This impact assessment was finalised in December 2022 and is being published retrospectively.

It has been superseded by the [Oliver McGowan draft code of practice consultation](#) stage impact assessment.

Title: Mandatory training on learning disability and autism **IA No:**	**Impact Assessment (IA)**
RPC Reference No: N/A	**Date: 30/12/2022**
Lead department or agency: Department of Health and Social Care	**Stage: Final**
	Source of intervention: Domestic
Other departments or agencies: NHS England and Improvement; Health Education England	**Type of measure: Primary legislation**
	Contact for enquiries: Ksenia Shagabutdinova

Summary: Intervention and Options	**RPC Opinion:** Not Applicable

Cost of Preferred Option			
Total Net Present Social Value (in 2022 prices)	**Business Net Present Value** (in 2022 prices)	**Net cost to business per year** (in 2019 prices, 2020 present value)	**Business Impact Target Status** Non qualifying provision
-£141.0m	-£136.6m	£0.6m	

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 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 disabilities and autism likely contributes to this. Over the past 15 years, key stakeholder 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 learning disabilities 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 main policy objective is to expand 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 on learning disability and autism. A secondary objective is to ensure consistency and quality of such training through the publication of a code of practice to outline the nature of the training, including content, delivery and ongoing 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 Assuring Transformation dataset, 'Learning from lives and deaths – people with a learning disability and autistic people' (LeDeR) reports and ongoing evaluation of training.

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

In 2019, the Government consulted on the introduction of mandatory training in learning disability and autism for health and social care staff and received broad support. In the response ('Right to be Heard'), the Government committed to developing and testing a standardised package, known as the Oliver McGowan Mandatory Training (OMMT), which has since been trialled and evaluated. The IA considers two options: (1) where only health and social care staff who may provide care or support to people with a learning disability or autistic people and who perform CQC-regulated activities receive OMMT, or (2) where all health and social care staff who perform CQC-regulated activities receive OMMT appropriate to their role. Under option 1, staff who only require general awareness of learning disability and autism will not receive training. Option 2 is the preferred option, because it most closely matches the recommendations from the OMMT trial evaluation and is associated with the highest net present value, as well as the highest potential to deliver non-monetised benefits. The "do nothing" option assumes that training is not mandated.

Will the policy be reviewed? It **will** be reviewed. **If applicable, set review date: 2028**				
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 Minister: Maria Caulfield

Date: 17/07/2023

Summary: Analysis & Evidence

Policy Option 0

Description: Training on learning disability and autism is not mandated

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**
High	n/a	n/a	n/a	**n/a**
Best Estimate	n/a		0	**0**

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

This option pertains to the counterfactual, that is, the status-quo with no new national policies implemented. Therefore, we assume that there are no additional costs and benefits to the baseline associated with the "do nothing" option and impacts are assessed as marginal changes against the "do nothing" baseline.

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**
High	n/a	n/a	n/a	**n/a**
Best Estimate	n/a		0	**0**

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

This option pertains to the counterfactual, that is, the status-quo with no new national policies implemented. Therefore, we assume that there are no additional costs and benefits to the baseline associated with the "do nothing" option and impacts are assessed as marginal changes against the "do nothing" baseline.

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: Only health and social care staff who may provide direct care or support to people with a learning disability or autistic people and who perform CQC-regulated activities receive OMMT.

FULL ECONOMIC ASSESSMENT

Price Base Year 2022	PV Base Year 2022	Time Period Years 10	Net Benefit (Present Value (PV)) (£m)		
			Low: -639.1	**High:** 165.5	**Best Estimate:** -297.6

COSTS (£m)	Total Transition (Constant Price)	Years	Average Annual (excl. Transition) (Constant Price)	Total Cost (Present Value)
Low	n/a	n/a	25.1	**233.9**
High	n/a		80.8	**755.0**
Best Estimate	n/a		56.5	**527.8**

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 £107.5m;
(2) opportunity costs to the NHS (£298.0m), private healthcare (£54.9m), public adult social care (£10.5m) and private adult social care (£56.9m).
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)
Low	n/a	n/a	12.7	**115.9**
High	n/a		43.5	**399.4**
Best Estimate	n/a		25.2	**230.2**

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

The best estimate of monetised benefits is based on the assumption that the policy can deliver a 5% reduction in hospital admissions and in avoidable mortality and includes the following (discounted in 2022 prices):
(1) cost savings to the NHS from reduced mental health hospital admissions at £60.0m;
(2) cost savings to the NHS from reduced mental health hospital re-admissions at £9.6m;
(3) wellbeing value of reduced avoidable mortality, estimated through statistical life years gained, at £160.6m.

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

The key non-monetised benefits are related to improved routine support provided by health and care staff, which is associated with preventing an escalation of both physical and mental health needs. The policy objective is associated with substantial benefits in the form of NHS cost savings from reduced acute hospital admissions and in the form of higher wellbeing value associated with lower morbidity or lesser effects of morbidity among people with a learning disability and autistic people. Other benefits include reducing inappropriate healthcare service usage, reducing delays to treatment and discharges, and reduction in clinical negligence claims and costs.

Key assumptions/sensitivities/risks	Discount rate	3.5%

All cost and benefits are discounted at 3.5%, except for the wellbeing 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 training audience, content and delivery; that roll out will last 5 years; and that the policy can deliver a 5% reduction in avoidable mortality and hospital admissions. The assumptions are described in detail in later sections. Key risk is that assumptions will change as the training Code of Practice and delivery model are further developed.

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: 0.5	**Benefits:** 0	**Net:** -0.5	Not applicable

Summary: Analysis & Evidence   Policy Option 2

Description: All health and social care staff who perform CQC-regulated activities receive OMMT appropriate to their role (including two levels: general awareness and more detailed level for those who may provide direct care and support).

FULL ECONOMIC ASSESSMENT

Price Base Year 2022	PV Base Year 2022	Time Period Years 10	Net Benefit (Present Value (PV)) (£m)		
			Low: -627.8	**High:** 703.1	**Best Estimate:** -141.0

COSTS (£m)	Total Transition (Constant Price)	Years	Average Annual (excl. Transition) (Constant Price)	Total Cost (Present Value)
Low	n/a		29.2	**272.8**
High	n/a	n/a	87.9	**821.2**
Best Estimate	n/a		64.0	**597.5**

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

The best estimate of monetised benefits (discounted in 2022 prices) includes:
(1) direct training and additional costs related to the delivery of training at £117.2m;
(2) opportunity costs to the NHS (£329.6m), private healthcare (£60.7m), public adult social care (£14.0m) and private adult social care (£75.9m).
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)
Low	n/a		21.3	**193.5**
High	n/a	n/a	106.4	**975.9**
Best Estimate	n/a		50.0	**456.5**

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

The best estimate of monetised benefits is based on the assumption that the policy can deliver a 5% reduction in hospital admissions and in avoidable mortality and includes the following (discounted in 2022 prices):
(4) cost savings to the NHS from reduced mental health hospital admissions at £119.0m;
(5) cost savings to the NHS from reduced mental health hospital re-admissions at £19.0m;
(6) wellbeing value of reduced avoidable mortality, estimated through statistical life years gained, at £318.5m.

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

The key non-monetised benefits are related to improved routine support provided by health and care staff, which is associated with preventing an escalation of both physical and mental health needs. The policy objective is associated with substantial benefits in the form of NHS cost savings from reduced acute hospital admissions and in the form of higher wellbeing value associated with lower morbidity or lesser effects of morbidity among people with a learning disability and autistic people. Other benefits include reducing inappropriate healthcare service usage, reducing delays to treatment and discharges, and reduction in clinical negligence claims and costs.

Key assumptions/sensitivities/risks	Discount rate (%)	3.5%

All cost and benefits are discounted at 3.5%, except for the wellbeing 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 training audience, content and delivery; that roll out will last 5 years; and that the policy can deliver a 5% reduction in avoidable mortality and hospital admissions. The assumptions are described in detail in later sections. Key risk is that assumptions will change as the training Code of Practice and delivery model are further developed.

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: 0.6	**Benefits:** 0	**Net:** -0.6	Not applicable

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 learning disabilities 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 learning disabilities, 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 learning disabilities accessing the right help at the right time.[8] This in turn leads to exacerbating health inequalities and increased risk of premature death.

4. People with learning disabilities often experience diagnostic overshadowing[9] 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.[10,11] 50% of health care

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

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

[11] 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.

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 learning disabilities might be a contributing factor in avoidable deaths[12].

5. Evidence indicates that greater knowledge of and more time spent with autistic people is associated with more positive attitudes towards autistic people.[13,14] Further, a training programme designed for parents of autistic children found their knowledge and skills increased and led to reduced anxiety in the children.[15] 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

6. 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.[16] 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 learning disabilities 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.[17]

7. In 2019, Health Education England published the Core Capabilities Framework for Supporting People with a Learning Disability[18] and the Core Capabilities Framework for Supporting Autistic People[19] 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[20], 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.

8. 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

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

[13] 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

[14] 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

[15] 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

[16] 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.

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

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

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

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

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.[21]

9. 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.[22]

Rationale for Government intervention

10. 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 these individuals, their carers, friends and families.

11. 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 learning disabilities 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.

Level of analysis used in the impact assessment

12. The introduction of a new mandatory requirement to complete training on learning disability and autism 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.

13. The operational delivery model for the mandatory training specified in legislation is subject to development and, therefore, the impact assessment (IA) is limited by assumptions about implementation.

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

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

[22] 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.

- the evaluation of the Oliver McGowan Mandatory Training Trial on Learning Disability and Autism;[23]

- wider evidence on the effectiveness of training on changing health and social care staff behaviour, noting that this was limited and represents an under-researched area;

- discussions with NHS England, Health Education England, Skills for Care and NHS Resolution;

- other publicly available data relevant to assumptions regarding training provision.

15. 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 in-depth sensitivity tests and provided high and low estimates within this document.

16. We intend to produce an updated IA as the delivery model becomes clearer and in line with consultation on the training Code of Practice.

Description of policy development

The Oliver McGowan Mandatory Training on Learning Disability and Autism

17. 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.

18. 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 learning disabilities.

