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

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

Impact Assessment (IA)

Date: 26th April 2024

Stage: Final

Source of intervention: Domestic

Type of measure: Secondary legislation

Contact for enquiries: Chrissie Frankland

RPC Opinion: Informal: no rating provided

Summary: Intervention and Options

Cost of Preferred Option			
Total Net Present Social Value (in 2023 prices)	**Business Net Present Value** (in 2023 prices)	**Net direct cost to business per year** (in 2019 prices, 2020 base year)	**Business Impact Target Status** Non qualifying provision
- £1,484m	- £464m	£54m	

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

People with a learning disability and autistic people experience significant health inequalities and on average die earlier than the general population. Around half of these deaths are considered to be avoidable. Research with health and social care staff indicates that a lack of understanding and knowledge of learning disability and autism likely contributes to this. Over the past 15 years, key organisations have recommended mandatory training to improve the quality of care and reduce avoidable deaths. Despite consensus on the importance of such training, health and social care staff continue to report a lack of training opportunities.

Without Government intervention, the issues above will persist, and the health inequalities experienced by people with a learning disability and autistic people due to lack of staff understanding will not diminish. This is why the Health and Care Act 2022 introduced a requirement that, from 1 July 2022, service providers registered with CQC must ensure their staff receive training on learning disability and autism appropriate to their role. A primary legislation impact assessment (PLIA) was published in July 2023 which separately sets out the costs and benefits of this legal requirement and the non-legislative options considered at the time.

In order to optimise the benefits of mandatory training and assure high-quality training provision, further Government action is needed to provide statutory guidance on how registered providers should meet their legal requirement. Under the Health and Care Act 2022, the Secretary of State for Health and Social Care has a duty to issue a code of practice about compliance with the legal requirement for training on learning disability and autism which must make provision about the content, delivery, monitoring and evaluation of training.

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

This impact assessment (IA) considers the introduction of the code of practice to support registered providers to comply with the legal requirement on learning disability and autism training which sets out proposed standards. This includes consideration of central support for the rollout of the Oliver McGowan Mandatory Training on Learning Disability and Autism (Oliver's Training), the Government's preferred and recommended training package for registered providers as outlined in the code, which intends to accelerate training uptake and thereby compliance with the legal requirement.

The overall policy objective is to ensure that health and social care staff, in scope of the Health and Care Act 2022 requirement, have the knowledge and skills to provide safe, compassionate, and informed care to people with a learning disability and autistic people. The code of practice sets out the standards for training that registered providers are expected to meet which are designed to ensure that all staff receive standardised, high-quality training on learning disability and autism. The desired effects are that people with a learning disability and autistic people receive consistently high-quality care, resulting in lower health disparities, have better health outcomes and are less likely to die prematurely. Indicators of success will include monitoring outcomes through the Health and Care of People with Learning Disabilities dataset, annual LeDeR (Learning from Lives and Deaths of People with a Learning Disability and Autism) reports, and independent evaluation of Oliver's Training.

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

In 2019, following public consultation, the Government committed to developing and testing a standardised learning disability and autism training package – the Oliver McGowan Mandatory Training on Learning Disability and Autism (Oliver's Training) – which has since been trialled and evaluated. Prior to this, there had been recommendations for better training on learning disability and autism and work undertaken to support this, such as the issuing of core capabilities frameworks for supporting people with a learning disability and autistic people. This was on a voluntary basis, however, and health inequalities persisted.

Whilst training on learning disability and autism has been mandated under the Health and Care Act 2022, there remains a need to ensure the legal requirement is effectively followed to accelerate improvements to the knowledge and skills of health and social staff and a reduction in the health inequalities experienced by people with a learning disability and autistic people. The code of practice sets out expectations for training content and delivery and states that Oliver's Training is the government's preferred and recommended training package for registered providers to meet their new statutory requirement. This final IA considers the preferred option: the roll out of Oliver's Training is delivered with Government funding to meet direct costs for the adult social care and public healthcare sectors and in line with the code of practice with proposed standards we consulted upon. The option is considered against Option 0 – 'business as usual', where providers are expected to meet their statutory requirement and Government neither issues a code of practice setting out expectations nor takes action to optimise roll out of Oliver's Training. Under Option 1, DHSC establishes an operational delivery model which will subsidise Oliver's Training roll out to the health and social care workforce from 2024/2025. Option 1 is preferred as it has been assessed as most likely to deliver the intended impacts of the policy under consideration, however it is contingent on DHSC's agreed funding in a future spending review. The negative net present value of Option 1 is due to the benefits not being included in the summary tables due to the degree of uncertainty in the supporting evidence. We have partially estimated potential benefits, notably missing some benefits for autistic people due to lack of data on the health and care support they receive.

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

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

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

Signed by the responsible Minister Stephen Kinnock Date: 07.05.2025

Summary: Analysis & Evidence

Policy Option 0

Description: This option represents the counterfactual, where business as usual continues with no further central guidance or support. In other words, this option means that health and care providers will need to meet the legal requirement for training on learning disability and autism but will not receive central guidance in a code of practice to understand expectations, or any central support to take up or have easier access to Oliver's Training.

FULL ECONOMIC ASSESSMENT

Price Base Year 2023	PV Base Year 2023	Time Period Years 10	Net Benefit (Present Value (PV)) (£m)		
			Low: n/a	**High:** n/a	**Best Estimate:** 0

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

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

Primary legislation introduced a requirement for mandatory training on learning disability and autism on 1 July 2022. Option 0 is where no further action is taken by government following the introduction of mandatory training. Under this option, a code of practice is not issued to support health and care providers to understand and meet expectations of the legal requirement, and no central support is provided to roll out Oliver's Training.

This option is only used as a counterfactual against which policy Option 1 is assessed and does not reflect a viable policy position. In practice, CQC-registered providers have been required to meet the legal requirement since July 2022 and the Secretary of State for Health and Social Care has a duty to issue a code of practice to support with this. Further government action is needed to ensure the requirement is implemented effectively to maximise its intended impact, including through central support to improve roll out of Oliver's Training which is both the government's recommended training package and the only known package which currently meets the standards set out in the code of practice. Without this intervention, there will be inconsistency and variation in the quality of training undertaken and delay in training uptake to comply with the legal requirement, and continued issues with accessing Oliver's Training, which will minimise the intended benefits of mandatory training to the health and care workforce and the intended impact to improve outcomes for people with a learning disability and autistic people.

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

At present, there isn't strong enough evidence to estimate these potential costs and we therefore assume the value of costs in Option 0 are zero for the purpose of this impact assessment. As flagged above, this is not a viable policy position to pursue and is used as a counterfactual to assess Option 1 against.

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

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

As above, this is the counterfactual against which policy Option 1 is assessed. With limited evidence on any existing costs, the value of costs and benefits are assumed to be zero.

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: A code of practice is issued to guide providers on how to meet the legal requirement. Oliver's Training is rolled out with Government funding for the adult social care and public healthcare sectors.

FULL ECONOMIC ASSESSMENT

Price Base Year 2023	PV Base Year 2023	Time Period Years 10	Net Benefit (Present Value (PV)) (£m)		
			Low: -1,642	High: -788	Best Estimate: - 1,484

COSTS (£m)	Total Transition (Constant Price)	Years	Average Annual (excl. Transition) (Constant Price)	Total Cost (Present Value)
Best-case scenario	n/a	n/a	91	**788**
Worst-case scenario	n/a		190	**1,642**
Best Estimate	n/a		172	**1,484**

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

The best estimate of costs (discounted in 2023 prices) includes:
(1) direct training and additional costs related to the delivery of training at £242m.
(2) staff time costs to the NHS (£840m), private healthcare (£146m), public adult social care (£29m) and private adult social care (£227m). The staff time costs refer to the economic cost for the sector to undertake Oliver's Training instead of other activities. For the purposes of this IA, staff time costs are treated as direct costs for measuring impacts on businesses.

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

No other major costs identified at this stage.

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

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

Due to the degree of uncertainty around supporting evidence, we have not included any monetised benefits in these summary tables. However, in the main body of this Impact Assessment, we have provided an illustrative analysis showing an estimation of partial benefits if Oliver's Training reduced the gap in health inequalities of people with a learning disability and autistic people compared to the general population by 6%. Since this 6% is uncertain, we also show a break-even analysis in the sensitivity analysis section.

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

The key non-monetised benefits are related to the societal value of reduced morbidity and better management of conditions among people with a learning disability and autistic people, associated with improved routine support provided by health and care staff. Our analysis is only a partial estimation of benefits, as we were only able to estimate limited benefits for autistic patients due to lack of available data on their health and care, however, many of the identified benefits for patients with a learning disability also apply to autistic patients. We were only able to estimate a selection of possible NHS cost savings, notably missing savings from prevention of obesity and upper respiratory tract conditions, increased access to vaccination programmes and earlier identification of dental issues.

