Diabetic Medicine, 29(7), 855-862. Accessed here

[112] NHS Digital. National Diabetes Audit (NDA) 2022-23 quarterly report for England, Integrated Care Board (ICB), Primary Care Network (PCN). Accessed here.

[113] Wang, H. et al. (2021) Healthcare resource use and costs for people with type 2 diabetes mellitus with and without severe mental illness in England: longitudinal matched-cohort study using the Clinical Practice Research Datalink. BJPsych, 221(1), 402-209. Accessed here.

[114] Becker, F., et al. (2022) Lifetime cost-effectiveness simulation of once-weekly exenatide in type 2 diabetes: A cost-utility analysis based on the EXSCEL trial. Diabetes Research and Clinical Practice, 183, 109152. Accessed here.

191. After finding the average of all three sources and dividing by 15 years, the average cost to the NHS of treating type 2 diabetes per person per year was £3,082.

192. Based on the Health and Care data set, there are 19,772 people with a learning disability and non-type 1 diabetes in England. We multiplied this by the expected reduction of 6%, which resulted in an estimated 1,186 fewer people with non-type 1 diabetes after the OMMT roll-out.

193. To find the cost savings to the NHS associated with the prevention of non-type 1 diabetes, £3,082 x 1,186 (decrease in number of people with non-type 1 diabetes) = £3,656,714.

194. The expected overall cost savings to the NHS from a reduction in the prevalence of chronic constipation and non-type 1 diabetes are £1,518,091 and £3,656,714, respectively, making a total cost saving from a reduction in potentially preventable conditions of £5,174,805.

Reduction in the risk of deaths from cancer associated with increased participation in cancer screening

195. The OMMT intends to increase the participation of people with a learning disability in public health interventions, such as cancer screening, by increasing accessibility and improving their experience. The Health and Care for People with Learning Disabilities publication also reports on the cancer screening rates for people with a learning disability compared to the general population rates. The publication includes data for the three key screening programmes in the UK: breast, cervical, and colorectal cancer.

    - The screening rate for colorectal cancer for people aged 60-74 with a learning disability is 50% of eligible people, compared to 67% in the general population.

    - For breast cancer, there is a 47% uptake in females aged 50-69 years with a learning disability compared to 62% in females aged 50-69 in the general population.

    - For cervical cancer, the screening rates in females aged 25-64 with a learning disability is 31% compared to 67% in the general population.

    This shows that people with a learning disability are less likely to take part in a screening programme. The OMMT has the potential to increase screening rates in people with a learning disability to reach the rates seen in the general population by improving their experiences in healthcare settings so that they feel more comfortable attending appointments. This could lead to early detection and diagnosis of cancer, reducing the risk of death and the cost to the NHS (early-stage cancers cost less to treat than advanced stages).

196. To find the NHS savings due to the reduction in the risk of death from colorectal cancer, the average cost of early stage (stages 1 and 2) cancers was subtracted from the average cost of advanced stage (stages 3 and 4) cancers. This was calculated from three different sources to create an average.

    1. A study of cancer care costs in England found that early-stage colorectal cancer cost an average of £14,196 in a year, whilst the cost of advanced stage colorectal cancer cost an average of £15,411[115]. With GDP uplift to 2022/23 prices, the cost difference between early and advanced stage was £1,575.

[115] Laudicella, M., Walsh, B., Burns, & Smith, C. (2016) Cost of care for cancer patients in England: evidence from population-based patient-level data. British Journal of Cancer, 114, 1286-1292. Accessed here.

2. An economic evaluation of patient-level routine health system data for cancer care found that costs for stage 1 and stage 2 colorectal cancer in the first 12 months were £7,295 and £9,702 respectively, making an average cost for early-stage cancer of £8,499. Stage 3 cancer was costed at £13,306 per year. As the data did not cost for stage 4 cancer, advanced stage cancer was costed at £13,306[116]. After GDP uplift to 2022/23 prices, the cost difference for between early and advanced stage cancer for the first 12 months was £6,020.

3. Data published by the Department of Health in 2011 found that the cost of stage 1 cancer was £9,121 and the cost for stage 2 colorectal cancer was £13,918. The average for early-stage cancer was therefore £11,520. Stage 3 cancer costs were £21,604 and stage 4 cancer costs were £13,344, therefore, the average cost for advanced stage colorectal cancer was £17,474.[117] After GDP uplift to 2022/23 prices, the average cost difference between early and advanced stage colorectal cancer was £7,846.

4. The average difference between annual costs for early and advanced stage colorectal cancer for all three sources was £5,147.

197. We then calculated the number of people with a learning disability who will have a reduced risk of dying from colorectal cancer following screening after the OMMT roll-out.

    1. As only people aged 60-74 are eligible for colorectal cancer screening programmes, we calculated that the number of 60–74-year-olds in the general population in March 2021 was 8,820,114[95]. The prevalence of learning disability among people aged 60-74 is 0.5%, so the number of people aged 60-74 with a learning disability is 42,143.[93]

    2. By multiplying 42,143 by 50% (colorectal cancer screening rates for people with a learning disability), we found that 21,188 people aged 60-74 with a learning disability had colorectal cancer screening in 2021.[93]

    3. The expected impact of the OMMT in increasing the uptake of colorectal cancer screening is 6%. We multiplied the number of people aged 60-74 with a learning disability who had a colorectal cancer screening by 6% - the additional number of people aged 60-74 with a learning disability who are expected to have a colorectal screening after the OMMT roll-out is 1,271.

    4. The expected proportion of people who will have a reduced risk of dying from colorectal cancer following screening is 23%.[118] 1,271 multiplied by 23% = 292, the number of people aged 60-74 with a learning disability who will have a reduced risk of dying from colorectal cancer following screening.

198. By multiplying the average cost difference between early and advanced stage cancer (£5,147) by the number of people aged 60-74 with a learning disability who will have a reduced risk of dying from colorectal cancer following screening (292), we calculated that the NHS cost savings due to a reduction in the risk of death from colorectal cancer in 2022/23 prices is £1,504,980.

---

[116] Hall, P., Hamilton, P., Hulme, C., Meads, D., Jones, H., Newsham, A., Marti, J., Smith, A., Mason, H., Velikova, G., & Wright, P. (2015) Costs of cancer care for use in economic evaluation: a UK analysis of patient-level routine health system data. British Journal of Cancer, 112, 948-956. Accessed here.