19. 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'*.[24] 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 learning disabilities or autistic people,

- how to mandate training, and

- how to monitor and evaluate its impact.

20. The ten-week 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

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[23] National Development Team for Inclusion (2022). Evaluation of the Oliver McGowan Mandatory Training Trial in Learning Disability and Autism. Accessed here.
[24] DHSC (2019). Learning disability and autism training for health and care staff. Accessed here.

with learning disabilities and autistic people would have a better experience of health and social care services.

21. 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'*.[25] 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)[26] 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.

22. 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 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,[27] and the report and its findings have been used to inform this IA.

Trial and evaluation of the Oliver McGowan Mandatory Training

23. 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 who may need to provide care and/or support for autistic people and people with a learning disability.

24. 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 learning disabilities 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.

25. 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),[28] and that the training trialled is ready to be used without further amends.

26. 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.

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[25] 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.

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

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

[28] 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.

Non-legislative options considered in policy development

27. Some non-mandatory learning disability and autism training is available to health and social care staff, and there are core capabilities frameworks that outline what training staff might require, nevertheless, wide-spread provision and uptake is low (see paragraphs 6-8). This is likely to be due to a variety of reasons including: prioritisation and allocation of resources, current availability of good quality training, and an understanding on how to access training. Moreover, those who have had training have indicated they want more.[29]

28. Non-legislative routes to implement learning disability and autism training have therefore been deemed unlikely to fully address the market failure. Without Government intervention, as has been the status quo, the current market for and engagement in learning disability and autism training is insufficient to generate enough understanding and knowledge to lead to changes in provision of health and social care for people with a learning disability and autistic people. It is more likely that a combination of legislative and non-legislative measures is needed to address the market failure.

29. Options other than training have also been considered; specifically, whether a public awareness campaign could help to deliver the same policy objectives. Organisations like Mencap have previously led such campaigns, so additional intervention by the Government in this capacity has been deemed unlikely to generate sufficient incremental impact. Moreover, this option would not target health and social care specifically in a way that would contextualise the issue. There is already awareness among health and social care staff that avoidable deaths occur and that a lack of knowledge may contribute to this, and there is an appetite to undertake training. Increasing this awareness alone does not necessarily lead to changes in attitudes and behaviour, which is key to ensuring that staff have the knowledge and skills to provide safe, compassionate and informed care.

30. While there has been little research into the effectiveness of mandatory training, evidence from NDTI's evaluation of the OMMT trial shows an increase in knowledge, skills and confidence and some positive impact on behaviour change among participants. This demonstrates that mandatory training could help us to move forward in achieving our policy objectives. By trialling the training and involving people with lived experience in its delivery, we are ensuring that the training is meaningful and sustainable.

Legislation: mandatory training on learning disability and autism

31. As of 1 July 2022, under the Health and Care Act 2022[30], all staff working in settings that perform Care Quality Commission (CQC) regulated activities[31] are required to undertake 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[32] that such staff should be provided with the training necessary to enable them to perform their duties.

32. CQC have one set of regulations that apply to all 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[33], where each regulated activity is described and examples of services that are likely to carry out these

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

[30] Part 6, Section 181 of the Health and Care Act 2022. Accessed here.
[31] CQC (2022). Scope of registration: regulated activities. Accessed here.
[32] Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Accessed here.
[33] Schedule 1 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Accessed here.

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

33. Children's social care is outside of the scope of CQC regulated activities.

Policy objective

34. The main policy objective of the legislation is to expand 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. A secondary objective of the legislation is to allow for a Code of Practice to be developed and consulted on. The Code will outline the nature of the training including content, delivery and the ongoing monitoring and evaluation which should be undertaken to meet the new legal requirement.

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 including monitoring outcomes through the Assuring Transformation dataset and the findings of annual LeDeR reports, as well as ongoing evaluation of the training and its effectiveness on learning outcomes for participants.

Description of options considered in the IA

Option 0 – the counterfactual: No mandatory training on learning disability and autism for CQC regulated health and social care staff

39. This is the counterfactual scenario against which all other options are compared. This assumes that learning disability and autism training is not mandated amongst CQC regulated health and social care staff. There is evidence which suggests a small proportion of health and social care staff have already received learning disability and autism training, although it is unclear how many and across what timeframe. Whilst we do not have estimates for the healthcare workforce, Skills for Care's adult social care workforce estimates state that:[34]

   - the proportion of adult social care workers who have received training in relation to autism and learning disability is of the order of 9.7%; and

   - the proportion of registered nurses (working in adult social care) who have received training in relation to autism and learning disability is of the order of 5.2%.

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

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[34] Skills for Care (2021). Adult Social Care Workforce Estimates (table 7.3, based on an average). Accessed here.

40. We expect that training requirements will be judged according to the two tiers used in the OMMT to determine the level of training staff should receive for their role. The details of who is eligible for each tier are covered in paragraph 23.

41. We assume a 5-year roll out period to align with the 5-year review of the training Code of Practice specified in legislation. We assume that any changes necessary to the delivery of training will be determined through the Code review process and therefore assume an implementation period that coincides with this timeframe.

42. For the purposes of this IA, we quantified and monetised two policy options. We use this specific combination of options to align with the OMMT trial and recommendations set out in the NDTi evaluation.[35]

   Option 1 – Roll out of the OMMT only to staff who may need to provide care or support to people with a learning disability and autistic people and who perform CQC-regulated activities. The staff who require general awareness of learning disability and autism, but do not provide direct care or support, will not receive any training in this option. (In relation to OMMT, Option 1 is tier 2 only training.)

   Option 2 – Roll out of the OMMT to all healthcare and adult social care staff, appropriate to their role and level of involvement with people with a learning disability and autistic people, who perform CQC-regulated activities. (In relation to OMMT, Option 2 is tier 1 and tier 2 training.)

Details of alternative options considered

43. For the purposes of this IA, we considered roll out of both the OMMT tiers 1 and 2 to staff who perform activities outside the scope of CQC regulations, in addition to the health and adult social care staff who perform CQC-regulated activities. 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.

44. 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.

45. 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.

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

Preferred option with description of implementation plan

46. Option 2 is the preferred option, because it most closely matches the recommendations set out in the NDTi evaluation report of the OMMT trial.[36] Our cost benefit analysis, presented below, showed that option 2 has a higher Net Present Value than option 1.

47. The implementation plan for option 2 is subject to development and will be informed by the Code of Practice, which will accompany the legislation. DHSC will be leading on the development of the Code of Practice. The Government must carry out a public consultation on the Code of Practice – timings for the consultation are currently being considered.

48. DHSC will be working with statutory bodies (NHS England and Health Education England) and Skills for Care to develop an operational delivery model for the OMMT. We expect some elements of the OMMT programme, which have been trialled already, to be made available before the Code of Practice is published.

49. 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.

50. We will be taking a pragmatic and flexible approach to implementing this intervention and there could be some further piloting/experimentation during the initial deployment phase (at least the next 12 months but likely to be longer).

51. For the purposes of this IA, we assumed an implementation plan based on the OMMT trial. These assumptions are presented under specific headings below. There is a degree of uncertainty around these assumptions. (For details about our approach, please see the earlier section: 'Level of analysis used in the impact assessment.')

Who will undertake each tier of the OMMT

52. For the purpose of this IA, we assumed the definitions used as part of the OMMT trial.

    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[37] and the Capabilities Framework for Supporting Autistic People[38]. While the three organisations

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

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

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

involved in the trial (trial partners) designed their training in different ways, there was some core content that needed to be covered at a minimum for each tier.

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. Hospital passports. Culture (professional bias and subconscious beliefs), professional behaviour and impact on outcomes and other people's behaviour.

- Communication: how to communicate in an accessible way; how to understand what the person (and their family) is saying. Reference ASK – LISTEN – DO.

- Learning from LeDeR, annual health checks.

The OMMT delivery method

56. For the purposes of this IA, we assumed the recommended delivery method from the NDTi evaluation report (also see paragraphs 24 & 25).[39]

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. We expect 20 training participants per each webinar.

Tier 2 requires completion of the 1.5-hour e-learning module from tier 1. It is then delivered via a 1-day face-to-face session (8 hours) with two EbEs and a co-trainer. We expect 30 training participants per each session.

The OMMT training frequency / refresh

57. For the purposes of this IA, we assumed the training will be delivered once to each post holder in the healthcare and adult social care sectors, without any allowances for repeated or refresher training. Consideration to the frequency of OMMT and the need for refresher sessions will be given during the development of the Code of Practice. We intend to produce an update IA in line with the consultation on the Code of Practice.

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

Monetised costs of Options 1 and 2

58. Option 0 assumes no changes to the existing requirements in legislation. This option pertains to the counterfactual, that is, the status-quo with no new national policies implemented. Therefore, there are no additional costs or benefits to the baseline associated with option 0. As cited in paragraph 38, we have some understanding of current levels of training uptake and would expect these estimates to remain stable into the future under this option.

59. Options 1 and 2 share the same underlying assumptions, unless explicitly otherwise stated. They differ in terms of the scope of the workforce that would be considered eligible for the OMMT, where option 2 covers all of the CQC regulated health and adult social care workforce, while option 1 covers only a proportion.

60. There is evidence that staff working in adult social care and some NHS settings may have already undertaken some learning disability and autism training which could potentially be substituted for the OMMT (see paragraph 39). However, as there is no information about when this training was delivered, we have not included any substitutability for any learning disability and autism training staff may have already undertaken in this analysis. Potential substitutability will be addressed in an updated IA in line with the consultation on the code of practice.

61. 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 learning disabilities 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. This will become clearer as the implementation plan is developed, including eligibility criteria. We included this in our sensitivity tests.

62. We assume a roll out period of 5 years and a 10-year appraisal period across both options.

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

63. To calculate the percentage of NHS workforce that require tier 1 (T1) and tier 2 (T2) training we used published workforce data broken down by role. Roles where staff were likely to need general awareness only were assigned to T1, e.g., support staff, including administrative and non-clinical staff, and roles where staff were likely to provide care to people with a learning disability or autistic people were assigned to T2, e.g., nurses, doctors, midwives.