Key assumptions/sensitivities/risks	Discount rate	3.5%

All cost and benefits estimations are discounted at 3.5%, except for the societal value derived from the increase in statistical life years, which is discounted at 1.5%. Key assumptions are that training will follow recommendations from Oliver's Training trial evaluation in terms of audience, content and delivery, and that roll out will last 3 years. The assumptions are described in detail in later sections. Key risk is that Oliver's Training is not rolled out to all staff.

BUSINESS ASSESSMENT (Option 1)

Direct impact on business (Equivalent Annual) (in 2019 prices, 2020 base year) £m:			Score for Business Impact Target (qualifying provisions only) £m:
Costs: 53.9	**Benefits:** 0	**Net: 53.9**	Not applicable

Contents

Problem under consideration and rationale for intervention

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

1. People with a learning disability and autistic people experience premature mortality – the disparity between the median age at death for people with a learning disability and the general population is 20 years for males and 23 years for females[1], while autistic adults, on average, die 16 years earlier than non-autistic adults.[2] Autistic adults who do not have a learning disability are 9 times more likely to die from suicide compared to the general population.[3]

2. A significant proportion of these deaths are avoidable. Published in November 2023, the Learning Disabilities Mortality Review (LeDeR) Programme annual report found that 42% of adult deaths in 2022 were avoidable.[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. 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]

4. 80% of autistic adults have reported difficulty in accessing a GP compared to 37% of non-autistic respondents, with the barriers they face including difficulty booking appointments, for example having to use the phone, patient-provider communication, with both receptionists and doctors, sensitivities to the surroundings, such as waiting rooms, past negative lived experience, and anxiety over stigma or 'wasting the doctor's time'. Suggestions to help reduce these barriers include formal autism training, environmental adaptations, and improved general knowledge on autism for all staff. [8]

5. Evidence indicates that health and social care professionals who do not work in learning disability services tend not to be as comfortable working with people with a learning disability, because they do not know enough about learning disabilities and have not had

[1] The Learning Disabilities Mortality Review (LeDeR) Programme: Annual Report 2022. 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] Autistica

[4] The Learning Disabilities Mortality Review (LeDeR) Programme: Annual Report 2022. Accessed here.

[5] National Institute for Health and Care Excellence [NICE] (2021). Impact report: People with a Learning Disability. Accessed here.

[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] Ramsey, L., Albutt, A., Perfetto, K. *et al.* (2022). Systemic safety inequities for people with learning disabilities: a qualitative integrative analysis of the experiences of English health and social care for people with learning disabilities, their families and carers. *Int J Equity Health* 21(13).

[8] Doherty , M., Neilson, S., O'Sullivan, J., Carravallah, L., Johnson, M., Cullen, W. and C K Shaw, S. (2022). Barriers to healthcare and self-reported adverse outcomes for autistic adults: a cross-sectional study. *BMJ Open*, 12(2), E056904

specialist training, leading to delays and difficulties in referrals to specialist services and delays in people with a learning disability accessing the right help at the right time.[9] This in turn leads to exacerbating health inequalities and increased risk of premature death. Staff training is not only needed for specialist services, but to help autistic people and people with a learning disability to develop good basic everyday habits and living routines, for example maintaining good oral hygiene[10].

6. Evidence suggests that communication with people with a learning disability is a major barrier to individuals accessing health and social care.[11] Patients with a learning disability often feel that healthcare professionals do not adapt their communication for someone with a learning disability and talk to the carer or parent instead of the individual. This often leads to individuals struggling to express their health concerns, missed or delayed diagnoses,[12] and not understanding medication dosage or possible side effects and management of them. Therefore, better communication skills among healthcare and social care professionals could help people with a learning disability explain the health problem they are experiencing and receive more timely intervention, leading to reduced health inequalities and avoidable death.

7. People with a learning disability often experience diagnostic overshadowing[13] 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.[14,15] 50% of health care professionals surveyed by Mencap reported a lack of knowledge around learning disability; 42% reported that a lack of continuing professional development might be contributing to avoidable deaths; and 26% reported that negative attitudes towards people with a learning disability might be a contributing factor in avoidable deaths.[16]

8. There are difficulties associated with diagnosing mental or physical health conditions in the autistic population, due to conditions presenting themselves differently and the challenges the patient may face in self-reporting their problems[17]. Additionally, there is evidence that healthcare staff lack the skills and knowledge to make reasonable adjustments for diagnostic tools. This includes a lack of focus on the customisation of early intervention processes and health screenings, as well as recognising and monitoring deteriorating mental health.

9. Evidence indicates that greater knowledge of and more time spent with autistic people is associated with more positive attitudes towards autistic people.[18,19] Further, a training programme designed for parents of autistic children found their knowledge and skills

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[9] 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.

[10] The Challenging Behaviour Foundation (2023) Physical-Emotional-and-Mental-Health.pdf (challengingbehaviour.org.uk)

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

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

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

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

[15] 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.

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

[17] Autism-friendly MRI: Improving radiography practice in the UK, a survey of radiographer practitioners - ScienceDirect

[18] 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

[19] 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

increased and led to reduced anxiety in the children.[20] 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

10. 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% of hospital trusts provided content related to learning disabilities in their induction for clinical and non-clinical staff, respectively.[21] 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. It also found that almost half of staff responding thought that a lack of training on learning disability might be contributing to avoidable deaths and two thirds would like more training focussed on learning disability. In general practice, professionals have indicated they need to provide good care to people with a learning disability and autistic people but there is no mandatory training around this in primary healthcare; 64% of GPs reported they received less than a day's training on how to meet the needs of people with a learning disability and 60% said additional training is necessary.[22]

11. In 2019, Health Education England published the Core Capabilities Framework for Supporting People with a Learning Disability[23] and the Core Capabilities Framework for Supporting Autistic People[24] 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,[25] which specify 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 core capability frameworks at the time.

12. 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 specific health conditions. For instance, the CQC's 'State of Health Care and Adult Social Care in England 2019/2020' report indicated that mental health training in the context of learning disability services, which is not mandated, varied across trusts, and training did not always consistently provide staff or services with the understanding, level of awareness or practical knowledge to effectively embed learning into practice.[26]

13. The second LeDeR (Learning from lives and deaths – People with a learning disability and autistic people) report, covering the period July 2016 to November 2017, recommended the introduction of mandatory training on learning disability, which, alongside campaigning

[20] 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

[21] 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.

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

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

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

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

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

from stakeholders, led to the Government consulting on the introduction of mandatory training on both learning disability and autism. In 2019, 'Right to be heard', the Government's response to the consultation set out 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.[27]

Rationale for Government intervention

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

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

16. The Health and Care Act 2022 introduced a requirement that, from 1 July 2022, service providers registered with CQC must ensure their staff receive training on learning disability and autism appropriate to their role. A primary legislation impact assessment (PLIA) was published in July 2023 which sets out the rationale, costs and benefits of this legal requirement and the non-legislative options considered at the time. In order to optimise the benefits of mandatory training and assure high-quality training provision, further government action is needed to provide statutory guidance on how registered providers should meet their legal requirement. Under the Health and Care Act 2022, the Secretary of State for Health and Social Care (SofS) has a duty to issue a code of practice about compliance with the legal requirement for training on learning disability and autism which must make provision about the content, delivery, monitoring and evaluation of training.

Level of analysis used in the impact assessment

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

[27] 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.

18. The code of practice, which the SofS is required to issue under the legislation which sets out the new mandatory requirement, must specify how training should be delivered to staff by service providers. Its purpose is to ensure that all staff receive standardised, high-quality training, appropriate to their role which can facilitate the change in knowledge and skills that is needed to reduce health inequalities experienced by people with a learning disability and autistic people. The consultation on the draft code of practice fully closed on 16 October 2023 and responses have been considered to inform any revisions needed to the code of practice and the analysis in this impact assessment. Further information is set out under 'Description of policy development'.

19. A primary legislation impact assessment (PLIA) was published in July 2023 which separately sets out the rationale, costs and benefits of the legal requirement for learning disability and autism training and the non-legislative options considered at the time.[28] This impact assessment (IA) builds on the analysis in the PLIA, focusing on the introduction of the code of practice and support for registered providers to understand and meet the expectations of the legal requirement. This includes consideration of central support to roll out the Oliver McGowan Mandatory Training on Learning Disability and Autism (Oliver's Training) which the code of practice states is the government's recommended and preferred package to support CQC-registered health and care providers to meet the legislative requirement.