[117] Department of Health (2011). The Likely impact of earlier diagnosis of cancer on costs and benefits to the NHS. Accessed here.

[118] Towler, B., Irwig, L, Glasziou, P., Kewenter, J., Weller, D., & Silagy, C. (1998) A systematic review of the effects of screening for colorectal cancer using the faecal occult blood test, Hemoccult. BMJ, 317(7158), 559-565. Accessed here.

199. To find the NHS savings due to the reduction in the risk of death from breast cancer, the average cost of early stage (stages 1 and 2) cancers was subtracted from the average cost of advanced stage (stages 3 and 4) cancers. This was calculated from three different sources to create an average.

    1. A study looking at the costs of early invasive breast cancer in the UK found that the annual cost for stage 1 cancer was £5,167 and for stage 2 cancer was 7,613, making the average cost of early-stage breast cancer £6,390. The paper had costs for stage 3 cancer only, so the cost for advanced stage breast cancer was £13,330[119]. The cost difference between early and advanced stage breast cancer in 2022/23 prices is £8,184.

    2. An economic evaluation of patient-level routine health system data for cancer care found that costs for stage 1 and stage 2 breast cancer in the first 12 months were £6,765 and £10,003 respectively, making an average cost for early-stage cancer of £8,384. Stage 3 cancer was costed at £14,181 per year. As the data did not cost for stage 4 cancer, advanced stage cancer was costed at £14,181[106]. After GDP uplift to 2022/23 prices, the cost difference for between early and advanced stage breast cancer for the first 12 months was £7,257.

    3. A study of cancer care costs in England found that early-stage breast cancer cost an average of £10,746 in a year, whilst the cost of advanced stage breast cancer cost an average of £13,315[105]. With GDP uplift to 2022/23 prices, the cost difference between early and advanced stage was £3,330

    4. The average cost difference between early and advanced stage breast cancer in 2022/23 prices is £6,257.

200. We then calculated the number of people with a learning disability who will have a reduced risk of dying from breast cancer following screening after OMMT roll-out.

    1. As only females aged 50-69 are eligible for breast cancer screening programmes, we calculated the number of females aged 50-69 in the general population in March 2021 was 7,001,002.[95] The prevalence of learning disability among females aged 50-69 is 0.4%, so the number of females aged 50-69 with a learning disability is 30,471.[93]

    2. By multiplying 30,471 by 47% (breast cancer screening rates for people with a learning disability), we found that 14,382 females aged 50-69 with a learning disability had a breast cancer screening in 2021.[93]

    3. The expected impact of OMMT in increasing the uptake of breast cancer screening is 6%. We multiplied the number of females aged 50-69 with a learning disability who had a breast cancer screening by 6% – the number of females with a learning disability who will have a breast cancer screening after OMMT roll-out will be 863.

    4. The expected proportion of people who will have a reduced risk of dying from breast cancer following screening is 20%.[120] 863 multiplied by 20% = 173, the number of

[119] Sun, L., Cromwell, D., Dodwell, D., Horgan, K, Gannon, M., Medina, J., Pennington, M., Legood, R., dos-Santos-Silva, I., & Sadique, Z. (2020) Costs of Early Invasive Breast Cancer in England Using National Patient-Level Data. Economic Evaluation, 23(10), 1316-1323. Accessed here.

[120] Independent UK Panel on Breast Cancer Screening. (2012) The benefits and harms of breast cancer screening: an independent review. The Lancet, 380(9855), 1778-1786. Accessed here.

females aged 50-69 with a learning disability who will have a reduced risk of dying from breast cancer following screening.

201. By multiplying the average cost difference between early and advanced stage cancer (£6,257) by the number of females aged 50-69 with a learning disability who will have a reduced risk of dying from breast cancer following screening (173), we calculated that the NHS cost savings due to a reduction in the risk of death from breast cancer in 2022/23 prices is £1,079,841.

202. To find the NHS savings due to the reduction in the risk of death from cervical cancer, the average cost of early stage (stages 1 and 2) cancers was subtracted from the average cost of advanced stage (stages 3 and 4) cancers. This was calculated from two different sources to create an average.

    1. A report from Demos using data from Queen Mary's University London found that the cost of stage 1a cervical cancer was £1,379 and stage 1b cervical cancer was £8,164. As these stages are other non-invasive cancers, the average cost of non-invasive (early-stage) cancer is £4,772. The source defined the other stages of cervical cancer as invasive cancer (or advanced stage) and quoted an average cost of £19,261[121]. After GDP uplift to 2022/23 prices, the difference between early and advanced stage cervical cancer was £18,453.

    2. Using NHS reference costs and information from Cancer Research UK[122], the cost of each stage of cervical cancer was calculated from the costs of treatments. For stage 1 cancer, a patient receives either a cone biopsy or loop excision (£465), a simple hysterectomy (£1,230), or a trachelectomy (£5,486). An average was calculated from each of these costs to find the average cost for stage 1 cervical cancer (£2,394). For stage 2 cancer, a patient receives either a radical hysterectomy (£3,938), chemoradiotherapy (£24,168), or both (£28,105). An average was calculated from all three costs to find the average cost for stage 2 cervical cancer (£18,737). The average cost for early-stage cervical cancer (stage 1 and 2) was calculated at £10,565. For stage 3 cancer, a patient usually receives chemoradiotherapy (£24,168) so the average cost for stage 3 cancer was £24,168. Stage 4 cancer patients usually receive a hysterectomy, radiotherapy, and chemotherapy (£26,751) so the average cost for stage 4 cervical cancer was £26,751[111,123]. After GDP uplift to 2022/23 prices, the cost difference between early and advanced stage cervical cancer was £18,266.

    3. The average cost difference between early and advanced stage cervical cancer in 2022/23 prices was £18,359.

203. We then calculated the number of people with a learning disability who will have a reduced risk of dying from cervical cancer following screening after OMMT roll-out.

    1. As only females aged 25-64 are eligible for cervical cancer screening programmes, we calculated the number of females aged 25-64 in the general population (15,123,099).[95] The prevalence of learning disability among females aged 25-64 is 0.5%, so the number of females aged 25-64 with a learning disability is 69,215.[93]

[121] Demos. (2014) "Revealing the true cost of cervical cancer…": Behind the screen. Accessed here.

[122] Cancer Research UK (2020) Cervical cancer: Stages, types, and grades. Accessed here.