   - For NHS Hospital & Community Health Service (HCHS)[40], we calculated that 45% will require T1 and 55% will require T2.

   - For General Medical Practice,[41] we calculated that 53% and 47% of staff will require T1 and T2, respectively.

   - For NHS dental workforce,[42] as we only have information that solely includes dentists, we assigned 100% of staff to T2.

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[40] NHS Digital (2022). NHS Hospital and Community Health Service (HCHS) monthly workforce statistics – Staff in Trusts and CCGs. Accessed here.

[41] NHS Digital (2022). General Practice Workforce, 30 April 2022. Accessed here.

[42] NHS Digital (2021). NHS Dental Statistics for England – 2020/21 Annual Report. Accessed here.

Based on these calculations, for the total NHS workforce, we estimated that 45% and 55% of staff will require T1 and T2, respectively.

64. We applied the same split between T1 and T2 (45% and 55% respectively) to the private healthcare workforce, given we were unable to find a comprehensive published breakdown of their roles. As there is uncertainty around these estimates, we varied them in the sensitivity tests presented in this document.

65. For private dentists, we assigned everyone to T2, as we did for the NHS dentists.

66. SfC estimate that 56% of the adult social care workforce will require T1 and 44% will require T2. This is based on the estimated proportions of staff working to the Core Capabilities Frameworks definitions. This split will apply equally across public and private adult social care providers. As there is some uncertainty around these estimates, we varied them in the sensitivity tests.

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

67. Using NHS HCHS monthly workforce statistics,[43] General Practice Workforce dataset[44] and NHS Dental Statistics[45] from 2021/22, we estimated that there are a total of around 1,590,000 staff working in the NHS.

68. We were unable to find corresponding published figures for the size of the independent healthcare workforce, with sources providing different figures. Using data from the Independent Healthcare Provider Network, a membership organisation for independent healthcare providers, we estimated that around 215,000 people are employed in the independent healthcare sector.

69. To estimate the size of the independent dentistry workforce, we applied the ratio of independent to NHS healthcare workforce to the size of the NHS dentistry workforce, giving us an estimated 3,000 dentists working in the private sector.

70. Overall, we calculated that, to the nearest million, 1.5 million health and adult social care staff will require T1 and 1.5 million will require T2, totalling to approximately 3.0 million workers. These numbers are used to estimate costs for each option in subsequent sections of the IA. Table 1 below presents the number and respective proportion of staff expected to undertake T1 and T2 training by each staff group.

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[43] NHS Digital (2022). NHS Hospital and Community Health Service (HCHS) monthly workforce statistics – Staff in Trusts and CCGs. Accessed here.

[44] NHS Digital (2022). General Practice Workforce, 30 April 2022. Accessed here.

[45] NHS Digital (2021). NHS Dental Statistics for England – 2020/21 Annual Report. Accessed here.

Table 1. Total number of health and adult social care staff to train across tier 1 and tier 2 (headcount, rounded to the nearest thousand, and proportion).

Staff group	Tier	Headcount	Proportion
NHS Hospital & Community Health Service	Tier 1	621,000	45%
	Tier 2	756,000	55%
	Total	**1,377,000**	**100%**
General Medical Practice	Tier 1	100,000	53%
	Tier 2	90,000	47%
	Total	**190,000**	**100%**
NHS dentists	Tier 1	0	0%
	Tier 2	24,000	100%
	Total	**24,000**	**100%**
Total NHS staff	Tier 1	721,000	45%
	Tier 2	869,000	55%
	Total	**1,590,000**	**100%**
Independent health care staff	Tier 1	97,000	45%
	Tier 2	118,000	55%
	Total	**215,000**	**100%**
Independent dentists	Tier 1	0	0%
	Tier 2	3,000	100%
	Total	**3,000**	**100%**
Total health care staff	Tier 1	818,000	45%
	Tier 2	990,000	55%
	Total	**1,808,000**	**100%**
Total CQC-regulated adult social care staff	Tier 1	664,000	56%
	Tier 2	521,000	44%
	Total	**1,185,000**	**100%**
Total combined workforce	Tier 1	1,482,000	50%
	Tier 2	1,511,000	50%
	Total	**2,993,000**	**100%**

Growth of the health and adult social care workforce and staff turnover

71. To estimate how many members of staff need to take part in training for the roll out to complete in 5 years, we cannot simply divide the size of the total workforce by 5 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, and in the next section ('Number of health and adult social care staff to receive OMMT in each year') we describe how we used these in calculations to estimate how many members of staff need to be trained each year for OMMT to reach everyone in post at the end of 5 years.

72. Using HCHS workforce data,[46] we calculated that the average workforce growth for the past ten years was 2.0%. 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.

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[46]NHS Digital (2022). Turnover from organisation benchmarking tool. Accessed here.

73. Using HCHS workforce data,[31] we calculated that the turnover rate was 14.1% from February 2021 to February 2022. Using HCHS staff joiners data,[47] we calculated that 34.3% of joiners from March 2020 to March 2021 came from health and care settings, including private healthcare and adult social care (meaning that these 34.3% of joiners were changing posts within our sectors, while 65.7% of joiners were new to our sectors).

74. We applied the same rates for annual workforce growth, annual turnover and annual joiners changing posts to General Medical Practice and to independent healthcare settings, because equivalent data is not available for these staff groups.

75. Using NHS dental statistics for England 2020/21,[48] for dental staff, we calculated an annual growth rate of 0.7% by using a 10-year average from 2010/11 and an annual turnover rate of 6.63% by using an 8-year average (from 2011/12 to 2019/20). We were unable to find information on joiners in this sector and we assumed that all joiners came from outside our sectors to avoid underestimations. We applied the same rates to the independent dental sector.

76. Using adult social care workforce data for 2020/21, we calculated the annual growth rate of 2.6%, the annual turnover rate of 32.8%, and the proportion of joiners changing posts within our sectors at 70.4% (meaning that out of the 32.8% of posts that had vacancies in the year, 70.4% were replaced by joiners who were changing posts within our sectors).[49,50] We used the same rates both for private and public adult social care providers.

77. We assumed these rates are the same for staff undertaking T1 and T2 and will not change regardless of the length of roll out. Workforce growth, turnover rate and proportion of joiners from within health and adult social care sectors are accounted for in the 10-year appraisal period.

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

78. To calculate the number of staff that need to receive the OMMT in each year for a 5-year roll out period, we accounted for annual workforce growth rate, annual turnover and the proportion of joiners from within our sectors for each staff group. Below, we explain the approach to our calculations. We then provide the number of people that will be trained each year for each option in paragraphs 100 and 109 later in the IA.

79. 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 5 years. Specifically, we did this by:

   for year one

   - specifying a percentage of staff to be trained,

   - subtracting the proportion of staff trained in year one who will leave their post (with a correction for those joiners who leave to start a new post still in the healthcare or adult social care sectors),

[47]NHS Digital (2022). Joiners by source of recruitment and staff group, March 2020 to March 2021. Accessed here.

[48] NHS Digital (2021). Dental Statistics for England - 2020-21 Annual Report. Accessed here.

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

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

- arriving at the number of staff trained and in employment at the end of year one, then

from year two onwards

- specifying a percentage of staff to be trained in each year,

- subtracting the proportion of the accumulated staff trained in previous year(s) who will leave their post (with a correction for those joiners who leave to start a new post still in the healthcare or adult social care sectors), and

- subtracting the proportion of staff trained in each year who will leave their post (with a correction for those joiners who leave to start a new post still in the healthcare or adult social care sectors),

- adding the number of staff trained and in employment in our sectors to arrive at a cumulative total of trained staff.

The correction for those joiners who are moving within our sectors and who were trained prior to joining their new post increases, as a higher cumulative proportion of staff in the workforce is trained over time.

Using this method, we were able to find the specific percentage of staff that need to be trained each year so that all staff that remain in our sectors at the end of year 5 are trained. We set the percentage to be the same in each year to even the roll out.

80. These percentages were different for healthcare (excluding dentists), dental and adult social care staff groups due to different growth and turnover rates.

- For healthcare (excluding dentists), we anticipate that 25% of staff need to be trained each year to ensure that 91% of staff in post is trained at the end of the roll out period.

- For dentistry, these figures are 24% of the staff to receive training each year and 93% of staff in post is trained by the end of the roll out period.

- For the adult social care, these figures are 26% of staff to receive training each year and 90% of staff in post is trained at the end of the roll out period.

Note that we are not reaching 100% of staff, because there will be turnover in year 5 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 OMMT.

81. The same methodology was used to calculate the number of staff that needed to be trained across both options. Specific numbers are covered under each option later in this document.

Cost of a tier 1 session

82. T1 package includes a 1.5-hour e-learning module and a 1-hour online webinar. The e-learning module is already designed, so the only associated cost is hosting the training on an online learning platform. HEE advised that there would only be a nominal cost associated with this for NHS workers, because they have software readily available to upload any e-learning, which would then be accessible to workers. SfC suggested that using software designed for the NHS workforce is likely to negatively impact uptake and compliance with the training so this would need to be separate from NHS. SfC indicated larger providers may have their own systems where they can upload material. Many organisations including smaller adult social care providers and smaller private healthcare

providers will not have access to their own systems for hosting the e-learning. As such, we factored in a cost of £50,000 in 2022/23 (based on average costs taken from website design services and in discussion with HEE). This could cover building a website and hosting the e-learning, which could be accessible to health and social care staff working at organisations that do not have a platform to host the training. Larger organisations could also use this website, or choose to host on their own platforms, if appropriate at their own expense.

83. The 1-hour online 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. These sessions will have two EbEs and a co-trainer, where we assume a net pay rate of £18.69 per hour for EbEs (based on data shared from the OMMT trial) and a net pay rate of £22.37 per hour for the co-trainer (based on earnings of a Band 6, excluding oncosts[51]), adjusted for 2022/23 prices. Looking at roles on the website NHS Jobs suggests that a Band 6 under the job title "Education Training & Development Delivery Manager" would be likely to deliver mandatory non-clinical training such as this[52]. SfC indicated that they would recommend class sizes are no larger than 20 since the element of live interaction with autistic trainers and trainers with a learning disability is a valuable part of the webinar and there needs to be time for group discussion. Using this basis, we calculated the cost of the online webinar to be £2.99 per participant. Costs of coordinating and supporting the delivery of the T1 package are covered later. As a class size of 50 was used in the OMMT trial we included this variation in our sensitivity tests, as well as testing with a class sizes of 10, as discussions with stakeholders suggested that smaller classes could be more beneficial to participants.