20. The Government developed Oliver's Training as a standardised training package on learning disability and autism which was trialled with over 8,000 people in 2021. Further information is set out under 'Description of policy development'. Roll out of the training commenced following evaluation and is still ongoing, therefore, we do not yet have a full understanding of how health and care organisations are accessing and delivering the training package in practice to their employees. The IA is, therefore, limited by assumptions about the operational delivery model for Oliver's Training. In addition, we started with a premise that everyone would do Oliver's Training, but in reality, that number may be less than 100% of health and care staff, if organisations do not choose the Government recommended package. At this stage, Oliver's Training is the only known training package which meets the standards set out in the code of practice.

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

    - the evaluation of the Oliver McGowan Mandatory Training Trial on Learning Disability and Autism;[29]
    - discussions with NHS England, Skills for Care and NHS Resolution;
    - a rapid evidence review of 22 studies on the effectiveness of training on changing health and social care staff knowledge, skills and behaviour, noting that this was limited and represents an under-researched area (the review process undertaken for the available literature is included in the Annex figure 1);
    - the Health and Care of People with Learning Disabilities Experimental statistics, which reports on the key differences in healthcare between people with a learning disability and those without, and various data sources from a search for unit costs of NHS services and treatments (e.g., Greater Manchester Combined Authority Unit Cost Database and academic articles);

[28] DHSC (2023). Mandatory training on learning disability and autism: primary legislation impact assessment. Accessed here.
[29] National Development Team for Inclusion (2022). Evaluation of Oliver's Training Trial in Learning Disability and Autism. Accessed here.

- evidence submitted by people with lived experience, people with professional experience and organisations via the 2019 consultation on mandating learning disability and autism training and the 2023 consultation on the Oliver McGowan draft code of practice;

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

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

23. A limitation to our approach in estimating the benefits of rolling out Oliver's Training is that the benefits we have been able to estimate related to reducing health inequalities among autistic people are limited, due to a lack of data on the health and care of autistic people.

Description of policy development

The Oliver McGowan Mandatory Training on Learning Disability and Autism

24. 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.

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

26. 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'*.[30] The consultation covered proposals for:

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

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

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

28. 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'*.[31] 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)[32] 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.

29. 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 Oliver's Training trial. The evaluation of this trial was published in June 2022,[33] and the report and its findings have been used to inform this IA.

Trial and evaluation of Oliver's Training

30. Content and delivery of two tiers of Oliver's Training was trialled and evaluated:

    - tier 1 training, designed for those who require a general awareness of autistic people and/or people with a learning disability; and

    - tier 2 training, designed for those provide care and/or support for autistic people and people with a learning disability, but rely on others for complex management.

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

32. The evaluation report recommended that tier 1 training take the form of a 90-minute e-learning module followed by a 1 hour online interactive webinar with two Experts by Experience,[34] and that the tier 1 package trialled is ready to be used without further amends.

33. The report did not make recommendations on a specific tier 2 training package. Overall, all three training packages were considered to have performed well 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.

[31] 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.

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

[33] National Development Team for Inclusion (2022). Evaluation of Oliver's Training Trial in Learning Disability and Autism. Accessed here.

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

Legislation: mandatory training on learning disability and autism

34. As of 1 July 2022, new requirements came in under the Health and Care Act 2022[35] for service providers that perform CQC-regulated activities[36] to ensure their staff receive training on learning disability and autism, appropriate to their role. This builds on the existing requirement set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014[37] that such staff should be provided with the training necessary to enable them to perform their duties.

35. CQC have one set of regulations that apply to all service providers, ensuring consistency and alignment with the legislation throughout. Regulated activities are detailed in Schedule 1 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014,[38] where each regulated activity is described and examples of services that are likely to carry out these activities are provided. Where we refer to 'workforce' throughout this document, we are referring to those working under the scope of this definition.

36. Children's social care where services are not carrying out a regulated activity are outside of the scope of CQC regulations.

37. The legislation also specifies that the Secretary of State for Health and Social Care (SofS) must issue a code of practice about compliance with the new requirement. The code must make provision about various aspects of training, such as its content, delivery method, accreditation and procurement, and monitoring and evaluation of the impact of training. The SofS also has a duty to review the code and lay before Parliament a report setting out the findings of the review at least once every 5 years.

38. While the code of practice is in development and before and after it is published, CQC will continue to regulate health and social care providers and services registered with CQC on the training requirement, under the requirements of the Health and Social Care Act 2008 (Regulated Activities Regulations) 2014 *Regulation 18 Staffing*. The additional training requirements for staff, appropriate to their role, expand on existing requirements which have always expected compliance with Regulation 18. Regulation 18 already requires registered providers to ensure staff receive such appropriate support, training, professional development, supervision, and appraisal as is necessary to enable them to carry out the duties they are employed to perform.

39. Once published, CQC will take into account the code of practice and how registered providers are meeting and complying with the requirements of regulation. If a registered provider has not followed the relevant guidance contained in the code then they will be expected to give good reasons to CQC on why they have departed from it and be able to demonstrate that it meets the requirement in a different way.

Code of Practice Consultation

40. On 27 June 2023 DHSC published a consultation to gather opinions on the draft code of practice which sets guidance on how providers can meet the requirement for all staff to receive the mandatory training on learning disabilities and autism. This consultation was published in both easy read and non-easy read format.

41. The consultation ran until 19 September 2023 for the non-easy read version and 16 October 2023 for the easy read version. It received 461 overall responses, including email

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

and postal submissions, with 375 from the non-easy read consultation and 86 from the easy read consultation. 182 (40%) of these responses were from organisations, 183 (40%) from people with professional experience, and 96 (21%) from people with lived experience.

42. Email responses were only considered when they directly answered the consultation questions and were treated the same as responses submitted in the standard digital form. Some email responses did not include answers to the closed questions and therefore are not counted in the figures below.

43. One postal response was received, in response to the easy read consultation. This response was treated the same as responses submitted in the standard digital form as it included answers to the same questions.

44. When asked if the overall purpose of the code was clear, 81% of respondents agreed. This included 77% from the non-easy read consultation and 98% from the easy read consultation. All closed questions had over a 50% agreement rate. Those who used free-text responses were more likely to raise practical concerns, for instance whether there is enough service capacity or backfill whilst other staff are on training to avoid impacts on patient care.

Table 1. Summary of consultation responses, by type of respondent and method of response

	Non-easy read	Easy read	Email (non-easy read)	Email or Postal (easy read)	Total
Organisations	151	10	18	3	182
Individuals with professional experience	142	40	1	0	183
Individuals with lived experience	63	31	0	2	96
Total	356	81	19	5	461

Table 2. Agreement rates for consultation question "Do you agree or disagree that the purpose of the code is clear?"[39]

	Overall	Non-easy read	Easy read
Organisations	77%	75%	100%
Individuals with professional experience	84%	80%	98%
Individuals with lived experience	81%	73%	97%
Total	81%	77%	98%

45. The key themes taken from the consultation were:

a) **Generally positive reception:** Overall, responses across all groups were supportive of the code and found it clear.
b) **Support for co-production:** There was positive feedback on the co-production and co-delivery of the training with people with a learning disability and autistic people which was viewed as an important way to make training impactful, and recognition that co-production and co-delivery of Oliver's Training positively differentiates it from other training packages.
c) **Implementation concerns:** Organisations and professionals have greater implementation concerns than people with lived experience, mainly focused on

[39] Email submissions have not been included in the calculations for agreement rates.

resources and funding for delivery including whether there is enough service capacity or backfill to avoid impacts on patient care.

d) **Appropriate level of training:** There was further clarity requested on which tier of training staff need to complete, as well as how to access alternative or further training packages, such as training to achieve tier 3 (see paragraph 83 for detail on tier 3).
e) **Accreditation:** Some organisations asked for more clarity on accreditation.
f) **Monitoring and evaluation:** More information was needed on how training completion and outcomes will be monitored.
g) **Expectations on repeating training:** Whilst the majority agreed that repeated training every three years is important, some wanted clarity on whether the training content would be kept relevant and tailored to users from different settings.
h) **Support and remuneration for trainers:** Across all groups, there were concerns around support for co-trainers with lived experience.
i) **Personal experiences:** Some respondents felt there was a need for better representation of their lived experiences in training content and delivery.

46. The feedback raised on the draft code of practice in the consultation has been considered to inform any revisions needed to the code of practice, Broader feedback specific to Oliver's Training has been shared with relevant partners involved in operational delivery.

47. The consultation asked additional questions to help inform this Impact Assessment. This included closed questions, used to largely improve our knowledge of the proportion of staff in each sector requiring either tier 1 or tier 2 training (see paragraph 30 for detail on tiers 1 and 2).