[123] Department of Health and Social Care. NHS reference costs 2012 to 2013. Accessed here.

2. By multiplying 69,215 by 31% (cervical cancer screening rates for people with a learning disability), we found that 21,457 females aged 25-64 with a learning disability had a cervical cancer screening in 2021.[93]

3. The expected impact of OMMT in increasing the uptake of cervical cancer screening is 6%. We multiplied by the number of females aged 25-64 with a learning disability who had a cervical cancer screening by 6% – the number of females with a learning disability who will have a cervical cancer screening after OMMT roll-out will be 1,287.

4. The expected proportion of people who will have a reduced risk of dying from cervical cancer following screening is 13%.[124] 1,287 multiplied by 13% = 167, the number of females aged 25-64 with a learning disability who will have a reduced risk of dying from cervical cancer following screening.

204. By multiplying the average cost difference between early and advanced stage cervical cancer (£18,359) by the number of females aged 25-64 with a learning disability who will have a reduced risk of dying from cervical cancer following screening (167), we calculated that the NHS cost savings due to a reduction in the risk of death from cervical cancer in 2022/23 prices is £3,072,664.

Reduction in emergency acute hospital admissions

205. One of the intended outcomes of the OMMT is to reduce acute hospital admissions and re-admissions, as people with a learning disability and autistic people will have better access and better experience of primary health care, and they will be better supported to engage in preventative and public health interventions. There is a lack of up-to-date data on the number and patterns of acute hospital admissions for people with a learning disability and autistic people. To estimate the scale of this benefit, we relied on two sources using Hospital Episode Statistics from 2005-2009[125] and from 2009-2013.[126] Given the review of broad evidence on health inequalities experienced by people with a learning disability (see section 'Problem under consideration and rationale for intervention') and continuing high rates of mortality from avoidable medical causes, we considered these sources valid for the purposes of monetising the likely benefits in this IA.

206. According to Hosking et al. (2017),[106] the annual rate of emergency acute hospital admissions for people with a learning disability is 182 per 1,000, while the same rate for people without a learning disability is 68 per 1,000. This suggests that each year there are about 51,000 emergency acute hospital admissions for people with a learning disability and that this is about 19,000 more admissions than would be expected if there was no difference in the rates between people with and without a learning disability. Moreover, both sources show that people with a learning disability are more likely to be admitted for ambulatory care sensitive conditions (ACSCs), which can be treated effectively in primary care. We estimate that each year c. 10,000 emergency acute hospital admissions for people with a learning disability are due for ACSCs and that this is c. 6,500 more admissions of this kind that would be expected if there was no difference in the rates between people with and without a learning disability.

[124] Landy, R., Pesola, F., Castanon, A., & Sasieni, P. (2016) Impact of cervical screening on cervical cancer mortality: estimation using stage-specific results from a nested case–control study. British Journal of Cancer, 115, 1140-1146. Accessed here.

[125] Glover, G., & Everson, E. (2013) Hospital Admissions That Should Not Happen. NDTi. Accessed here.

[126] Hosking et al. (2017). Preventable Emergency Hospital Admissions among Adults with Intellectual Disability: comparisons with the general population in England. Annals of Family Medicine. Accessed here.

207. To monetise the benefit of reduced acute hospital admissions, we apply the expected impact of OMMT (6%) to the emergency admissions for ACSCs for people without a learning disability (9,767) – this arrives at 586 prevented emergency acute hospital admissions per year. We multiply this number by the average cost of a hospital admission (£3,162 per episode[127] in 2022/23 prices) and estimate that the NHS cost saving due to lower emergency acute hospital admissions is £1,853,210 per year in 2022/23 prices.

Reduction in mental health hospital admissions

208. In addition to reduced acute hospital admissions, the OMMT has the potential to reduce admissions and re-admissions to mental health hospitals, as better communication skills and improved healthcare support should prevent people from reaching a crisis point. Using data from Assuring Transformation,[128] we estimate the potential savings from hospital admissions of people with a learning disability and autistic people who require care in hospitals for their mental health or because they display or are at risk of displaying behaviour that challenges.

209. In the last 12 months to December 2022, the total reported number of admissions was at 1,675 and the total number of reported re-admissions was at 335.[129] We assumed that the impact of the OMMT on reducing mental health hospital admissions and re-admissions would be 3%, rather than 6%, as it is not the primary objective of the training and the training is not providing health and care staff with mental health support skills.

210. NHS Benchmarking data showed that the average total cost (including corporate costs and overheads) of an adult inpatient bed for people with a learning disability and autistic people was £283,739 in 2019/20 prices, which is equivalent to £315,112 in 2022/23 prices.[130]

211. By applying the assumed impact of OMMT (3%) to the December 2022 data on the total number of admissions and re-admissions (2,010) and the cost of an adult inpatient bed (£315,112), we estimate the saving from reduced mental health hospital admissions could be £19.0m per year in 2022/23 prices.

Reductions in avoidable mortality

212. To calculate the expected reduction in avoidable deaths, we multiplied the assumed 6% impact of the OMMT by the number of avoidable deaths each year among people a learning disability. We therefore estimate 110 fewer avoidable deaths a year, if all staff are trained and there has been no skills fade in staff already trained.

213. One measurement and valuation of direct health benefits from a policy intervention is estimating the number of statistical life years (SLYs) generated. The SLY is derived from the social value of a small change in the probability (the risk) of losing or gaining a year of life expectancy and is currently valued at £70,000 per SLY.[131]

214. Our calculation in the number of SLYs gained per avoided death consists of two main components: the difference in the median age at death for those who were reported to the LeDeR programme and the overall population with learning disability, as not everyone's

[127] Greater Manchester Combined Authority. Unit Cost Database. Accessed here.

[128] NHS Digital (2022). Learning Disability Services Monthly Statistics from Assuring Transformation dataset – May 2022. Accessed here.

[129] NHS Digital (2022). Learning Disability Services Monthly Statistics from Assuring Transformation dataset – December 2022. Accessed here.

[130] NHS Benchmarking Network (2022). [unpublished]

[131] HM Treasury (2022). The Green Book – Central Government Guidance on Appraisal and Evaluation. Accessed here.

death is reported to LeDeR, and the positive gain in life expectancy that could result from the OMMT.