Cost of a tier 2 session

84. Those who are required to complete T2 will also complete the e-learning component of T1. We do not anticipate any additional costs involved with this component, beyond those already listed for T1 (paragraph 81).

85. T2 is likely to be a full day (8 hours) of face-to-face training with two EbEs, co-trainer and a support worker. We anticipate that the net pay rate of the EbEs will be £18.69 and co-trainer will be £22.37 per hour each (as above, paragraph 82). We anticipate that the support worker will earn the equivalent of a Band 5 net pay rate at £16.73 per hour at 2022/23 prices (excluding oncosts).[53]

86. Costs from the NDTi evaluation suggest that venue hire will cost £250 a day (£31.25 per hour), with travel cost at £50 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). These costs will depend on mode of delivery and whether it is delivered on-site or off-site to workers' place of work. HEE advised that most health care staff (75%) will not need a venue as they are likely to have venue space on-site. 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 in the adult social care sector will need an off-site venue, so we assume that costs for 75% of adult social care staff will need to factor in venue and transportation costs. There will be regional variation in these costs.

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[51] Personal Social Services Research Unit (2021). Unit Costs of Health and Social Care 2021. Accessed here.

[52] NHS Jobs

[53] Personal Social Services Research Unit (2021). Unit Costs of Health and Social Care 2021. Accessed here.

87. SfC do not expect class sizes to be any larger than 30. This arrives at a training cost of £20.4 per participant without travel and venue, and £85.4 per participant if venue and travel are added. The final content of the face-to-face training has not yet been decided, so we have also included an initial cost to design the training: discussion with HEE suggests this would cost around £400,000. As class sizes of 15 and 50 were used in the OMMT trial, we included these variations in our sensitivity tests.

Additional costs related to the delivery of the OMMT tiers 1 and 2

88. This section covers:

- cost for recruiting EbEs and co-trainers

- cost of training the trainers in the specifics of the OMMT

- cost of supporting EbEs into employability (e.g., softer skills for the workplace such as time management, communication skills, etc.)

- costs for coordinating the sessions, and a central team to perform stakeholder engagement, quality assurance and communications.

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

89. EbEs and co-trainers would need to be recruited to deliver the OMMT. To recruit the EbEs and co-trainers we assumed that a recruitment manager and a HR manager would be required (both Band 6, £55.62 when adjusted for 2022/23 prices, including oncosts and overheads). Based on stakeholder engagement, we assume that time involved would be the same for recruitment of EbEs and co-trainers, specifically that:

- 30 hours of a recruitment manager's time would be required to write all job application materials, including job description and easy read versions, costing £5,000 to advertise

- everyone who applies would ask a query, and it would take 15 minutes for a HR manager to answer each query

- it would take 10 minutes for both the HR and recruitment manager to moderate each application form

- 10% of those who apply would be offered an interview, with one in three interviewees successful, costing £338.33 each; the cost per applicant who does not progress to interview is thus calculated to be £32.44; the cost per applicant who is unsuccessful at interview is calculated to be £180.75

- each interview would take 1 hour and 15 minutes (including administration) for both the HR and recruitment manager

- it would take 10 minutes for the HR manager to notify each unsuccessful applicant of the outcome and 3 hours of the HR manager's time in administration to appoint each successful candidate.

90. This comes out at £1,575.78 in recruitment costs per EbE or co-trainer recruited (this includes the cost for each unsuccessful applicant at application and interview), and £6,668.48 in fixed costs.

91. We assumed that EbEs work 8-hour days, as 0.5 FTE. This is to allow for the fact that employers should make reasonable adjustments (including reducing working hours) for

those with a disability.[54] They will receive 17.5 days annual leave, including bank holidays (using Agenda for Change criteria[55]). We assumed that co-trainers will be FTEs and so will receive 35 days leave, including bank holidays. Based on this, we calculated that EbEs will work 970 annual hours and co-trainers will work 1,800 annual hours. These annual working hours are used later to calculate the number of EbEs and co-trainers needed in a given year to deliver OMMT sessions. We assumed that all sessions involving EbEs will require two per session.

92.   We added an extra 15% headroom to EbE and co-trainer roles to allow time for administration and other activities.

93.   As there is some uncertainty around the involvement of EbEs, we included several variations in our sensitivity tests.

- We included EbE's work as 0.2 FTE and as 0.8 FTE.

- We tested the number of hours an EbE works per session, using an assumption that they are only required for half the session. This is because half the session will focus on learning disability and half will focus on autism, so one EbE may only be required to attend for their relevant part.

- We also increased their hours by 50% to allow for the fact they may need additional time to plan and prepare for the session.

Costs of training the trainers in the specifics of the OMMT

94.   EbEs and co-trainers will need to be trained in the specifics of the OMMT before they can deliver the sessions. We assumed that a cohort of 8 can be trained at the same time, over a two-day session of 16 hours, based on practice from similar train the trainer programmes.[56] Each session will involve one EbE and one co-trainer to deliver.

95.   We assumed that the EbE and co-trainer delivering this session will both be Band 6, where the EbE will earn £18.69 per hour (excluding oncosts and overheads) and the co-trainer will earn £22.37 per hour (excluding oncosts and overheads). This is consistent with our approach to using this grade to deliver the training to health and adult social care staff (paragraph 81). Based on the OMMT trial,[57] we anticipate that the venue hire is £250 per day (£31.25 per hour) and that travel is £50 per person for both days. We assumed that accommodation will be required at £80 per night. We assumed travel and accommodation will be required for all those attending. The cost is therefore £307.13 to train a trainer (i.e., EbE or co-trainer).

Cost of supporting EbEs into employability

96.   In addition to the training already mentioned, we anticipate that EbEs will also require general employability training. The evaluation of the trial highlighted that some EbEs would have benefitted from such training before delivering the OMMT.[58] This will cover softer skills for the workplace, such as time management and communication skills, as well as support to manage their work and travel assistance. We estimated that all EbEs will

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[54] HM Government. Disability Rights. Accessed here.

[55] NHS. Agenda for change – pay rates. Accessed here.

[56] Public Health England (2018). Mental health promotion and prevention training programmes: Emerging practice examples. Accessed here.

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

[58] National Development Team for Inclusion [unpublished].

require this, although this might need to be assessed on a case-by-case basis and depending on how experienced they are.

97. We assumed that 14 sessions will be required for each course, with each session lasting 3.5 hours (half a day) and involving a cohort of 6 EbEs. We assumed two people will be delivering the training and they will earn the equivalent of a Band 6 salary at £22.37 per hour when adjusted for 2022/23 prices, excluding oncosts and overheads. The cost is calculated to be £365.44 per EbE. These assumptions are based on stakeholder engagement of other programmes.

Costs of coordinating the sessions and central support costs

98. We assumed a model for the healthcare sector where there will be local teams who will coordinate the sessions, including booking people onto sessions. These will then feed into a central team via regional teams. We assumed this central team will be responsible for quality assurance, communication, stakeholder engagement and overall monitoring and evaluation. This model could be mirrored for the adult social care sector or adapted to incorporate the adult social care sector. For the purposes of this IA, the costs cover both sectors.

99. We assumed that one hour would be required for coordination of each T1 session and three hours required for each T2 session (since T2 will require additional input, such as arranging a venue and travel due to the face-to-face delivery of the training). We assumed this will be done by a Band 5 staff at the local level (£42.23 per hour[35] adjusted to 2022/23 prices, including oncosts and overheads), implying a coordination cost of £42.23 per T1 session and of £126.68 per T2 session.

100. We assumed that a Band 8c FTE will be required to lead the central team, with 7 FTEs at Band 7 (one for each of the NHS regions and 3 working centrally) and one FTE Band 6 providing administrative support (salaries are taken from PSSRU 2021[26] adjusted for 2022/23 prices and include oncosts, overheads and employer's national insurance plus 20.68 per cent of salary for employer's contribution to superannuation). This arrives at a cost of £1,095,800 at 2022/23 prices. This is an annual cost which would increase with inflation. Please note that 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.

Summary of costs for Option 1 – roll out of the OMMT tier 2 only

101. If the OMMT was rolled out to only staff eligible for T2, 25% of the health care staff (excluding dentists), 24% of dentists and 26% of adult social care staff eligible for T2 would need to be trained each year to ensure that the maximum percentage of the workforce is reached by year 5 of the rollout. This follows the model described in the earlier section: 'Number of health and adult social care staff to receive the OMMT in each year'. Considering this, we estimated the following numbers of staff will be trained each year from 2022/23 (table 2).[59]

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[59] *Whilst this IA does not consider refresher or repeat training, the Code of Practice and subsequent reviews will determine if repeat training will be necessary in future years beyond initial roll out.*

Table 2. Total number of staff trained per year under Option 1 (rounded and expressed in thousands).

	2022/23	2023/24	2024/25	2025/26	2026/27
Total healthcare workforce (excl. dentists)	223	430	622	801	965
Total adult social care workforce	126	242	351	453	535
Total dentists	6	12	17	22	26
Total trained T2 workforce at the end of the year	355	684	990	1,276	1,526

102. We calculated the number of EbEs and co-trainers needed for this option based on the number of people that could be trained, divided by the number of working hours an EbE and co-trainer have in a year (table 3). We applied the NHS turnover rate to EbEs and co-trainers (14.1%). The calculation also accounted for the 15% headroom we assumed for EbEs and co-trainers to account for other activities and sick leave.

Table 3. Number of EbEs and co-trainers to recruit and train in OMMT under Option 1.

	2022/23	2023/24	2024/25	2025/26	2026/27
Experts by experience	288	41	42	31	-
Co-trainers	155	22	23	17	-

103. After calculating the number of EbEs and co-trainers needed to be recruited and trained in each year, together with the number of sessions we need to run in each year, we calculated the various additional costs under policy option 1. These are shown in table 4.