48. At consultation stage, given limited evidence we used an assumption that clinical staff would complete tier 2 of Oliver's Training and non-clinical staff would complete tier 1 of Oliver's Training. Evidence from the consultation, alongside further insight from NHSE stakeholders, has informed us that a higher proportion of staff may be required to undertake tier 2 training and therefore we have used a high, central and low estimate for the proportion of staff undertaking tier 1 and 2 training (see paragraph 143 for detail).

49. We also reviewed open text responses which were used to improve the overall evidence base. Respondents provided additional evidence on the effectiveness of training, the link between staff training and impacts on patients and service users and general ideas, information and evidence relating to Oliver's Training. A large proportion of the evidence we received related to the measuring and monitoring of outcomes, which will be considered in our monitoring and evaluation process through the National Institute for Health and Care Research (NIHR). Additional evidence received has been used to inform the rationale and intervention section.

Policy objective

50. The main policy objective is to improve health and social care staff's 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, appropriate to their role.

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

52. 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.

53. 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.

54. We expect there will be several indicators of success, from monitoring training records and feedback, to using ongoing data collection programmes and commissioning an independent evaluation of Oliver's Training roll-out. With regards to monitoring training records, the code of practice states that health and care organisations should use their existing staff record management systems to record their staff's training completion and that they are expected to make such data available to the relevant monitoring body (e.g. their Integrated Care Board or local authority) and collaborate in any future impact evaluation activity. With regards to Oliver's Training, the code of practice specifies that organisations are expected to ask staff to complete standardised feedback surveys, which can be made available to DHSC and its delivery partners or for the purposes of an independent evaluation of Oliver's Training. Outcomes can also be monitored through ongoing data collection programmes, such as through the annual reports of the LeDeR programme which from March 2022 has been extended to include deaths of autistic people without a learning disability, and through the annual Health and Care of People with Learning Disabilities experimental statistics.

Description of options considered in the IA

Option 0 – business as usual

55. The primary legislation introducing mandatory training on learning disability and autism came into force on 1 July 2022 (paragraph 34). The code of practice intends to set out how CQC registered service providers can meet this new requirement. Whilst the code of practice was in development, it was expected that service providers would continue to follow guidance on existing responsibilities and requirements for staff training such as Regulation 18 (paragraph 38).

56. Option 0 is to continue with 'business as usual' whereby no further action is taken centrally to specify how providers are expected to meet the legal requirement. Under this option, a code of practice is not issued to support health and care providers to understand and meet expectations of the legal requirement, and no central support is provided to roll out Oliver's Training. Option 0 does not reflect a viable policy position and is only used as a counterfactual to calculate the costs and benefits of Option 1, the preferred option. Issuing a code of practice is specified in law (paragraph 37) and must make provisions for the content and delivery of training. Without this intervention, there will be inconsistency and variation in the quality of training undertaken and government will not be able to set clear guidance for providers to demonstrate compliance with the legal requirement.

Option 1 (preferred) – A code of practice is issued to guide providers on how to meet the legal requirement, and Oliver's Training is rolled out with Government funding for the adult social care and public healthcare sectors.

57. The code of practice sets out four standards to guide compliance with the legal requirement for staff to receive learning disability and autism training appropriate to their role. The standards are informed by the evidence and learning from the trial and

evaluation of Oliver's Training and responses from the public consultation on the draft version of the code. In summary, the standards are as follows:

1) All staff receive training that covers a minimum curriculum of capabilities from the Core Capabilities Frameworks for supporting people with a learning disability and autistic people.

2) All staff receive training that enables them to explore how they will put their learning into practice.

3) All staff receive a minimum amount of live and interactive training that is co-produced and co-delivered by people with a learning disability and autistic people *(minimum expectations of how this should be delivered are outlined in the code).*

4) All staff receive training that is based on evidence and is quality-assured through trialling, ongoing evaluation, and accreditation.

58. The code of practice specifies that Oliver's Training is the Government's recommended and preferred package to support registered providers to meet the legal requirement, which meets the standards (paragraph 57). This IA assumes that the tier 1 and tier 2 packages of Oliver's Training will be rolled out to all staff in CQC registered health and care services. We assume that the use of alternative training packages are economically indistinguishable from Oliver's Training in this IA, please see section 'details of alternative options considered' below.

59. To deliver Oliver's Training, health and care organisations can either source a training provider or seek training for staff within their organisation (or network) to deliver Oliver's Training packages in-house. This IA considers the preferred option for the roll-out of Oliver's Training that includes the best estimates of the costs and uptake of the training. We assume funding will cover the costs of delivering Oliver's Training sessions and, in line with usual practices of Government funding for training interventions, does not cover staff time costs of staff taking the training. The options consider how such variations in funding might affect implementation and roll-out, and subsequently how variations in implementation and roll-out influence associated costs and estimated benefits. Without central support, we assume that health and care providers will be less likely to take up Oliver's Training or may have less access to Oliver's Training.

60. The costs should be interpreted as direct costs incurred in providing Oliver's Training package. The benefits within our illustrative analysis should be interpreted as benefits accruing as a result of staff receiving Oliver's Training package, which has been designed, trialled and evaluated to target the skills, knowledge and behavioural changes that are necessary to reduce health inequalities experienced by people with a learning disability and autistic people.

61. As a starting point, we considered what an optimal roll-out of Oliver's Training would look like and how much financial cost it is associated with. An optimal roll-out is one that completes in 3 years, assuming a start date of the 2023/24 financial year; where training is repeated every 3 years; where all staff undertake either the full tier 1 package or the full tier 2 package, and in line with the recommended staff roles for each tier and the standards outlined in the code of practice; and a high proportion of organisations opt to deliver Oliver's Training in-house.

62. We assume that some Government funding is needed to cover the financial costs associated with optimal roll-out which is the basis of this option. This option assumes that Government funding will support the adult social care and public healthcare sectors to

complete roll-out in 3 years. In 2024/2025, we intend to provide central funding to support registered health and care providers to meet the costs of roll-out of Oliver's Training to their staff. The decisions about the level of funding to support roll-out beyond the current spending review period are subject to a subsequent spending review.

Details of alternative options considered

63. In the consultation stage IA, we also considered an **Option 2** which would involve the roll-out of Oliver's Training being supported with funding that covers partial costs of roll-out for the adult social care and public healthcare sectors. In this case, we assumed roll-out will deviate from optimal (paragraph 61) in the following ways: it will take 5 years to train all staff; some staff groups, for whom tier 1 was intended, may not complete the full tier 1 package; some staff groups, for whom tier 2 was intended, may complete the tier 1 package instead of the tier 2 package; fewer organisations may opt to become accredited providers of Oliver's Training to deliver in-house. These variations formed the basis of Option 2 at consultation stage. To maximise the intended impacts of mandatory training, we have deemed a faster roll-out under Option 1 as optimal and as a result the consultation stage Impact Assessment Option 2 was not pursued.

64. To achieve compliance with the training requirement, providers must demonstrate how their training arrangements meet the standards set out in the code of practice. As mentioned in paragraph 58, for the purposes of this IA we assume that any alternative training is indistinguishable from Oliver's Training. At this stage, there are currently no known alternative training packages that meet the standards set out in the code of practice. However, some organisations may wish to adapt or develop packages to meet the training standards specified in the code of practice over time and these packages may become available during implementation of the code of practice. We assume that any such alternative packages would incur similar costs to Oliver's Training.

Preferred option with description of implementation plan

65. The code of practice provides some details of the implementation plan for Oliver's Training, which are summarised under specific headings below.

Who will undertake each tier of Oliver's Training

66. The following definitions are used to describe the intended staff groups or roles for tier 1 and tier 2 of Oliver's Training:

    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.

Oliver's Training content

67. Oliver's Training is based on the capabilities and learning outcomes described in the Capabilities Frameworks for Supporting People with a Learning Disability[40] and the Capabilities Framework for Supporting Autistic People.[41]

68. Tier 1 minimum content includes:

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

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

- 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.

69. Tier 2 minimum content includes all of tier 1, plus:

- Avoiding diagnostic overshadowing.
- Frequently co-occurring conditions (co-morbidities).
- The laws: Mental Capacity Act, Human Rights Act, Autism Act.
- Reasonable adjustments: what they are in health, including hospital passports.
- Culture (professional bias and subconscious beliefs), professional behaviour and impact on outcomes and other people's behaviour.
- Communication: how to communicate in an accessible way; how to understand what the person (and their family) is saying.
- Reference to ASK – LISTEN – DO.
- Learning from LeDeR.
- Annual health checks.