215. The median age at death for males and females with a learning disability included in the LeDeR review (across adults and children) was 60 and 59 years, respectively, during 2018 to 2020.[132] This differs from the life expectancy for males and females with a learning disability reported by NHS Digital in the same period cited as 66 and 67 years, respectively.[133] The difference is 7 years for all people with a learning disability.

216. We also account for the fact that the life expectancy data is likely an underestimation of the median age at death for people with a learning disability. For the general population in England, the difference between life expectancy at birth and median age at death between 2018 to 2020 is 3.2 years. This is calculated by subtracting the median age at death for the general population (82.6 for males and 86.1 for females, giving an average of 84.4) from the median life expectancy at birth (79.3 years for males and 83.1 for females, giving an average of 81.2).[134]

217. For people with a learning disability, we estimate the difference between life expectancy at birth and median age at death is 1.6 years. We do this via the following method. Taking the average value from the LeDeR reports,[135,136] people with a learning disability are reported to have 2.9 times higher risk of avoidable death compared to the general population. This means there is a difference in risk of 1.9 compared to the general population (where the general population's is 1). We used this figure to downscale the increase in life expectancy from 3.2 to 1.6 years (3.2/ (2.9-1) = 1.6). On this basis, we assume that a prevented death from an avoidable medical cause is associated with an increase of 8.6 SLYs (7 years added to account for life expectancy + 1.6 years adjustment to actual years lived vs. life expectancy).

218. In addition, the OMMT has the potential to improve quality of life of people with a learning disability and autistic people, and so extend longevity due to better health service provision and health outcomes. This means that for every avoidable death prevented, a person will also gain years due to improved longevity. The final expected additional SLYs brought by the OMMT per prevented death from an avoidable medical cause is therefore calculated as 9.2.

219. Given the uncertainty of these assumptions, we also tested other values for the expected additional SLYs brought by the OMMT, from 11.0 years to 7.4 years, this is an increase and decrease of 20%.

220. Based on the above, by multiplying the number of SLYs gained per death avoided (9.2), the monetary value of a SLY (£70,000) and the number of avoided deaths related to the OMMT (110), we estimate the societal value of reduction in deaths to be £70,245,939 per year (in 2022/23 prices).

Summary of benefits under Option 1 and impact of NHS cost savings (DHSC preferred measure)

[132] University of Bristol (2020). The Learning Disabilities Mortality Review (LeDeR) Programme: Annual report. Accessed here.

[133] NHS Digital (2020). Health and Care of People with Learning Disabilities, Experimental Statistics: 2018 to 2019 [PAS]. Accessed here.

[134] ONS (2021). National Life Tables – Life Expectancy in the UK: 2018 to 2020. Accessed here.

[135] University of Bristol (2020). The Learning Disabilities Mortality Review (LeDeR) Programme: Annual report. Accessed here.

[136] King's College London (2022). Learning from lives and deaths – people with a learning disability and autistic people annual report 2021. Accessed here.

221. Overall, we estimate that, across a 10-year appraisal period, Option 1 is associated with £808.5m in monetised benefits (table 18).

Table 18. Monetised benefits for Option 1, discounted and price based 22/23 (in £millions).

Total benefits (£m)	23/24	24/25	25/26	26/27	27/28	28/29	29/30	30/31	31/32	32/33	Total
Prevention of non-type 1 diabetes	1.4	2.4	3.3	3.2	3.1	3.0	2.9	2.8	2.7	2.6	27.2
Prevention of chronic constipation	0.6	1.0	1.4	1.3	1.3	1.2	1.2	1.2	1.1	1.1	11.3
Increased rate of cancer screening	2.2	3.7	5.1	4.9	4.7	4.6	4.4	4.3	4.2	4.0	42.1
Reduced emergency acute hospital admissions	0.7	1.2	1.7	1.6	1.5	1.5	1.4	1.4	1.4	1.3	13.8
Reduced mental health hospital admissions	7.3	12.5	17.1	16.5	15.9	15.3	14.8	14.4	13.9	13.5	141.3
Reduced avoidable mortality	26.9	47.2	65.5	64.7	63.5	62.5	61.7	61.2	60.3	59.4	572.9
Total	**39.0**	**68.0**	**94.0**	**92.2**	**90.0**	**88.1**	**86.5**	**85.2**	**83.5**	**81.9**	**808.5**

222. Option 1 is associated with the total cost savings to the NHS of £235.6, which cover prevention of non-type 1 diabetes, prevention of chronic constipation, increased rate of cancer screening and reduced emergency acute and mental health hospital admissions over the 10-year appraisal period (in 2022/23 prices, discounted). These savings can be converted to delivering 15,707 QALYs (valued at £15,000) or £1,099.5m in societal value (where each QALY is valued at £70,000).

Summary of benefits under Option 2 and impact of NHS cost savings (DHSC preferred measure)

223. Overall, we estimate that Option 2 is associated with £603.6m in monetised benefits (table 19). As discussed in paragraph 146, we assumed the ratio of the number of staff trained to realised benefits is the same across Option 1 and Option 2.

Table 19. Monetised benefits for Option 2, discounted and price based 22/23 (in £millions).

Total benefits (£m)	23/24	24/25	25/26	26/27	27/28	28/29	29/30	30/31	31/32	32/33	Total
Prevention of non-type 1 diabetes	0.8	1.4	1.9	2.3	2.5	2.4	2.4	2.3	2.2	2.1	20.2
Prevention of chronic constipation	0.3	0.6	0.8	0.9	1.0	1.0	1.0	0.9	0.9	0.9	8.4
Increased rate of cancer screening	1.2	2.2	3.0	3.5	3.9	3.7	3.7	3.5	3.4	3.3	31.3
Reduced emergency acute hospital admissions	0.4	0.7	1.0	1.1	1.3	1.2	1.2	1.1	1.1	1.1	10.2
Reduced mental health hospital admissions	4.2	7.2	9.9	11.8	13.0	12.5	12.3	11.7	11.3	11.1	105.0
Reduced avoidable mortality	15.5	27.2	38.2	46.2	51.8	51.1	51.0	49.6	48.8	49.0	428.5

Total	**22.5**	**39.3**	**54.8**	**65.8**	**73.5**	**72.0**	**71.4**	**69.1**	**67.7**	**67.5**	**603.6**

224. Option 2 is associated with the total cost savings to the NHS of £175.2m, which cover prevention of non-type 1 diabetes, prevention of chronic constipation, increased rate of cancer screening and reduced emergency acute and mental health hospital admissions over the 10-year appraisal period (in 2022/23 prices, discounted). These savings can be converted to delivering 11,677 QALYs (valued at £15,000) or £817.4m in societal value (where each QALY is valued at £70,000).