Table 4. Breakdown of additional costs related to the delivery of OMMT under Option 1 (in £ millions, 2022/23 prices, discounted).

Costs (£m)	2022/23	2023/24	2024/25	2025/26	2026/27	Total
Coordinating the sessions	£1.7	£1.6	£1.6	£1.6	£1.5	£8.0
Supporting EbEs into employability	£0.1	£0.01	£0.01	£0.01	£-	£0.1
Training the trainers in OMMT	£0.1	£0.02	£0.02	£0.01	£-	£0.2
Recruitment	£0.7	£0.1	£0.1	£0.1	£-	£1.0
Central support team	£1.1	£1.1	£1.0	£1.0	£1.0	£5.1
Total for each year	**£3.7**	**£2.8**	**£2.8**	**£2.7**	**£2.5**	**£14.4**

104. As calculated in paragraph 85, we estimated that it will cost £20.4 per T2 participant on-site training and £85.4 per T2 participant off-site training (travel and venue required). With these per participant costs, we were able to calculate the total cost of T2 sessions (table 5).

105. Please note that T2 includes the 1.5-hour e-learning module as a prerequisite to the full day session; therefore, a one-off e-learning hosting cost would be incurred in the beginning of the roll out period. In addition, we included the one-off cost for the design of the full day T2 package.

Table 5. Cost of tier 2 sessions per year under Option 1 (in £millions in 2022/23 prices, discounted).

Costs (£m)	2022/23	2023/24	2024/25	2025/26	2026/27	Total
E-learning module hosting	£0.05	£-	£-	£-	£-	£0.05
T2 package design	£0.4	£-	£-	£-	£-	£0.4
T2 sessions	£19.2	£18.9	£18.7	£18.5	£17.2	£92.6
Total cost of T2 sessions	**£19.6**	**£18.9**	**£18.7**	**£18.5**	**£17.2**	**£93.0**

106. In healthcare and adult social care there will be an opportunity cost as staff undertake the OMMT in place of other activities. This is an economic cost under the policy option. The opportunity cost is calculated based on the time needed to complete the training and the corresponding salary staff would otherwise earn for the duration of the training (table 6).

107. We took the weighted average salary for healthcare, dentist and adult social care staff according to their training tier and calculated the time cost involved.[60,61] We assumed all adult social care staff receive the same salary across public and private bodies, because almost 84% of the adult social care workforce are working in the private sector.[62] For private healthcare staff, we calculated that their salary would have a 34% margin above the weighted average salary for those working for the NHS. This is based on the comparison of the estimated average NHS and private healthcare salaries from two websites.[63,64] Given the limited data and a wide range of private healthcare salaries, we also tested different margins above the weighted average for the NHS in our sensitivity analyses.

Table 6. Opportunity costs per year for staff groups with varying salary levels under Option 1 (in £millions in 2022/23 prices, discounted).

Costs (£m)	2022/23	2023/24	2024/25	2025/26	2026/27	Total
Healthcare workforce (excl. dentists)	£70.3	£69.2	£68.2	£67.2	£65.4	£340.4
Dentists	£2.7	£2.7	£2.6	£2.5	£2.1	£12.6
Adult social care workforce	£14.0	£13.8	£13.7	£13.6	£12.3	£67.4
Total opportunity costs	**£87.0**	**£85.8**	**£84.5**	**£83.4**	**£79.7**	**£420.4**
Private healthcare workforce (excl. dentists)	£11.0	£10.9	£10.7	£10.6	£10.3	£53.4
Private dentists	£0.3	£0.3	£0.3	£0.3	£0.2	£1.5
Private adult social care workforce	£11.8	£11.7	£11.6	£11.5	£10.4	£56.9
Total private sector opportunity cost	**£23.1**	**£22.9**	**£22.6**	**£22.3**	**£20.9**	**£111.8**
NHS (healthcare and dentists) workforce	£61.6	£60.7	£59.8	£58.9	£57.0	£298.0
Public adult social care workforce	£2.2	£2.2	£2.1	£2.1	£1.9	£10.5

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[60] NHS Digital (2022). NHS Staff Earnings Estimates, December 2021, Provisional Statistics. Accessed here (table 2b).

[61] Skills for Care (2021). Adult Social Care Workforce Estimates (appendix table 6.2). Accessed here.

[62] Skills for Care (2021). Adult Social Care Workforce Estimates (appendix table 6.2). Accessed here.

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

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

Total public sector opportunity cost	**£63.8**	**£62.9**	**£61.9**	**£61.0**	**£58.9**	**£308.5**

108. In summary, we estimate that Option 1 will cost £527.8m expressed in 2022/23 prices and discounted for future years of the 5-year roll out period. Table 7 below present a summary of all costs under this option.

Table 7. Summary of total costs for Option 1 (in £millions in 2022/23 prices, discounted).

Costs (£m)	2022/23	2023/24	2024/25	2025/26	2026/27	Total
T2 sessions	£19.6	£18.9	£18.7	£18.5	£17.2	£93.0
Additional costs related to the delivery of T2	£3.7	£2.8	£2.8	£2.7	£2.5	£14.4
Opportunity costs	£87.0	£85.8	£84.5	£83.4	£79.7	£420.4
Total	**£110.3**	**£107.5**	**£106.0**	**£104.5**	**£99.4**	**£527.8**

109. While the implementation plan is decided, we assume that DHSC/NHSE will be responsible for funding training costs (T2 sessions and additional costs) across the healthcare and adult social care sectors. Under this assumption, DHSC/NHSE will require £107.5m (in 2022/23 prices, discounted) to cover these and 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 for Option 1 is estimated to be 7,164 QALYs, or a societal value of £501.5 million (the societal value of a QALY is valued at £70,000).

Summary of costs for Option 2 – roll out of tier 1 and tier 2 OMMT

110. If the OMMT is rolled out to all staff eligible for T1 and T2, 25% of the healthcare (excl. dentists) staff, 24% of dentists and 26% of adult social care staff will need to be trained each year to ensure that the maximum percentage of the workforce is trained by year 5 of the roll out. This follows the model described in the earlier section: 'Number of health and adult social care staff to receive the OMMT in each year'. Considering this, we estimated the following numbers of staff will be trained each year from 2022/23 (table 8).[65]

Table 8. Total numbers of staff trained per year under Option 2 (rounded and expressed in thousands).

	2022/23	2023/24	2024/25	2025/26	2026/27
Total healthcare workforce (excl. dentists)	412	795	1,150	1,481	1,784
Total adult social care workforce	285	551	798	1,029	1,216
Total dentist workforce	6	12	17	22	26
Total trained workforce at the end of the year	703	1,358	1,965	2,532	3,026

111. We calculated the number of EbEs and co-trainers needed for this option based on the number of people that could be trained, divided by the number of working hours an EbE and co-trainer have in a year (table 9). We applied the NHS turnover rate to EbEs and co-trainers (14.1%). The calculation also accounted for the 15% headroom we assumed for EbEs and co-trainers to account for other activities and sick leaves.

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[65] *Whilst this IA does not consider refresher or repeat training, the Code of Practice and subsequent reviews will determine if repeat training will be necessary in future years beyond initial roll out.*

Table 9. Number of EbEs and co-trainers to recruit and train in OMMT under Option 2.

	2022/23	2023/24	2024/25	2025/26	2026/27
Experts by experience	341	49	50	37	-
Co-trainers	184	26	27	20	-

112. After calculating the number of EbEs and co-trainers needed to be recruited and trained in each year, together with the number of sessions we need to run in each year, we calculated the various additional costs under policy option 2 (table 10).

Table 10. Breakdown of additional costs related to the delivery of OMMT under Option 2 (in £ millions in 2022/23 prices, discounted).

Costs (£m)	2022/23	2023/24	2024/25	2025/26	2026/27	Total
Coordinating the sessions	£2.5	£2.4	£2.4	£2.4	£2.2	£11.9
Supporting EbEs into employability	£0.1	£0.02	£0.02	£0.01	£-	£0.2
Training the trainers in OMMT	£0.2	£0.02	£0.02	£0.02	£-	£0.2
Recruitment	£0.8	£0.1	£0.1	£0.1	£-	£1.2
Central support team	£1.1	£1.1	£1.0	£1.0	£1.0	£5.1
Total for each year	**£4.7**	**£3.7**	**£3.6**	**£3.5**	**£3.2**	**£18.6**

113. As calculated in paragraphs 81 and 85, we estimated that it will cost £2.99 per T1 training participant, £20.4 per T2 participant training on-site and £85.4 per T2 participant training off-site (travel and venue required). With these per participant costs, we were able to calculate the costs of T1 and T2 sessions (table 11).

Table 11. Costs of tier 1 and tier 2 sessions per year (in £millions in 2022/23 prices, discounted).

Costs (£m)	2022/23	2023/24	2024/25	2025/26	2026/27	Total
E-learning module hosting	£0.05	£-	£-	£-	£-	£0.05
T2 package design	£0.4	£-	£-	£-	£-	£0.4
T1 sessions	£1.2	£1.1	£1.1	£1.1	£1.0	£5.6
T2 sessions	£19.2	£18.9	£18.7	£18.5	£17.2	£92.6
Total cost of both T1 and T2 sessions	**£20.8**	**£20.1**	**£19.8**	**£19.6**	**£18.3**	**£98.6**

114. As with option 1, the opportunity costs are calculated as the time cost for the staff to receive the tier of the OMMT appropriate to their job role. The assumptions and calculation approach to calculate the opportunity costs in Option 2 is identical to those used in Option 1 (paragraph 105) (table 12).