Oliver's Training delivery method

70. Tier 1 is delivered via a 90-minute e-learning module that training participants can complete in a single session or multiple depending on their individual preference, and a subsequent 1-hour live interactive webinar with two co-trainers (Experts by Experience) and a facilitating trainer. There is capacity for 30 training participants per each webinar.

71. Tier 2 is delivered via a 90-minute e-learning module that training participants can complete in a single session or multiple depending on their individual preference, and a subsequent 1-day face-to-face session (7.5 hours) with two co-trainers (Experts by Experience) and a facilitating trainer. There is capacity for 30 training participants per each session.

Oliver's Training frequency

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

Oliver's Training accreditation and procurement

73. The code of practice specifies that organisations or individuals delivering training which meets the codes standards (including Oliver's Training) must undergo a quality assurance process to become an accredited provider. Health and social care employers can choose either to become an accredited provider by training staff within their own organisation or networks to deliver Oliver's Training or can source training from a list of accredited providers. We refer to the two options as in-house delivery and procured delivery, respectively.

74. NHSE is seeking to procure an organisation to accredit Oliver's Training, in line with its existing delivery model and the standards set out in the code of practice. NHSE has an approved trainer process in place for Oliver's Training at present that will be replaced by an accreditation process when an accreditation body is appointed. The awarded organisation will be confirmed in 2024 and will be required to co-produce accreditation standards and co-deliver an accreditation scheme for a period of 3 years. The accreditation body must be capable of accrediting delivery of Oliver's Training in the health and social care sectors. The accreditation body will be required to become self-funding and demonstrate value for money. NHSE will work with the awarded organisation to support any start-up costs as relevant and necessary.

75. To further support quality assurance of training delivery, particularly before an appointed accreditation body is in place, DHSC will be awarding an organisation in 2024/25 to develop and maintain a list of endorsed training providers that can deliver Oliver's Training to the adult social care workforce. In this IA, we have assumed that the adult social care sector, more than the private healthcare sector, will opt for procured training options. DHSC's endorsement scheme intends to improve and increase capacity of training provision to the adult social care workforce and address the delivery considerations specific to this sector raised in the consultation on the draft code of practice. This included concerns around variation in quality and price of the current market of training providers delivering Oliver's Training to the adult social care sector. The awarded organisation responsible for endorsement will be expected to work alongside NHSE's accreditation body when it begins to operate in 2024.

Further support for roll-out

76. To date, Government has significantly invested in the development and trial of Oliver's Training with over 8000 people in 2021 and its subsequent evaluation. Further information on the trials can be found on the webpage for Oliver's Training. We are continuing to support roll-out of the training to the health and social care workforce through activity to upskill trainers and subsidise the costs of training for staff which is summarised below.

77. Integrated Care Boards (ICBs) have received £17m to support delivery of Oliver's Training to their local workforces in 2023/24. We are considering routes to provide further funding in 2024/25 to accelerate uptake of training to a greater proportion of the health and care workforce in line with the optimal rollout and final option set out in this IA.

78. We are continuing work to boost the number of co-trainers (Experts by Experience) available to deliver Oliver's Training through building on NHSE's existing cascade model to upskill trainers and build trainer capacity across systems at pace.

79. At this stage, DHSC cannot commit to a specific implementation plan beyond the first year of implementation. Delivery of the activities set out above is supported by existing funding allocated to DHSC and NHSE through the current spending review period, which ends at the end of March 2025.

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

Costs of Option 1

81. This section provides a breakdown of costs we have considered in the roll-out of Oliver's Training. Firstly, we display our assumptions and methodologies for modelling these costs, we then outline and summarise our monetised costs. Within our analysis, we have considered the following five main cost groups under option 1 (in 2022/23 prices, discounted over a 10 year period):

- Direct training costs (£240.1m). We have calculated this based on the cost of each type of training session (tier 1 or tier 2) based on the staff costs of delivering it, then divided by the number of participants to get a cost per participant. We have then multiplied by the number of people who will need to attend each training session, taking into account leaver and joiner rates. This also accounts for the salaries of all trainers.

- Recruitment costs (£0.5m). This includes the fixed cost of recruitment associated with preparation of job advertisements and application materials, as well as a variable cost associated with the number of co-trainers and facilitating trainer recruited each year.

- Employment support for co-trainers (£0.09m). This includes the cost of dedicated sessions to support co-trainers with softer workplace skills over their first year of employment.

- 'Train the trainer' session costs (£1.0m). This is the cost for all co-trainers and facilitating trainers to attend dedicated 'train the trainer' sessions prepared by NHSE. One session teaches all co-trainers and facilitating trainers how to deliver webinars, and trainers then can attend a further session to learn how to train others and become lead trainers. This cost also includes costs of a small national team to co-ordinate sessions and peer review, and maintain a register of Oliver's Training trainers.

- Staff time costs (£1,242.0m). This is based on the number of staff in each workforce sector who require either tier 1 or tier 2 of Oliver's Training multiplied by the hours they would spend on training and their mean annual earnings.

The total monetised costs under option 1, discounted over a 10-year appraisal period, are £1,483.8m. The total monetised costs under option 1, discounted over the 3-year rollout period, are £494.9m.

82. The cost inputs for option 1 are presented first. Under option 1 we assume that:

- the length of roll-out is 3 years,
- everyone either completes the full tier 1 or full tier 2 of Oliver's Training, as intended for their staff group,
- as many staff as possible receive training in-house (details in paragraph 151).

83. We assumed that all those eligible, where relevant for each option, will receive the training. However, in practice it is possible that some staff will not need the training. For example, doctors and nurses who specialise in the care of people with a learning disability and autistic people are less likely to need tier 1 or tier 2 of Oliver's Training, as they are already

equipped with appropriate and extensive knowledge and skills. As outlined in the code of practice, they may instead seek training that is aligned with tier 3 capabilities. Tier 3 is recommended for health and social care staff and other professionals with a high degree of autonomy, able to provide care in complex situations and who may also lead services for people with a learning disability and autistic people. However, this cohort represents 0.9% of the clinical nursing population and 0.1% of the qualified doctor population so will likely have a minimal impact on cost estimations for rollout of Oliver's Training.[42]

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

Cost of a tier 1 session

85. Oliver's Training tier 1 package includes a 90-minute e-learning module and a 1-hour webinar. The e-learning module is already rolled out – it is hosted on the eLearning for healthcare platform.[43] The module is open to the public and free to anyone; therefore, there are no further costs anticipated with delivering the e-learning to health and care staff.

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

87. Prior to the webinar, participants submit questions for the trainers, who then meet to discuss the questions and structure the session. Based on conversations with NHSE[44], we assume that such preparation increases the time the trainers spend on each webinar from 1 hour to 2 hours 15 min for each co-trainer and 2 hours 45 min for a facilitating trainer. This consists of 30 minutes for a facilitating trainer to set up IT and communications, 60 minutes for trainers to discuss and plan answers to pre-asked questions, and 30 minutes for pre-session preparation and debriefing. These are conservative time estimates, based on timings for an established trio of trainers.

88. We assume that all members of the training team will need to spend time on non-delivery activities, such as performance management and professional development, as well as sick absences. We, therefore, allow 20% headroom for their working hours[45].

89. To calculate the cost of each webinar delivered in-house (see table 3), we multiply the involvement of each team member in terms of planning and delivery hours by their cost per hour. To calculate the cost of each webinar delivered in-house per participant, we divide that figure by the number of participants, 30, arriving at £9.26 per participant (in 2022/23 prices).

Table 3. tier 1 webinar delivery team salary description, annual salary and cost per webinar in 2022/23 prices

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

[43] Elearning: Oliver's Training on Learning Disability and Autism. Accessed here.

[44] A project lead for Oliver's Training.

[45] Based on conversations with NHSE, we assume one day a week will be spent on this non-delivery activity.

	Agenda for Change pay scale[46]	Annual salary	Cost per webinar, incl. planning and delivery time, oncosts and overheads[47]
Team Leader	Band 7, intermediate step point	£43,806	£9.69
Administrative assistant	Band 4, intermediate step point	£26,282	£14.54
Co-trainers	Band 5, intermediate step point	£29,180	£145.25
Facilitating trainer	Band 6, intermediate step point	£35,572	£108.20

90. If the webinar is procured and therefore delivered to participants by an external organisation, we need to reflect the costs in market prices by applying an indirect tax correction[48] - the cost of a procured tier 1 webinar per participant becomes £11.01 (in 2022/23 prices).