Net present value of Options 1 and 2

225. The net present value of both options is negative over a 10-year appraisal period – this is shown in table 20 below. However, we were not able to fully monetise all benefits and, therefore, the estimate of net benefit does not represent a complete picture of the net benefit of the options to society. The monetisation is partial, because we could not monetise any benefits related to autistic people (see paragraph 178), because we could not monetise the societal value of improved morbidity and better management of morbidity for people with a learning disability, and because we could only monetise a selection of NHS cost savings.

226. In addition, the largest component of our estimated costs are economic opportunity costs of staff undertaking training in place of other activities. This component is sensitive to the assumptions that the OMMT will displace other activities, rather than be integrated as part of contractual headroom for mandatory training. We show how this assumption affects costs in the best-case and worst-case scenarios in our sensitivity analysis (see paragraph 236) and breakeven analysis (see paragraphs 240-242).

227. With our methodology, Option 2 has a higher NPV. However, we do not know how the deviation from the preferred roll-out which formed the basis of Option 2 would influence the scale of the unmonetised policy benefits. This means that we cannot conclude that Option 2 would still have a higher NPV than Option 1, had we been able to monetise the full spectrum of benefits of the OMMT.

228. Our preferred option remains Option 1, because it represents it involves a wider roll-out and, therefore, has the highest chance of bringing about the intended outcomes and impacts, as described in the theory of change outline (see paragraph 144 and figure 1).

Table 20. NPV summary for Options 1 and 2 (in £millions in 2022/23 prices, discounted).

	Option 1	**Option 2**
Total costs across 10 years	1,251.8	847.9
Total benefits across 10 years	808.5	603.6
Net present value	**- 443.3**	**- 244.3**

Indirect benefits of the OMMT

229. We discussed the direct benefits of the OMMT in terms of societal value and NHS cost savings. There may also be other indirect benefits, which are summarised below.

Improvement in the wellbeing of family and carers

230. With potential improved health outcomes among people with a learning disability and autistic people, unpaid carers could have more time available, which would have otherwise been dedicated to caring. This could potentially lead to improvements in their wellbeing and enable them to engage more in social and economic activities, increasing their household income.

Reduction in clinical negligence claims

231. The OMMT is intended to improve the level of care received by people with a learning disability and autistic people in healthcare services. This could potentially lead to reductions in the number of claims for clinical negligence, as well as the amount claimed per case.

232. Clinical negligence claims vary greatly depending on the nature of the claim, the age of the claimant and other factors considered that constitute the claim. For that reason, we were unable to produce a reasonable estimation on how much clinical negligence claim savings could be associated with the OMMT.

LeDeR review cost savings

233. Everyone with a learning disability aged four and above and every adult (aged 18 and over) with a diagnosis of autism is eligible for a LeDeR review.[137] The child death review process reviews the deaths of all children who are aged 4-17. This will be the primary review process for children with a learning disability and autistic children; the results are then shared with the LeDeR Programme.

234. Reducing avoidable deaths is one of the longer-term impacts of the OMMT. We expect this would also reduce LeDeR review costs. However, we were unable to estimate these cost savings, because the number of cases and the time required to review each death notified to the LeDeR programme vary greatly.

Sensitivity analysis

Scenario testing for both options

235. This section outlines which key assumptions and variables in the cost and benefit model (central scenario) could feasibly change to represent alternative scenarios: the best- and worst-case scenarios.

236. The assumptions tested in this section are limited to those we think will have material impact on the NPV of the policy options, or scenarios that could potentially occur, which we gauged through engaging with stakeholders. We present two scenarios where key assumptions are varied simultaneously to provide estimates of the best and worst cases. Table 21 presents a summary of all variations that were used in our sensitivity testing.

Table 21. Summary of key assumptions, variables and sensitivities.

Key assumptions and variables	Central scenario	Worst-case scenario	Best-case scenario
Option 2 only – proportion of public healthcare and all ASC staff who perform a lower level of training than optimal	20% - e-learning only instead of full tier 1	30% - e-learning only instead of full tier 1	10% - e-learning only instead of full tier 1
	20% - tier 1 instead of tier 2	30% - tier 1 instead of tier 2	10% - tier 1 instead of tier 2

[137] NHS England (2021). Learning from lives and deaths – People with a learning disability and autistic people (LeDeR) policy 2021. Accessed here.

Content and format of refresher sessions	Tier 1 – same as original package Tier 2 – same as original package	N/A	Tier 1 – same as original package Tier 2 – e-learning plus shorter (3.5 hour) face-to-face session
The margin on private healthcare staff salary over NHS salaries	34%	54% (20% pts increase)	14% (20% pts decrease)
ASC staff - parts of the OMMT that can come under Continuous Professional Development / headroom	None	N/A	Tier 1 – e-learning only, none of webinar Tier 2 – e-learning only, none of face-to-face session
Healthcare staff - parts of the OMMT that can come under Continuous Professional Development / headroom	Tier 1 – e-learning only, none of webinar Tier 2 – e-learning only, none of face-to-face session	N/A	Tier 1 – all comes under CPD / headroom Tier 2 – all e-learning and half (4 hours) of face-to-face session
Expected impact of OMMT on health outcomes	6%	3% (50%)	9% (200%)
Statistical life years (SLY)	9.2 years gained per death avoided	7.4 years gained per death avoided (-20%)	11.0 years gained per death avoided (+20%)

237. Tables 22 and 23 below show the comparison of NPV, cost and benefit estimates for the central, worst- and best-case scenarios for Options 1 and 2, respectively. They combine all worst- and best-case assumptions simultaneously in their respective scenarios. They show that assumptions about CPD/headroom and the expected impact of the OMMT on health outcomes influence the estimates most strongly.

Table 22. Summary of costs and benefits under the best- and worst-case scenarios for Option 1 (in £millions, 2022/23 prices, discounted).