Table 12. Opportunity costs per year for staff groups with varying salary levels under Option 2 (in £millions in 2022/23 prices, discounted)

Costs (£m)	2022/23	2023/24	2024/25	2025/26	2026/27	Total
Healthcare workforce (excl. dentists)	£78.0	£76.8	£75.7	£74.6	£72.6	£377.7
Dentists	£2.7	£2.7	£2.6	£2.5	£2.1	£12.6
Adult social care workforce	£18.6	£18.5	£18.3	£18.2	£16.4	£90.0
Total opportunity costs	**£99.4**	**£98.0**	**£96.6**	**£95.3**	**£91.0**	**£480.3**
Private healthcare workforce (excl. dentists)	£12.2	£12.0	£11.9	£11.7	£11.4	£59.2
Private dentists	£0.3	£0.3	£0.3	£0.3	£0.2	£1.5
Private adult social care workforce	£15.7	£15.6	£15.5	£15.3	£13.8	£75.9
Total private sector opportunity cost	**£28.3**	**£28.0**	**£27.6**	**£27.3**	**£25.4**	**£136.6**
NHS (healthcare and dentists)	£68.2	£67.1	£66.1	£65.1	£63.0	£329.6
Public adult social workforce	£2.9	£2.9	£2.9	£2.8	£2.6	£14.0
Total public sector opportunity cost	**£71.1**	**£70.0**	**£69.0**	**£68.0**	**£65.6**	**£343.6**

115. In summary, we estimate that Option 2 will cost £597.5m expressed in 2022/23 prices and discounted for future years of the 5-year roll out period. The summary costs for this option are shown in table 13 below.

Table 13. Summary of total costs for Option 2 (in £millions in 2022/23 prices, discounted).

Costs (£m)	2022/23	2023/24	2024/25	2025/26	2026/27	Total
T1 and T2 sessions	£20.8	£20.1	£19.8	£19.6	£18.3	£98.6
Additional costs related to the delivery of T1 and T2	£4.7	£3.7	£3.6	£3.5	£3.2	£18.6
Opportunity costs	£99.4	£98.0	£96.6	£95.3	£91.0	£480.3
Total	**£124.8**	**£121.7**	**£120.1**	**£118.4**	**£112.5**	**£597.5**

116. While the implementation plan is decided, we assume that DHSC/NHSE will be responsible for funding training costs (T1 and T2 sessions and additional costs) across the healthcare and adult social care sectors. Under this assumption, DHSC/NHSE will require £117.2m (in 2022/23 prices, discounted) to cover these and 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 for Option 1 is estimated to be 7,814 QALYs, or a societal value of £547.0 million (the societal value of a QALY is valued at £70,000).

Monetised benefits of Options 1 and 2

117. We use 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.[66]

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

Outline of the theory of change

118. 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. This is not intended to be comprehensive at this stage.

    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; 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 and re-admissions; reduced mortality associated with preventable causes of death; reduced mortality associated with treatable causes of death; higher levels of wellbeing among people with learning disability and autistic people, as well as their family and carers.

Assessing outputs: number of staff trained over time

119. In calculating the monetised benefits, we account for the rising cumulative proportion of staff that receive training during the roll out period, as well as for this proportion declining over time due to turnover. In this IA, we do not include any repeated or refresher training sessions. If these are included in the implementation plan later, as part of the code of practice, we intend to reflect that in an updated IA.

120. Table 14 below shows the percentage of trained staff in relation to the total workforce size across regulated health and adult social care. Option 1, where only staff eligible for T2 receive training, is associated with a lower level of monetised benefit than Option 2 due to a smaller proportion of the workforce having received training.

Table 14. Proportion of trained staff across the appraisal period under Options 1 and 2.

	2022/ 23	2023/ 24	2024/ 25	2025/ 26	2026/ 27	2027/ 28	2028/ 29	2029/ 30	2030/ 31	2031/ 32
Option 1	12%	22%	31%	39%	46%	41%	36%	32%	28%	25%
Option 2	23%	43%	61%	77%	91%	80%	71%	63%	56%	50%

121. 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.[67] 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 based on self-reported data. We therefore assume the effect of OMMT will decline by 10% (as the midpoint of 5% to 15%) for the first year after roll out, with this fading over time. A limitation of our approach is that we only model this decline from year 6 of the appraisal period, after the end of the roll out period.

Assessing training outcomes

122. The NDTi evaluation of the OMMT trial provides a direct assessment of learning outcomes among training participants. The report states that for both T1 and T2 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." [68] (NDTi report pages 38 and 69)

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

Assessing service outcomes

123. 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 T1 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 T2 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*

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[67] 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

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

ask before my first visit if there are things they like or don't like so I can adapt my practice."[69] (NDTi report page 75)

In addition, the evaluation report shows that

- 27-44% of T1 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 T2 participants, who said that they could make changes to how things are done in their workplace, reported doing so after taking the training respectively.

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."*[70] (NDTi report page 76)

Assessing shorter-term and longer-term impacts

124. 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.

125. 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.[71] 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.

126. 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.[72] 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).

127. A pilot study of Sensory Adapted Dental Environment (SADE) intervention aimed to reduce sensory-related distress and anxiety in autistic children facing dental treatment.[73] The study tailored the experience, using multisensory environments and sensory integration theories, with the treatment environment adapted. The study found that SADE reduced

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

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

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

[72] 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

[73] 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.

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.

128. 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.[74]

129. Based on the literature reviewed above, together with results from the OMMT trial evaluation, to monetise the potential benefits of the OMMT, we assumed that it could have a small-to-medium impact of 5% 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). Due to uncertainty around this figure, we included an increase and decrease to this impact factor of 50% in our sensitivity testing.

Reduction in mental health hospital admissions and re-admissions

130. One of the intended outcomes of introducing mandatory training on learning disability and autism 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. In addition, such training has the potential to reduce admissions and re-admissions to mental health hospitals, as better care and support should prevent people reaching a crisis point. Our analysis was driven largely by data availability, such that we were able to quantify the benefits on reduced mental health hospital admissions and re-admissions, but were unable to quantify these for acute hospital treatment, where we lack data on number of admissions and re-admissions for people with a learning disability and autistic people and on the cost of treatment.

131. Using data from Assuring Transformation,[75] we estimate the potential savings from hospital admissions and re-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.

132. 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 £308,729 in 2022/23 prices.[76]

133. In the last 12 months to May 2022, the total reported number of admissions was at 1,660 and the average re-admission rate within a year was 16%.[77]

134. By applying the assumed impact of OMMT (5%) to the May 2022 data on people with a learning disability and autistic people in inpatient care (1,660) and the cost of an adult

[74] 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.

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

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

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

inpatient bed (£308,729), we estimate the saving from reduced hospital admissions could be £25.6m per year. By further applying the average re-admission rate for patients being re-admitted within a year (16%), we estimate the saving from reduced hospital re-admission could be £4.1m.

<u>Reductions in avoidable mortality</u>

135. From 2018 to 2020, the average rate of avoidable deaths among people with a learning disability was 683 people per 100,000,[78] more than 3 times higher than the general population (average of 224 avoidable deaths per 100,000 population in 2018 and 2019). Applying the avoidable death rate to the population of people with a learning disability and autistic people, this suggests that there are around 2,050 avoidable deaths among people with a learning disability and autistic people each year. As the avoidable deaths data do not capture autistic people, it adds another dimension of uncertainty to the benefits we report in relation to avoidable deaths.

136. To calculate the expected reduction in avoidable deaths, we multiplied the assumed 5% reduction by the number of avoidable deaths each year among people a learning disability and autistic people. We therefore estimate 102 fewer avoidable deaths a year, if all staff are trained and there has been no skills fade in staff already trained.

137. 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.[79]

138. Our calculation in the number of SLYs gained per avoided death consists of three main components: (1) the difference in life expectancy for those who were reported in the LeDeR report and the wider population with learning disability and/or autism, (2) the general increase in life expectancy, and (3) the positive gain in life expectancy that could result from the OMMT.

   (1) The median age at death for people with a learning disability and autistic people studied in the LeDeR review (adults and children included) was 60 years during 2018 to 2020.[80] This differs from the average age of death for people with a learning disability and autistic people reported by NHS Digital in the same period, cited as 66.5 years old.[81]

   (2) We also account for the increase in life expectancy from birth during 2018 to 2020. For the general population, the increase in life expectancy in the same period is 3.1 years. This is calculated by subtracting the median age at death for the general population (82.3 for males and 85.8 for females, giving an average of 84.05) from the median life expectancy at birth (79.0 years for males and 82.9 for females, giving an average of 80.95).[82]

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[78] University of Bristol (2020). The Learning Disabilities Mortality Review (LeDeR) Programme: Annual report. Accessed <u>here</u>. *We calculated the avoidable death rate among people with a learning disability by taking the average of the death rates reported from 2018 to 2020. This data is presented in figure 4.2 (page 39).*

[79] HM Treasury (2022). The Green Book – Central Government Guidance on Appraisal and Evaluation. Accessed <u>here</u>.

[80] University of Bristol (2020). The Learning Disabilities Mortality Review (LeDeR) Programme: Annual report. Accessed <u>here</u>.

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

[82] ONS (2021). National Life Tables – Life Expectancy in the UK: 2018 to 2020. Accessed <u>here</u>.

Taking the average value from the LeDeR reports,[83,84] people with a learning disability and autistic people are reported to have 2.6 times higher risk of avoidable death compared to the general population. This means there is a difference in risk of 1.6 compared to the general population (where the general population's is 1). We used this figure to downscale the increase in life expectancy to 1.90 years (3.1/(2.63-1) = 1.90).

(3) We assume that the OMMT would positively impact life expectancy among people with a learning disability and autistic people where it is successful. To calculate the extent of this, we compared the difference in average age at death of people with a learning disability and autistic people between the overall population covered in NHS Digital and the population covered in LeDeR reported above (66.5-60.0 years = 6.5 years). We then accounted for the increase in life expectancy, as described above (6.5+1.90=8.40 years).

139. 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 expected additional SLY brought by the OMMT per avoidable death is therefore calculated as 0.42 year (8.40*5%).

140. In total, we estimate that those who may have otherwise suffered an avoidable death to gain 8.82 years of life (8.40 + 0.42). Given the uncertainty of these assumptions, we also tested other values for the expected additional SLY brought by the OMMT, from 10.58 years to 7.06 years, this is an increase and decrease of 20%.

141. Based on the above, by multiplying the number of SLYs gained per death avoided (8.82 SLYs), the monetary value of a SLY (£70,000) and the number of avoided deaths related to the OMMT (102.3), we estimate the wellbeing value of reduction in deaths to be £63.2m per year (in 2022/23 prices).