Cost of a tier 2 session

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

92. Based on conversations with NHSE, we assume that there will be some preparation ahead of each session, which will increase the time the facilitating trainer spends on a session from 7.5 hours to 8.3 hours (or 8 hours 20 min) and increases the time each co-trainer spends on a session from 3.75 hours to 4.15 hours (or 4 hours 9 minutes).

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

94. To calculate the cost of each session delivered in-house (see table 4), we multiply the involvement of each team member in terms of hours by their cost per hour. To calculate the cost of each session delivered in-house per participant, we divide that figure by 30, arriving at £25.87 per participant (in 2022/23 prices).

Table 4. tier 2 face-to-face session delivery team salary description, annual salary and cost per face-to-face session in 2022/23 prices

	Agenda for Change pay scale[49]	Annual salary	Cost per face-to-face session, incl. planning and delivery time,

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

			oncosts and overheads[50]
Team Leader	Band 7, intermediate step point	£43,806	£72.68
Administrative assistant	Band 4, intermediate step point	£26,282	£109.02
Co-trainers	Band 5, intermediate step point	£29,180	£267.90
Facilitating trainer	Band 6, intermediate step point	£35,572	£326.58

95. Some of the face-to-face sessions may need to be delivered at hired venues when organisations do not have the right space on-site. Costs from the NDTi evaluation suggest that venue hire for 30 participants will cost £250 per day. Some staff may also need to travel to attend the face-to-face session. We allow a travel cost at £20 per person per day (transportation costs are likely to be greater for those with accessibility needs, for example, where a taxi is needed as opposed to private or public transport). There will be regional variation in these costs. When adding in venue and travel, the cost of a tier 2 session delivered in-house arrives at £54.21 (in 2022/23 prices).

96. If the tier 2 face-to-face session is procured, we need to reflect the costs in market prices by applying an indirect tax correction[51] - the cost of a procured session per participant arrives at £30.79 (in 2022/23 prices). When adding in venue and travel, the cost of a procured tier 2 session arrives at £59.12 (in 2022/23 prices).

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

Cost of repeated training sessions

98. The code of practice states staff must undertake training at least every three years or more regularly if required. Therefore, it's expected that staff complete Oliver's Training at least every 3 years – based on this, we assume that the cost of repeated training will be the same as the cost of the tier 1 and tier 2 sessions during the initial roll-out.

Familiarisation costs

99. We believe the Impact Assessment presents no new burdens on health and social care staff to understand the reasoning behind them completing Oliver's Training, as the requirement for and rationale behind mandatory training has already been set out within existing legislation under the Health and Care Act 2022 (see paragraph 16). We have considered potential familiarisation costs associated with roll-out of Oliver's Training,

[50] To calculate the cost per hour, we assume 1,338 working hours per annum and apply 48% uplift for oncosts and overheads on guidance from NHSE. The cost per face-to-face session for co-trainers includes two people,
[51] Department for Transport (2022). TAG Unit A1.1 Cost-Benefit Analysis, p.13. Accessed here.

however have not included this within our final cost calculations, as we believe the time to read and understand training content for tiers 1 and 2 should be covered within existing staff time allowed for Continuous Professional Development (CPD).

100. For this reason, we have only considered familiarisation costs related to preparation time for training. As an illustration of what this may cost, we have calculated an estimated familiarisation cost based on time to prepare for tier 1 and tier 2 training below. A breakdown of costs by sector has been provided in table 5.

Table 5. Estimated familiarisation cost per year by workforce sector under Option 1 (rounded, in £millions, in 2022/23 prices).

Staff group	Familiarisation cost (per year, £m)
NHS HCHS	6.8
GP	1.2
NHS dentists and DCPs	0.5
Independent HCHS	1.3
Independent dentists and DCPs	0.2
Public ASC	0.4
Independent ASC	3.1
Total workforce	**13.4**

101. For tier 1 training, we assume participants may take time to submit questions to the trio of trainers prior to the session and have estimated this at 0.25 hours (or 15 minutes). Using the expected number of staff completing tier 1 training, and their mean pay per hour (see paragraphs 135-142), we calculate that the familiarisation cost for tier 1 training would be £6,740,777 per year for all sectors (in 2022-23 prices).

102. For tier 2 training, we assume participants may take time to read the information provided on the location of training and plan any travel and may read or print out additional information that is provided on the contents of the session. We have estimated this at 0.17 hours (or 10 minutes). Applying this to the expected number of staff completing tier 2 training, and their mean pay per hour (see paragraphs 135-142), we calculate that the familiarisation cost for tier 2 training would be £6,698,340 per year for all sectors (in 2022-23 prices).

103. If additional understanding or time is required for those specialising in healthcare for people with a learning disability or autistic people, then training should be sought that covers tier 3 capabilities. However, this cohort represents 0.9% of the clinical nursing population and 0.1% of the qualified doctor population[52] so will likely have a minimal impact on cost estimations for rollout of Oliver's Training. We also assume those requiring tier 3 will be replacing their current training with Oliver's Training, meaning any additional familiarisation time is already being covered within existing training. This therefore does not represent an additional cost.

[52] NHS Digital (2022). NHS Workforce Statistics – August 2022. Accessed here.

Costs related to in-house delivery of Oliver's Training tiers 1 and 2

104. To deliver Oliver's Training in-house, organisations will need to recruit co-trainers and facilitating trainers. These trainers will need to learn the specifics of Oliver's Training packages via dedicated 'train the trainer' sessions prepared by NHSE. We also expect that co-trainers will require some support into employment, for example, related to softer skills for the workplace, such as time management and communication skills. The associated costs are presented in this section under specific headings.

Cost of recruiting co-trainers and facilitating trainers

105. First, we consider the fixed cost of recruitment, related to the preparation of job advert and application materials and publicising the job advert. NHSE have prepared trainer job descriptions and we assume that organisations will make use of these descriptions. We assume that a recruitment manager (Band 6,[53] £57.61 per hour, including oncosts and overheads, in 2022/23 prices) will spend 15 hours preparing the recruitment process. We assume that publicising the job advert will cost £5,000. Together, this arrives at a fixed cost of c.£5,864.11 (in 2022/23 prices) per each year of recruitment.

106. Based on stakeholder engagement, we assume that a HR manager (Band 6,[54] £57.61 per hour, including oncosts and overheads, in 2022/23 prices) will work with the recruitment manager on the following co-trainer recruitment process:

- everyone who applies will ask a query, and it takes 10 minutes for the HR manager to answer each query.
- it will take 20 minutes each for the HR and recruitment managers to moderate each application form.
- 33% of those who apply will be offered an interview (i.e., for every 9 people that apply, 3 go on to interview); the cost per applicant who does not progress to interview is thus calculated to be £28.80.
- the interview will take 1 hour and 15 minutes (including administration) each for the HR and recruitment managers.
- 33% of interviewees will be successful (i.e., for every 3 candidates that interview, 1 is offered the role)
- it will take 10 minutes for the HR manager to notify each unsuccessful applicant of the outcome; the cost per applicant who is unsuccessful at interview is calculated to be £182.42.
- it will take 3 hours of the HR manager's time in administration to appoint each successful candidate; the cost per successful applicant is calculated to be £345.64.

107. This comes out at c.£893 in recruitment costs per facilitating trainer recruited (inclusive of the cost for each unsuccessful applicant at application and interview stages).

108. Based on stakeholder engagement, we assume that an adjusted process will be required for the recruitment of co-trainers, such that:

- everyone who applies will ask a query, and it takes 10 minutes for the HR manager to answer each query.

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

- it will take 20 minutes each for the HR and recruitment managers to moderate each application form.
- 33% of those who apply will progress to an assessment stage (i.e., for every 9 people that apply, 3 go on to be assessed further); the cost per applicant who does not progress to interview is thus calculated to be £47.62.
- the assessment stage will run for 6 co-trainers as a group and consist of a group task lasting 90 minutes and individual presentations lasting 10 minutes each and will require 10 minutes for clarification questions and 60 minutes for scoring, amounting to 3.7 hours each for the HR and recruitment managers.
- 33% of candidates will be successful at the assessment stage (i.e., for every 3 candidates who are assessed, 1 is offered the role)
- it will take 20 minutes for the HR manager to notify each unsuccessful applicant of the outcome and provide feedback; the cost per applicant who is unsuccessful at the assessment stage is calculated to be £136.52.
- it will take 3 hours of the HR manager's time in administration to appoint each successful candidate; the cost per successful applicant is calculated to be £288.91.

109. This comes out at c.£859 in recruitment costs per co-trainer recruited (inclusive of the cost for each unsuccessful applicant at application and interview stages, based on our assumptions of a 33% success rates of passing both application and assessment stages).