	Central scenario	Worst-case scenario	Best-case scenario
Training costs	212.2	212.2	190.0
In-house delivery costs	1.5	1.5	1.3
Central support team costs	0.9	0.9	0.9
Opportunity costs	1,037.2	1,053.7	412.0
Total costs	**1,251.8**	**1,268.3**	**604.2**
Reduced NHS costs	235.6	117.8	353.4
Societal value of reduced avoidable mortality	572.9	231.6	1,032.8
Total benefit	**808.5**	**349.4**	**1,386.3**
Net Present Value	**- 443.3**	**- 919.0**	**782.0**

Table 23. Summary of costs and benefits under best- and worst-case scenarios for Option 2 (in £millions, 2022/23 prices, discounted).

	Central scenario	Worst-case scenario	Best-case scenario
Training costs	140.9	107.1	156.9
In-house delivery costs	1.9	1.8	1.8
Opportunity costs	705.1	575.0	325.8
Total cost	**848.0**	**683.9**	**484.4**
Reduced NHS costs	175.2	78.1	291.1
Societal value of reduced avoidable mortality	428.5	154.5	856.1
Total benefit	**603.6**	**232.6**	**1,147.2**
Net Present Value	**- 244.3**	**- 451.3**	**662.8**

Breakeven analysis for both options

238. This section summarises the breakeven analysis in terms of the quantified NPV (see section 'Net present value of Options 1 and 2'.

What would the expected impact of the OMMT need to be for a breakeven NPV under central scenario

239. We estimate the figure needed for the expected impact of the OMMT to be 9.11% and 8.30% for Options 1 and 2, respectively, to allow the options to have a breakeven NPV (zero). This means that under our preferred option (central scenario Option 1) the needed impact for breakeven is 3.11% points higher than our current assumption of 6%.

240. Please note that we believe the quantified NPV substantially understates the policy benefits (see paragraph 224) – if the NPV included monetisation of all benefits, then the level of impact to reach breakeven would be lower than stated above.

What parts of the OMMT would need to be absorbed under Continuous Professional Development / headroom for NHS staff for a breakeven NPV under central scenario

241. Under the central scenario, we assumed that all time taken by healthcare staff to complete the OMMT tier 1 webinars and tier 2 face-to-face sessions will have an economic opportunity cost, as staff take training instead of performing other activities. However, in conversations with HEE, we acknowledge that NHS staff have protected time for Continuous Professional Development (CPD), as well as more general headroom in their contracts, and this time / headroom is typically used for mandatory training. It is therefore possible that some of the time that NHS staff take to complete the OMMT will be absorbed under CPD / headroom and will not pose an economic opportunity cost.

242. We calculated that, under Option 1, all of tier 1 webinars and about two-thirds of tier 2 face-to-face sessions (4.5 hours) would need to be absorbed under CPD / headroom for NHS staff to reach a breakeven NPV (zero). This is equivalent to 2.5 hours and 6 hours of NHS staff time, on tier 1 and 2 respectively, and may not be feasible given other mandatory training requirements.

243. We calculated that, under Option 2, all of tier 1 webinars and about half of tier 2 face-to-face sessions (4 hours) would need to be absorbed under CPD / headroom for NHS staff to reach a breakeven NPV (zero). This is equivalent to 2.5 hours for those taking tier 1 and 5.5 hours for those taking tier 2 – this may not be feasible to achieve.

Direct costs and benefits to business calculations

244. We expect there will be costs to businesses – these will be a mix of opportunity and direct training costs. They are relevant for independent healthcare and independent adult social care providers. We did not estimate any benefits for businesses.

245. Opportunity costs are not included in the Equivalent Annual Net Direct Cost to Business (EANDCB) calculations, as they do not represent direct costs. These have been shown in tables 7 and 14 for Options 1 and 2, respectively.

246. Under Option 1, we assume that DHSC funding will be available to cover training costs for adult social care staff, whether they work in public or independent organisations. Therefore, under Option 1, only direct training costs for independent healthcare providers are included for EANDCB purposes – these are shown in table 24. After applying relevant discount and deflation factors to bring the costs to 2019 prices, 2020 base year, they become £16.8m for Option 1. Under a ten-year appraisal period, these costs' annual equivalent becomes £2.0m.

Table 24. Summary of direct training costs relevant for businesses under Option 1 (in £million in 2022/23 prices, not discounted).

Costs (£m)	23/24	24/25	25/26	26/27	27/28	28/29	29/30	30/31	31/32	32/33	Total
Private HCHS	2.0	2.0	2.0	2.1	2.1	2.1	1.9	1.9	1.9	1.7	**19.6**
Private dentists	0.4	0.4	0.4	0.4	0.5	0.5	0.4	0.4	0.4	0.4	**4.2**
Total	**2.4**	**2.4**	**2.4**	**2.5**	**2.6**	**2.6**	**2.3**	**2.3**	**2.3**	**2.1**	**23.9**

247. Under Option 2, we assume there will be less DHSC funding and we do not yet know what it might cover. We therefore account for the possibility that such funding will not cover training costs for independent adult social care providers. Full costs to businesses are shown in table 25. They become £47.0m reflected in 2019 prices, 2020 base year. Under a ten-year appraisal period, these costs' annual equivalent becomes £5.5m.

Table 25. Summary of direct training costs relevant for businesses under Option 2 (in £million in 2022/23 prices, not discounted).

Costs (£m)	23/24	24/25	25/26	26/27	27/28	28/29	29/30	30/31	31/32	32/33	Total
Private HCHS	2.0	2.0	2.0	2.1	2.1	2.1	1.9	1.9	1.9	1.7	**19.6**
Private dentists	0.4	0.4	0.4	0.4	0.5	0.5	0.4	0.4	0.4	0.4	**4.2**
Private ASC	3.2	3.2	3.2	5.4	5.4	3.9	5.5	5.6	3.4	4.7	**43.5**
Total	**5.5**	**5.6**	**5.6**	**7.9**	**8.0**	**6.4**	**7.8**	**7.9**	**5.7**	**6.8**	**67.4**

Risks and assumptions

248. This IA was prepared in advance of specific details on the roll-out of the OMMT being agreed. The assumptions underpinning the costs and benefits outlined in this IA are based on evidence from similar activities and, where particularly uncertain, have been developed

in consultation with colleagues at NHSE, HEE and SfC. For example, this was the case for estimating the cost of recruiting the EbEs and co-trainers to deliver the OMMT.

249. Much of the specifics of the OMMT roll-out will be determined by the code of practice. After the consultation and informed by the responses, we will produce another IA where we will revisit our assumptions.