142. We have not applied an adjustment to this assumed impact of the OMMT to account for optimism bias,[85] and instead we tested different values for the assumed impact of OMMT and for the expected additional SLY in in our sensitivity analyses, which is deemed to provide a range suitable for the expected uncertainty.

143. Overall, we estimate that, across a 10-year appraisal period, Option 1 is associated with £230.2m in monetised benefits and Option 2 is associated with £456.5m in monetised benefits. All figures are presented in summary tables below: table 15 for Option 1 and table 16 for Option 2.

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

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

[67] *Optimism bias is the tendency for appraisers to be over-optimistic about project parameters, including capital costs, operating costs, project duration and benefits delivery as defined in the Green Book.*

Table 15 – Monetised benefits for Option 1, discounted and price based 22/23 (in £millions)

Total benefits (£m)	2022/23	2023/24	2024/25	2025/26	2026/27	
Reduced hospital admissions	£3.0	£5.4	£7.4	£9.0	£10.2	
Reduced hospital re-admissions	£0.5	£0.9	£1.2	£1.4	£1.6	
Reduced avoidable mortality	£7.3	£13.6	£19.0	£23.6	£27.2	
Total	**£10.8**	**£19.9**	**£27.6**	**£34.0**	**£39.0**	

Total benefits (£m)	2027/28	2028/29	2029/30	2030/31	2031/32	Total
Reduced hospital admissions	£7.9	£6.1	£4.7	£3.6	£2.8	£60.0
Reduced hospital re-admissions	£1.3	£1.0	£0.7	£0.6	£0.4	£9.6
Reduced avoidable mortality	£21.4	£16.8	£13.2	£10.4	£8.2	£160.6
Total	**£30.5**	**£23.8**	**£18.6**	**£14.6**	**£11.4**	**£230.2**

Table 16 – Monetised benefits for Option 2, discounted and price based 22/23 (in £millions)

Total benefits (£m)	2022/23	2023/24	2024/25	2025/26	2026/27	
Reduced hospital admissions	£5.9	£10.7	£14.7	£17.9	£20.2	
Reduced hospital re-admissions	£0.9	£1.7	£2.4	£2.9	£3.2	
Reduced avoidable mortality	£14.5	£27.0	£37.7	£46.8	£53.9	
Total	**£21.4**	**£39.5**	**£54.7**	**£67.6**	**£77.4**	

Total benefits (£m)	2027/28	2028/29	2029/30	2030/31	2031/32	Total
Reduced hospital admissions	£15.6	£12.0	£9.3	£7.1	£5.5	£119.0
Reduced hospital re-admissions	£2.5	£1.9	£1.5	£1.1	£0.9	£19.0
Reduced avoidable mortality	£42.4	£33.3	£26.2	£20.6	£16.2	£318.5
Total	**£60.5**	**£47.2**	**£36.9**	**£28.8**	**£22.5**	**£456.5**

Non-monetised benefits of Options 1 and 2

Reduction in health and social care costs

144. The purpose of the OMMT is to improve how routine health and social care support benefits people with a learning disability and autistic people. There are substantial benefits that could be realised through the roll out of the OMMT which we are unable to monetise at this stage.

Cost savings to the NHS and adult social care related to a reduction in escalation of needs

145. Most notably, non-monetised benefits relate to cost savings to the NHS from preventing an escalation of health needs among people with a learning disability and autistic people. 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. In addition, this could extend to other health care services, for example reducing repeated GP appointments or inappropriate A&E usage.

146. The OMMT is intended to help social care staff to better understand the needs of people with a learning disability and autistic people, and this could potentially lead to further cost savings in adult social care services owing to a reduction in escalated support needs.

Wellbeing value of reduced morbidity among people with a learning disability and autistic people

147. There is evidence that people with a learning disability are more likely to suffer from specific health conditions than the general population.[86] In some instances, these conditions may be preventable or they may be managed to reduce detrimental effects to wider 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. However, we have not been able to quantify morbidity or its effects on health and wellbeing, and we intend to seek further inputs on addressing this gap in our analysis alongside the Code of Practice consultation process.

Other non-monetised benefits

148. There could also be a benefit in reducing delays to treatment and delayed discharges as staff should be better equipped with the knowledge and skills to provide safe, compassionate and informed care for people with a learning disability and autistic people. This could both improve the health outcomes of people with a learning disability and autistic people and save costs in potentially speeding up discharges.

149. 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, potentially increasing their household income.

Reduction in clinical negligence claims

150. 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.

151. 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.

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

LeDeR review cost savings

152. 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.[87] 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.

153. The OMMT is intended to improve the quality of care and health outcomes among people with a learning disability and autistic people, so we assume there would be a reduction in avoidable deaths amongst this group. We expect this would 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

154. This section outlines the key assumptions and variables in the cost and benefit analysis model we explained above (the central scenario) and presents alternative scenarios: the best- and worst-case scenarios.

155. The assumptions tested in this section are limited to those we think will have material impact on the Net Present Value (NPV) of the policy options, or scenarios that could potentially occur, which we gauged through engaging with stakeholders. We present how changing these assumptions affects the NPV, while keeping other variables in the cost benefit analysis constant (as they are under the central scenario). We then present the two scenarios where key assumptions are varied simultaneously to provide estimates of the best- and worst-case scenarios.

156. Given the uncertainties around some variables, after engaging with key OMMT stakeholders, we included some possible scenarios in the sensitivity tests, where it might not be possible to mirror the change in the variable in both the best- and worst-case scenario. Table 17 below presents a summary of all variations that were used in our sensitivity testing.

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

Table 17. Summary of key assumptions, variables and sensitivities.

Key assumptions and variables	Central scenario	Worst-case scenario	Best-case scenario
Proportion of staff receiving tier 1 and tier 2 training in the adult social care sector	56% (T1) and 44% (T2)	36% (T1) and 64% (T2) (20% pts shift)	76% (T1) and 24% (T2) (20% pts shift)
Proportion of staff receiving tier 1 and tier 2 training in the private healthcare sector	45% (T1) and 55% (T2)	25% (T1) and 75% (T2) (20% pts shift)	65% (T1) and 35% (T2) (20% pts shift)
The margin on private healthcare staff salary over NHS salaries	34%	54% (20% pts increase)	14% (20% pts decrease)
EbE's participation time in the training	Tier 1 training – 1 hour Tier 2 training – 8 hours	Tier 1 training – 1.5 hours Tier 2 training – 12 hours (150%)	Tier 1 training – 0.5 hour Tier 2 training – 4 hours (50%)
FTE for EbEs	0.5 FTE	0.2 FTE (0.3 FTE decrease)	0.8 FTE (0.3 FTE increase)
Class size for tier 1 and tier 2 training	Tier 1 training – 20 Tier 2 training – 30	Tier 1 training – 10 Tier 2 training – 15	Tier 1 training – 50 Tier 2 training – 50
OMMT training uptake rate	100%	N/A	90%
Parts of OMMT that can come under Continuous Professional Development / headroom for NHS staff	None	N/A	Tier 1 – all comes under CPD / headroom Tier 2 – all e-learning and half (4 hours) of face-to-face session
Tier 2 training participants to go through the entire tier 1 training	Tier 2 training participants will only go through the e-learning module in tier 1 training before receiving tier 2 training. They do not do the online webinar.	Tier 2 training participants will go through the entire tier 1 training before receiving tier 2 training.	N/A
Expected impact of OMMT in reducing avoidable deaths, mental health hospital admissions and readmissions	5.00%	2.50% (50%)	10.00% (200%)
Statistical life years (SLY)	8.82 years gained per death avoided	7.06 years gained per death avoided (-20%)	10.58 years gained per death avoided (+20%)

157. Amongst all the variables and assumptions in table 17, we identified three that would create material impact on the overall NPV of the policy options; these are: (1) proportion of staff receiving T1 versus T2 training in the adult social care sector; (2) proportion of staff receiving T1 versus T2 in the private healthcare sector; and (3) the expected impact of the OMMT in reducing avoidable deaths, mental health hospital admissions and re-admissions. In table 18 below, we present their impact on the NPV of the different policy options under different scenarios.

Table 18. Impact of varying assumptions and key variables on NPV (2022/23 prices, discounted).

Key assumptions and variable	Scenario	Policy option	NPV (£m)	Change in NPV (£m)
Proportion of staff receiving tier 1 and tier 2 training in the adult social care sector	Central (56% for Tier 1 training and 44% for Tier 2 training)	Option 1	-297.6	-
		Option 2	-141.0	-
	Worst-case scenario (36% for Tier 1 training and 64% for Tier 2 training) – 20% pts change	Option 1	-314.1	-16.5
		Option 2	-184.5	-43.5
	Best-case scenario (76% for Tier 1 training and 24% for Tier 2 training) – 20% pts change	Option 1	-281.1	+16.5
		Option 2	-97.4	+43.6
Proportion of staff receiving tier 1 and tier 2 training in the private healthcare sector	Central (45% for Tier 1 training and 55% for Tier 2 training)	Option 1	-297.6	-
		Option 2	-141.0	-
	Worst-case scenario (25% for Tier 1 training and 75% for Tier 2 training) – 20% pts change	Option 1	-313.1	-15.5
		Option 2	-160.2	-19.2
	Best-case scenario (65% for Tier 1 training and 35% for Tier 2 training) – 20% pts change	Option 1	-282.6	+15.0
		Option 2	-122.3	+18.7
Expected impact of OMMT in reducing avoidable deaths, hospital admissions and re-admissions	Central (5.00%)	Option 1	-297.6	-
		Option 2	-141.0	-
	Worst-case scenario (2.50%) – 50% of the original value	Option 1	-414.6	-117.0
		Option 2	-373.0	-232.0
	Best-case scenario (10.00%) – 200% of the original value	Option 1	-52.1	+245.5
		Option 2	345.9	+486.9

Breakeven analysis for both options

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

158. We estimate the figure needed for the expected impact of the OMMT in reducing avoidable deaths and mental health hospital admissions and re-admissions to be 11.02% and 6.48% for Options 1 and 2, respectively, to allow the options to have a breakeven NPV (zero). This means that under our central scenario the needed impact for breakeven is only 1.48% points higher than our current assumption of 5% and, therefore, may be feasible.