Costs of 'train the trainer' sessions

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

111. We assume that a small national team will be needed to co-ordinate sessions, maintain a register of Oliver's Training trainers and co-ordinate peer review. This team will consist of a Project Lead (1 FTE at Agenda for Change[55] (AfC) Band 8a), Manager (1 FTE at AfC Band 7), co-trainers (2.5 FTE at AfC Band 5) and administrative assistants (1 FTE at AfC Band 4 and 1 FTE at AfC Band 3). The annual cost of this team, inclusive of oncosts and overheads, arrives at £317,817.

112. We assume that this training is split across two sessions: 'Delivering Webinars' and 'Training Others'. The first session prepares co-trainers and facilitating trainers to deliver Oliver's Training tier 1 webinars, and the second session teaches co-trainers and facilitating trainers how to train others and become trainer trainers. Based on conversations with NHSE, we assume that: each session lasts 2.75 hours (or 2 hours 45 minutes); all trainers will complete 'Delivering Webinars', and 20% will go on to complete 'Teaching Others'. These sessions will be run by a Lead trainer (AfC Band 6) and a facilitating trainer (AfC Band 5) and will accommodate 21 participants (or 7 'trios' who go on to deliver the webinars together). This arrives at a cost of £9.38 per participant (in 2022/23 prices).

113. We assume that a 'train the trainer' session to prepare facilitating trainers to deliver Oliver's Training tier 2 face-to-face sessions will last 2 days (or 16 hours), will be run by a

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

Lead trainer (AfC Band 6) and a facilitating trainer (AfC Band 5) and will accommodate 15 participants. This arrives at a cost of £76.40 per co-trainer (in 2022/23 prices).

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

115. We assume that a 'train the trainer' session to prepare Lead trainers to deliver Oliver's Training to other trainers will last 4 days (or 32 hours), will be run by an existing Lead trainer (AfC Band 6) and will accommodate 14 participants. This arrives at a cost of £89.94 per Lead trainer (in 2022/23 prices).

116. Based on conversations with NHSE, we assume that these sessions will be delivered across regions in convenient locations for participants and we have not included venue hire, travel, or accommodation costs. It may be that this assumption does not apply to all.

Cost of supporting co-trainers into employment

117. NHSE published guidance on 'Involving people with a learning disability and autistic people in delivering Oliver's Training on Learning Disability and Autism'[56] and a report by NDTi based on Oliver's Training trial on 'Learning about involvement of experts by experience in design and delivery of training.'[57] It is expected that co-trainers will require support when starting employment, which may be offered in the form of formal learning or on-the-job coaching or co-working.

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

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

119. To estimate how many members of staff need to take part in training for the roll out to complete in 'X' years, we cannot simply divide the size of the total workforce by 'X' for two reasons: (1) the workforce is expanding over time and (2) each year there is staff turnover. Due to turnover, each year some of the trained staff leave their posts and people coming in as their replacements need to be trained. In the paragraphs below we state how we obtained the growth and turnover figures for each staff group. These inputs were shared across both options. Please see Tables 6a, 6b and 6c for to see the proportions of each workforce category we have assumed to undertake each tier of training in our high, central and low-cost estimates.

Public healthcare workforce

120. For NHS Hospital and Community Health Services (HCHS) staff, we used the NHS Workforce Statistics – September 2023.[58] For our low-cost estimate, we split staff groups

[56] HEE (2022). Involving people with a learning disability and autistic people in delivering Oliver's Training on Learning Disability and Autism. Accessed here.

[57] NDTi (2022). Oliver's Training evaluation: Learning about involvement of experts by experience in design and delivery of training. Accessed here.

[58] NHS Digital (2022). NHS Workforce Statistics – August 2022. Accessed here.

into those doing tier 1 ('support to clinical staff', 'NHS infrastructure support' and 'other staff or those with unknown classification') and those doing tier 2 ('professionally qualitied clinical staff'). We then calculated the average annual workforce growth rates for the past 10 years. This was 3.3% for staff doing Oliver's Training tier 1 and 2.3% for staff doing Oliver's Training tier 2. For our high-cost estimate, we analysed public sector organisational responses to Oliver's Training consultation, and split staff by tier 1 and 2 based on the proportions of staff expected to complete tier 1 and 2. For our central estimate, we took a mid-point of the high-cost and low-cost methodology outputs. However, due to this data only representing the current workforce with no time series data, we still used the NHS Workforce Statistics to estimate workforce growth rates for both tiers.

121. We applied these average annual growth rates to each of the years in the 10-year appraisal period for NHS HCHS staff. We are aware that there are commitments in expanding the medical workforce in the NHS Long Term Plan (LTP), including increasing international recruitment and increasing nursing and medical school places. However, we have not accounted for these commitments as our calculation already includes the recent increases in staff numbers due to the response to COVID-19, which we have assumed will be absorbed in the LTP projections. For our high-cost estimate, we analysed private/independent sector organisational responses to Oliver's Training consultation, and split staff by tier 1 and 2 based on the proportions of staff expected to complete tier 1 and 2. For our central estimate, we took a mid-point of the high-cost and low-cost methodology outputs. However, due to this data only representing the current workforce with no time series data, we still used the NHS Workforce Statistics to estimate workforce growth rates for both tiers.

122. We used the NHS Workforce Statistics – September 2023 to find out the numbers of joiners and leavers from June 2022 to June 2023. In absence of regularly published statistics on the source of recruitment for NHS workforce, we used HCHS joiners by source of recruitment data from March 2020 to March 2021.[59] From these two data sources, we estimated that c.136,000 staff members left their post between June 2022 and June 2023, of which 69,900 left for another post within healthcare or social care and 66,100 left the healthcare and social care sectors altogether. This means that 4.6% of NHS HCHS staff who had been employed at the start of July 2022 left the combined health and core workforce by June 2023 (the leavers rate). We applied the same rate to each year of the appraisal period.

123. For General Practice, we used the General Practice Workforce Statistics – November 2023.[60] For our low-cost estimate, we split the staff groups into those doing tier 1 ('all admin/non-clinical') and those doing tier 2 ('all GPs', 'all nurses', 'all direct patient care'). These statistics contain data from 2016 to 2023, meaning that we could only calculate average annual growth rates over the past 8 years. These were 1.2% for staff doing Oliver's Training tier 1 and 2.1% for staff doing Oliver's Training tier 2. We applied these rates to each of the 10 years in the appraisal period for GP staff. For our high-cost estimate, we analysed public sector organisational responses to Oliver's Training consultation, and split staff by tier 1 and 2 based on the proportions of staff expected to complete tier 1 and 2. For our central estimate, we took a mid-point of the high-cost and low-cost methodology outputs. However, due to this data only representing the current workforce with no time series data, we still used the NHS Workforce Statistics to estimate workforce growth rates for both tiers.

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

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

124. We could not find data on staff turnover or source of recruitment for General Practice. Instead, we applied the 4.6% leavers rate to each year of the appraisal period.

125. For NHS dentist workforce, we used a combination of the NHS Dental Statistics for England, 2022-23, Annual Report[61] and monthly General Dental Council (GDC) registration reports to June of each year.[62] We assumed that all dentists and dental care professionals (DCPs) will require Oliver's Training tier 2 package. The average annual workforce growth rate was calculated for both groups combined over the past 10 years at 0.8%, and this rate was applied to each year of the appraisal period.

126. For non-clinical staff who work in NHS dentistry settings, we used CQC Registration Report data[63] to count the number of dental locations. We then applied the split of NHS to independent dentists to estimate the number of NHS dental locations. We then used a high (4), central (3) and low (2) estimate of the number of non-clinical/admin staff per dental location. In our low-cost estimate, we assumed that non-clinical dental staff would require Oliver's Training tier 1 package. Through stakeholder engagement, we found that all staff employed in dentistry will require tier 2 training and therefore assumed all non-clinical staff will complete tier 2 training in both our central and high-cost estimate.

127. We could not find data on staff turnover or source of recruitment for dentists, DCPs and non-clinical staff. Instead, we applied the 4.6% leavers rate for each year of the appraisal period.

Independent healthcare workforce

128. There is a lack of published data on the size and trends of the independent HCHS workforce. Based on conversations with the Independent Healthcare Providers Network, we estimated the size of the workforce to be 215,000. For our low-cost estimate, we assumed that proportionately the same number of staff will do tier 1 and tier 2 packages as in the NHS HCHS workforce. We also applied the same growth rates and leavers rate as for NHS HCHS workforce. For our high-cost estimate, we analysed private/independent sector organisational responses to Oliver's Training consultation, and split staff by tier 1 and 2 based on the proportions of staff expected to complete tier 1 and 2. For our central estimate, we took a mid-point of the high-cost and low-cost methodology outputs. However, due to this data only representing the current workforce with no time series data, we still used the NHS Workforce Statistics to estimate workforce growth rates for both tiers.