250. The main assumptions presented in this IA that pose a risk are the following.

- We assumed that the 6% impact size calculated using Table 17 is the same for all outcomes brought by the OMMT. However, given that the OMMT is expected to influence a wide range of outcome types, there may be variation in the actual size of the impact, for example, cancer screening attendance may be more easily amenable to change, while avoidable mortality may be harder to change due to larger variation and complexity of its determinants. We have not accounted for this in our benefit calculations (see paragraph 162).

- There is uncertainty around the feasibility of recruiting and training the EbEs required for delivery. It is possible that in practice there is greater variability than what we have accounted for in the analysis. These figures are also likely to vary regionally.

- There is a lack of data on the number of staff in private healthcare. There is also uncertainty around the salary and proportions requiring tier 1 and tier 2 OMMT, therefore, we have applied the same assumptions as for the NHS for the analysis.

- Related, whilst we have accounted for workforce turnover and growth rates of those who would be trained and assume this will remain relatively stable over time, recent analysis projects shortfalls in the NHS workforce for 2030/31.[138] Therefore, workforce numbers could fluctuate more than we expect and have accounted for in our analysis, potentially leading to differences in estimated costs and benefits.

- We assume the benefits brought by the OMMT are the same for people receiving tier 1 and tier 2 training. However, given how staff receiving tier 1 and tier 2 training have different levels of engagement with people with a learning disability and autistic people in their jobs and the difference in the coverage of the training between the two tiers, there may be variation in the extent of such benefits, which our benefits calculations do not account for.

- We use data from the LeDeR reports to inform several assumptions. This does not account for autistic people, although it will in future reports. Therefore, the monetised benefits (for example, those related to SLYs) have been underestimated in this regard in our analysis.

251. There are other programmes of work that have overlapping aims which may also influence some of the costs and benefits we expect to see from the roll out of the OMMT. For example, we recognise in this IA that there may be costs saved from reduced mental health hospital admissions and readmissions among people with a learning disability and autistic people. However, this could also be impacted by wider policies such as the Building the Right Support National Plan which aims to reduce reliance on inpatient care in mental health hospitals among people with a learning disability and autistic people. We

[138] Shembavnekar N, Buchan J, Bazeer N, Kelly E, Beech J, Charlesworth A, McConkey R, Fisher R. NHS workforce projections 2022. The Health Foundation (https://doi.org/10.37829/HF-2022-RC01).

would not be able to distinguish which programme of work exactly may lead to different impacts.

252. There is a risk that health and care staff will feel alienated if the messaging around the policy is one of underperformance or negligence. The messaging has and continues to be about improved outcomes for people with a learning disability and autistic people rather than about placing blame on staff. This should remain the case to avoid alienating the staff and service providers whom we need to embrace the policy.

Impact on small and micro businesses

253. The new legislation that introduces mandatory training on learning disability and autism applies to all staff working in CQC-regulated settings, independent of their size. This means that all small and micro businesses that perform CQC-regulated activities will need to provide training on learning disability and autism appropriate to their staff roles.

254. Across the adult social care sector in England, approximately 90% of domiciliary care providers and 78% of residential care providers are SMBs.[139] For the healthcare sector across the UK, 97% of providers are SMBs.[140] As SMBs comprise most of the markets, we would expect any potential burdens and benefits to fall largely to them.

255. We do not anticipate that there will be many disproportionate burdens on SMBs for the specific policy options outlined in this IA. Whilst we would usually anticipate that SMBs could be disproportionally impacted by fixed costs associated with familiarisation and complying with legislation, this mandatory training legislation builds on the existing requirement set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.[141] Therefore, SMBs should already be equipped in managing the requirements for the OMMT. However, it is possible that there will be disproportionate impacts to SMBs in such fixed costs in the future, if the 5-year code of practice review leads to changes in the model of delivery and content of training.

256. Following advice from SfC, there is a potential risk of destabilising SMBs' in the social care sector who deliver training, especially those who deliver specific learning disability and autism training, if they are not able to become accredited providers of the OMMT or offer training that meets the code of practice standards. However, this is closely related to the operational delivery model for the OMMT, which is in development. We will consider this risk in greater detail alongside code of practice consultation responses and further developments in the OMMT implementation plan. We will include more information as part of our later IA.

Wider impacts

Equalities

257. The policy objective is to reduce inequalities in health and care outcomes, as well as in the experience of heath and care services, for people with a learning disability and autistic people. We therefore expect this policy to have a positive impact on promoting equalities.

258. The public sector equality duty (PSED) may be relevant to this intervention. However, the implementation plans for this policy are still being considered. As required by law we will run a formal, public consultation on the draft code of practice, following which we will

[139] Skills for Care (2022). The size and structure of the adult social care sector and workforce in England. Accessed here.

[140] Department for Business, Energy & Industrial Strategy (2021). Business population estimates 2021. Accessed here.

[141] The Health and Social Care Act 2008 (Regulated Activities) Regulation 14. Accessed here.

produce another IA. We intend to carry out an Equalities Impact Assessment, at the same time as this since our policy interventions will be further developed.

Unintended consequences

259. There may be a potential risk of unintended consequences where staff time is redirected to training, meaning health and social care services may be limited for patients and could in turn result in greater delays to care, and worsening of health inequalities and outcomes. This could also be exacerbated by any projected shortfalls in the workforce in 2030/31.

260. We have seen a rise in waiting times for access to health care, which varies across the country, with more deprived areas, where health outcomes are often worse, experiencing the largest wait times.[142,143,144] Therefore, there is a risk that this potential unintended consequence could exacerbate such regional variation issues.

Competition and innovation

261. We do not foresee any impact on competition and innovation as a result of this intervention.

Monitoring and Evaluation

262. As set out in the Health and Care Act 2022, the Secretary of State is required to issue a code of practice in relation to the new legislative requirement for CQC registered providers to ensure their health and social care staff receive mandatory training on learning disability and autism (as it's described in the legislation).

263. The code of practice will provide guidance about the nature of the training, including provisions about monitoring compliance and evaluating the impact of the training. The Secretary of State is required to run a public consultation before publishing the code of practice. As a result, we cannot pre-empt what the outcomes of this consultation will be, nor can we pre-empt the delivery model which will influence how outputs can be monitored and evaluated. At this stage, we can however explore what metrics will underpin any future assessment of the success of this new legislative requirement. This takes a long-term approach in recognition that any behavioural and cultural changes take time to yield changes.