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

159. Under the central scenario, we assumed that all time taken by NHS staff to complete the OMMT 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.

160. We calculated that, under Option 1, all of tier 2 training would need to be absorbed under CPD / headroom for NHS staff to reach a NPV of £0.42m (just above breakeven). This is

equivalent to 9.5 hours of staff time and may not be feasible given other mandatory training requirements.

161. We calculated that, under Option 2, all of tier 1 training, all of tier 2 e-learning and 25% of tier 2 face-to-face session would need to be absorbed under CPD / headroom for NHS staff to reach a NPV of £0.42m (just above breakeven). This is equivalent to 2.5 hours for those taking tier 1 and 3.5 hours for those taking tier 2 – this may be feasible to achieve.

Summary of costs and benefits under worst- and best-case scenarios for both options

162. Tables 19 and 20 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. The analysis suggests that worst-case assumptions could lead to our preferred Option 2 to have a -£627.8 million NPV. In the best-case scenario, Option 2 would have a NPV of £703.1 million.

163. However, some figures in the best- and worst-case scenarios are unlikely to be feasible in practice. For example, in the worst-case scenario, we are expected to hire almost 2,900 EbEs in the first year, which is unlikely to be feasible in reality. Therefore, the figures presented in this section should be interpreted with caution.

Table 19. 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
Costs			
Training costs (tier 2 sessions + additional costs)	£ 107.5	£ 222.5	£ 59.2
Opportunity costs	£ 420.4	£ 532.5	£ 174.7
Total costs	**£ 527.8**	**£ 755.0**	**£ 233.9**
Benefits			
Reduced hospital admissions	£ 60.0	£ 35.6	£ 88.2
Reduced hospital re-admissions	£ 9.6	£ 5.7	£ 14.1
Reduced avoidable mortality	£ 160.6	£ 74.5	£ 297.0
Total benefit	**£ 230.2**	**£ 115.9**	**£ 399.4**
Net Present Value	**- £ 297.6**	**- £ 639.1**	**£ 165.5**

Table 20. 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
<u>Cost</u>			
Training costs (tier 2 sessions + additional costs)	£ 117.2	£ 239.0	£ 63.3
Opportunity costs	£ 480.2	£ 582.3	£ 209.5
Total cost	**£ 597.5**	**£ 821.2**	**£ 272.8**
<u>Benefits</u>			
Reduced hospital admissions	£ 119.0	£ 59.5	£ 215.6
Reduced hospital re-admissions	£ 19.0	£ 9.5	£ 34.5
Reduced avoidable mortality	£ 318.5	£ 124.4	£ 725.8
Total benefit	**£ 456.5**	**£ 193.5**	**£ 975.9**
Net Present Value	**- £ 141.0**	**- £ 627.8**	**£ 703.1**

Summary of opportunity costs and cost savings related to DHSC/NHSE spending

164. For the purposes of this IA and while the implementation plan for the OMMT is decided, we assumed that DHSC/NHSE will be responsible for funding training costs (T2 sessions and additional costs) across the healthcare and adult social care sectors. Table 21 below presents a summary of the associated opportunity costs for all scenarios under both policy options.

Table 21. Opportunity cost of DHSC/NHSE spending and saving under the central, best- and worst-case scenarios for the Options 1 and 2 (QALYs rounded to the nearest number).

Option 1	Central scenario	Worst-case scenario	Best-case scenario
Opportunity cost for spending in QALYs terms	7,164 QALYs	14,831 QALYs	3,945 QALYs
Opportunity cost in societal value	£501.5m	£1,038.2m	£276.2m
Cost savings in QALYs terms	4,640 QALYs	2,756 QALYs	6,823 QALYs
Cost savings in societal terms	£324.8m	£192.9m	£477.6m
Option 2			
Opportunity cost for spending in QALYs terms	7,814 QALYs	15,930 QALYs	4,223 QALYs
Opportunity cost in societal value	£547.0m	£1,115.1m	£295.6m
Cost savings in QALYs terms	9,199 QALYs	4,600 QALYs	16,672 QALYs
Cost savings in societal terms	£644.0m	£322.0m	£1,167.1m

Direct costs and benefits to business calculations

165. From our estimations, we expect there will be costs to businesses. Specifically, these will be a mix of opportunity and direct training costs. They are relevant for private healthcare providers, incl. dentists, and for private adult social care providers. These costs are summarised in tables 22 and 23 below. We did not estimate any benefits for businesses.

166. Opportunity costs are not included in the Equivalent Annual Net Direct Cost to Business (EANDCB) calculations, as they do not represent direct costs. In addition, we assume that DHSC funding will be available to cover training costs for adult social care staff, whether they work in public or private organisations. Therefore, only direct training costs for private healthcare staff (incl. dentists) are included for EANDCB purposes – these are shown in the last rows of tables 22 and 23. After applying relevant discount and deflation factors to bring the costs to 2019 prices, 2020 base year, they become £4.7m and £5.0m for Options 1 and 2, respectively. Under a ten-year appraisal period, these costs become £0.5m and £0.6m per year for Options 1 and 2, respectively.

167. If we account for a possibility that DHSC funding will not be made available to cover training costs for adult social care stuff, then these costs become £38.1m and £40.2m reflected in 2019 prices, 2020 base year, for Options 1 and 2, respectively. Under a ten-year appraisal period, these costs become £4.4m and £4.7m for Options 1 and 2, respectively.

Table 22. Summary of opportunity (indirect) and direct training costs relevant for businesses under Option 1 (in £million in 2022/23 prices, not discounted).

Costs (£m)	2022/23	2023/24	2024/25	2025/26	2026/27	Total
Private healthcare (excl. dentists) – opportunity cost	£11.0	£11.3	£11.5	£11.7	£11.8	£57.2
Private healthcare (excl. dentists) – direct training costs	£1.1	£1.1	£1.1	£1.2	£1.2	£5.7
Private dentists – opportunity cost	£0.3	£0.3	£0.3	£0.3	£0.3	£1.6
Private dentists – direct training cost	£0.03	£0.03	£0.03	£0.03	£0.02	£0.1
Private adult care social – opportunity cost	£11.8	£12.1	£12.4	£12.7	£11.9	£60.9
Private adult care social – direct training cost	£8.1	£8.3	£8.5	£8.8	£8.2	£41.9
Total private sector	**£32.4**	**£33.2**	**£33.9**	**£34.7**	**£33.3**	**£167.5**
Direct costs to business	**£1.1**	**£1.1**	**£1.2**	**£1.2**	**£1.2**	**£5.8**

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

Costs (£m)	2022/23	2023/24	2024/25	2025/26	2026/27	Total
Private healthcare (excl. dentists) – opportunity cost	£12.2	£12.5	£12.7	£13.0	£13.0	£63.4
Private healthcare (excl. dentists) – direct training costs	£1.2	£1.2	£1.2	£1.2	£1.3	£6.1
Private dentists – opportunity cost	£0.3	£0.3	£0.3	£0.3	£0.3	£1.6
Private dentists – direct training cost	£0.03	£0.03	£0.03	£0.03	£0.02	£0.1
Private adult care social – opportunity cost	£15.7	£16.1	£16.6	£17.0	£15.9	£81.3
Private adult care social – direct training cost	£8.6	£8.8	£9.0	£9.2	£8.6	£44.2
Total private sector	**£38.0**	**£38.9**	**£39.9**	**£40.8**	**£39.1**	**£196.7**
Direct costs to business	**£1.2**	**£1.2**	**£1.2**	**£1.3**	**£1.3**	**£6.2**

Risks and assumptions

168. 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.

169. Much of the specifics of the OMMT roll out will be determined by the Code of Practice. Timings for a consultation on the Code of pPractice are still being considered. As part of this process, we will produce another IA where we will revisit our assumptions.

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

- 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.[88] 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.

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[88] 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).

- 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, it is likely that the monetised benefits (for example, those related to SLYs) have been underestimated in our analysis.

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

172. 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

173. The extent of the impact on small and micro businesses (SMBs) will become clearer once the Code of Practice is published. We will review this when we produce another IA at the time of consultation on the Code of Practice.

174. Across the adult social care sector in England, approximately 90% of domiciliary care providers and 78% of residential care providers are SMBs.[89] For the healthcare sector across the UK, 97% of providers are SMBs.[90] As SMBs comprise most of the markets, we would expect any potential burdens and benefits to fall largely to them.

175. 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.[91] 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.

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

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

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

176. 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. However, as this is related to the model of delivery, we will consider this in greater detail alongside other code of practice developments as part of our later IA.

Wider impacts

Equalities

177. 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.

178. The public sector equality duty (PSED) may be relevant to this intervention. However, the development of the implementation plan for this policy is at an early stage. As required by law we will run a formal, public consultation on the draft code of practice, following which we will produce another IA. We intend to carry out an Equalities Impact Assessment at the same time, since we expect our policy interventions will be further developed.

Unintended consequences

179. 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 (see paragraph 162).

180. 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.[92,93,94] Therefore, there is a risk that this potential unintended consequence could exacerbate such regional variation issues.

Competition and innovation

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

Monitoring and Evaluation

182. 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).

183. 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

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

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

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

approach in recognition that any behavioural and cultural changes take time to yield changes.

184. 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.

185. 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 and skills.

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

187. 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.

188. 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.

189. As we have already evaluated the trial of the OMMT, we are using learning from this evidence to inform roll out, including whether the training packages need to be amended to best meet our objectives. While we have not yet finalised the packages of training, we will use the NDTi evaluation to inform the agreed approach.

190. Whilst discussions are ongoing, we anticipate that the training package will be evaluated during roll out to understand the impact on learning outcomes for health and social care staff. This could be on a national level or on a local level. As part of the evaluation of roll out, we will consider the extent to which participation in training leads to motivation to apply the learning in practice and change behaviour. We will monitor outcomes for people with a learning disability and autistic people through data provided in the Assuring Transformation dataset and the findings of the annual LeDeR reports.