264. Process outputs that could be monitored as part of early implementation could include: the number and proportion of health and adult social care staff who have completed the OMMT and the number and proportion who complete the OMMT in each year of intended roll out, alongside the number and proportion who have reportedly made or are observed to have made changes to their day-to-day work. Such outputs may also be monitored through CQC enforcement activities.

265. Training outcome measures, from the perspective of health and social care staff, could include those similar to the NDTi OMMT trial evaluation such as: satisfaction with the training (measured through agreement to pitch, pace and content of the training, perceptions on utility and overall quality of the training); self-reported changes in knowledge, confidence, attitudes and skills.

266. From the perspective of people with a learning disability and autistic people, quantitative and qualitative measures could include the following: increases in patient satisfaction of

[142] ONS (2022). Health state life expectancies by national deprivation deciles, England: 2018 to 2020. Accessed here.

[143] Public Health England (2021). Health Profile for England 2021. Accessed here.

[144] Nuffield Trust (2022). How do waiting times for NHS planned care vary across England. Accessed here.

services; increases in positive perceptions of health and social care staff knowledge and understanding of learning disability and autism; decreases in diagnostic overshadowing.

267. Metrics for longer-term success should include the following: increases and future stability in life expectancy; reduction in the number of avoidable deaths; reduction in the number and severity of negligence cases; reductions in the proportions of people with a learning disability with preventable health conditions; increases in the number and proportion of people with a learning disability attending cancer screening.

268. We will monitor outcomes for people with a learning disability and autistic people through data provided in the Assuring Transformation dataset, the annual Health and Care of People with Learning Disabilities publication and the findings of the annual LeDeR reports.

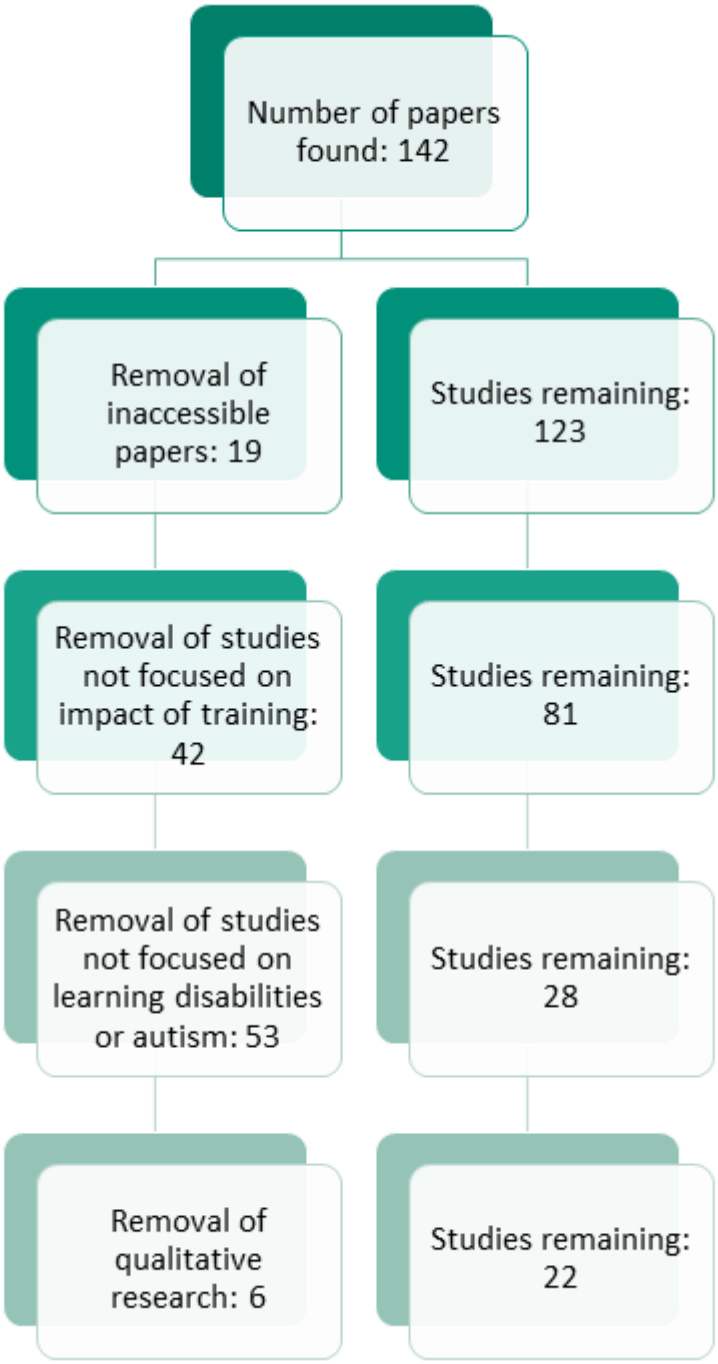
269. As set out in the Health and Care Act 2022, the Secretary of State must at least once every five years review the code of practice and lay before parliament a report setting out the findings of the review. These requirements ensure the monitoring and evaluation of the new legislation.

270. The trial of the OMMT has been evaluated and the learning from this evidence has been used to inform roll out and amendments to the training packages to best meet our objectives. The training has begun to be rolled out, with the e-learning launched in October 2022, the interactive webinar sessions launched in January 2023, and tier 2 face to face 1 day training due to be launched in March 2023. The code of practice consultation will inform any further changes to the training.

271. We are aiming to have an independent evaluation of the OMMT roll-out to understand the impact on learning outcomes for health and social care staff. We will use a two-stage evaluation, the first being a process evaluation to understand how the OMMT is implemented in practice, and the second being an impact evaluation to understand the impact the OMMT has on staff, people with a learning disability and autistic people, and trainers. The process evaluation will also evaluate the use and effectiveness of the code of practice, which we expect will be published in advance of when we expect this research to begin. Early findings from the evaluation will inform changes to the code of practice when it is reviewed 5 years after publication. The evaluation will also help to inform policy decisions for the OMMT in the future, including changes to the training and future funding bids to continue delivery.

Annex

Figure 1: tree diagram of the search and sorting process of the papers included in the rapid evidence review of the impact of previous training and interventions.


Number of papers found: 142
Removal of inaccessible papers: 19
Studies remaining: 123
Removal of studies not focused on impact of training: 42
Studies remaining: 81
Removal of studies not focused on learning disabilities or autism: 53
Studies remaining: 28
Removal of qualitative research: 6
Studies remaining: 22