129. For independent dentist workforce, we used the monthly GDC registration reports for the past 5 years and subtracted the estimated figures for NHS dentists and DCPs (see paragraph 125). We estimated the average annual growth rate at 4.2%. We also applied the 4.6% leavers rate calculated for NHS HCHS staff. These are crude calculations to give a sense of scale for the purposes of splitting costs between the public sector and businesses; however, we acknowledge that dentists and DCPs can perform both NHS and independent services, and these cannot be easily split.

130. For non-clinical staff who work in private/independent dentistry settings, we used CQC Registration Report data to count the number of dental locations. We then applied the split of NHS to independent dentists to estimate the number of private/independent dental

[61] NHS Digital (2022). NHS Dental Statistics for England, 2022-23, Annual Report. Accessed here.

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

[63] CQC Registration Report. Accessed here.

locations. We then used a high (4), central (3) and low (2) estimate of the number of non-clinical/admin staff per dental location.

Public and independent adult social care workforce

131. For adult social care (ASC) workforce, we used SfC ASC Workforce Statistical Appendix 2022/23.[64] The data does not split public and independent or regulated and non-regulated workforce over time, and instead we calculated the average annual growth rate over the past 10 years for the total ASC workforce at 0.9%. We applied this rate to each year of the 10-year appraisal period.

132. For regulated workforce, we found that 31% of staff had left their role in the previous year and that, among joiners, 57% were recruited from within ASC. Based on these figures, we estimated an annual leavers rate at 12.7% (31%*(100-57%)), meaning that we estimate that 12.7% of people who are employed at the start of the year will leave their post and ASC altogether by the end of the year. We applied the same rate for public and independent workforce to each year of the appraisal period.

Mean annual earnings for healthcare and social care staff groups

133. To calculate the staff time costs, we have multiplied the number of staff calculated in the section above, by the value of their working time that would be lost when undertaking Oliver's Training.

134. In healthcare and social care there will be a staff time cost as staff undertake Oliver's Training in place of other activities, including providing services to patients. While all regulated service providers must comply with the existing requirement set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014[65] that staff should be provided with the training necessary to enable them to perform their duties and, therefore, must make allowance for staff to take time for training, we do not know to which extent Oliver's Training can come under such existing allowances. Where they exceed the training time currently allocated to staff, this represents an economic cost under option 1 The staff time cost is calculated based on the time needed to complete the training and the corresponding earnings staff would otherwise earn for the duration of the training.

Public healthcare workforce

135. To calculate working hours for public healthcare staff, we used the Agenda for Change Terms and Conditions of Service Handbook.[66] We assumed that staff work 37.5 hours per week and take 37 days or 7.4 weeks of annual leave (inclusive of public holidays).

136. For NHS HCHS staff, we used NHS Staff Earnings Estimates, June 2023.[67] For those doing Oliver's Training tier 1 and tier 2 we estimated mean pay per hour of £17.34 and £29.86 respectively (both in 2022/23 prices).

137. For General Practice, we used GP Earnings and Expenses Estimates 2021/22[68] for GPs and estimates from NHS HCHS for similar roles in General Practice (e.g., nurses, admin staff). For those doing Oliver's Training tier 1 and tier 2 we estimated mean pay per hour of £17.34 and £44.32 respectively (in 2022/23 prices).

[64] Skills for Care (2022). Adult Social Care Workforce Estimates (table 4.9). Accessed here.

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

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

[67] NHS Digital (2022). NHS Staff Earnings Estimates, June 2023. Accessed here.

[68] NHS Digital (2022). GP Earnings and Expenses Estimates, 2021/22. Accessed here.

138. For NHS dental workforce, we used Dental Earnings and Expenses Estimates 2020/21[69] for dentists and estimates from NHS HCHS for DCPs. The mean pay per hour was estimated at £31.94 in 2022/23 prices.

139. For non-clinical/admin dental workforce, we assumed the same mean pay per hour as non-clinical/admin NHS HCHS staff.

Independent healthcare workforce

140. For independent HCHS workforce, we calculated that their earnings would have a 34% margin above the weighted average earnings for those working for the NHS. This is based on the comparison of the estimated average NHS and independent healthcare salaries from two websites.[70,71] We estimated the mean pay per hour of £23.22 and £39.99 for those doing Oliver's Training tier 1 and tier 2 respectively (both in 2022/23 prices).

141. There is no data available on the earning of the independent dental workforce; moreover, the earnings reported for NHS dental workforce can also contain earnings from providing independent services. For these reasons, we assumed the mean pay per hour for independent dental workforce is the same as the estimated mean pay per hour for NHS dental workforce, at £31.94 in 2022/23 prices.

Public and independent adult social care workforce

142. For ASC, we used SfC ASC Workforce Statistical Appendix 2022/23.[72] The mean pay per hour for public ASC workforce was estimated at £9.96 in 2022/23 prices and the mean pay per hour for independent ASC workforce was estimated at £14.83 per hour. Based on conversations with SfC, we assumed that there is no difference in pay between staff who will be doing Oliver's Training tier 1 and those who will be doing Oliver's Training tier 2.

Option 1: monetised costs

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

143. Table 6a, b and c below summarise our estimates of the size of each staff group who are expected to take Oliver's Training tier 1 and tier 2 packages at the start of training roll-out in 2023/24. For ASC, the available workforce statistics do not provide data by staff role and we relied on guidance from SfC that 63% of all ASC staff will require Oliver's Training tier 1 and 37% will require Oliver's Training tier 2. The figures are based on headcount statistics (or registrants' numbers in the case of independent dentists and DCPs) in healthcare and on filled posts in ASC. (For data sources, please see refer to the earlier section 'Yearly changes to the size of the healthcare and social care workforce: growth and turnover'.)

144. Overall, we calculated that in our central estimate, to the nearest million, 1.5 million health and care staff will require Oliver's Training tier 1 and 1.6 million will require Oliver's Training tier 2, totalling to approximately 3.1 million workers. The low-cost scenario shows 1.7 million staff requiring tier 1 and 1.4 requiring tier 2, and the high-cost scenario shows 1.3 million staff requiring tier 1 and 1.8 million requiring tier 2.

145. We have calculated workforce splits in three different scenarios: a low-cost estimate, a central estimate, and a high-cost estimate. This was guided by responses to the consultation as well as conversations with stakeholders, with organisations noting that

[69] NHS Digital (2022). Dental Earnings and Expenses Estimates, 2020/21. Accessed here.
[70] Payscale. Average salary for the National Health Service (NHS) employees in United Kingdom.
[71] Totaljobs. What is the average salary for Private Healthcare jobs?
[72] Skills for Care (2022). Adult Social Care Workforce Estimates (table 4.9). Accessed here.

several non-clinical staff will require tier 2 training. Therefore, the high-cost scenario accounts for a higher proportion of staff undertaking tier 2. The low-cost scenario does not consider this, and the central cost scenario is a mid-point between high-cost and low-cost methodology outputs.

Table 6a. Estimated size of health and adult social care staff groups in 2023/24, split by tier 1 and tier 2 participants under Option 1 (headcount or filled posts, rounded to the nearest thousand, and proportion). [And low cost workforce split]

Staff group	Tier	Headcount / Filled posts	Proportion
NHS HCHS	Tier 1	700,000	48%
	Tier 2	747,000	52%
	Total	**1,446,000**	**100%**
General Practice	Tier 1	102,000	53%
	Tier 2	93,000	48%
	Total	**194,000**	**100%**
NHS dentists and DCPs	Tier 1	16,000	19%
	Tier 2	69,000	81%
	Total	86,000	**100%**
Independent HCHS	Tier 1	129,000	60%
	Tier 2	86,000	40%
	Total	215,000	**100%**
Independent dentists and DCPs	Tier 1	7,000	19%
	Tier 2	28,000	81%
	Total	34,000	**100%**
Public CQC-regulated ASC	Tier 1	113,000	63%
	Tier 2	66,000	37%
	Total	179,000	**100%**
Independent CQC-regulated ASC	Tier 1	602,000	63%
	Tier 2	354,000	37%
	Total	**956,000**	**100%**
Total combined workforce	Tier 1	1,669,000	54%
	Tier 2	1,443,000	46%
	Total	**3,112,000**	**100%**

Table 6b. Estimated size of health and adult social care staff groups in 2023/24, split by tier 1 and tier 2 participants under Option 1 (headcount or filled posts, rounded to the nearest thousand, and proportion). [And central workforce split]

Staff group	Tier	Headcount / Filled posts	Proportion
NHS HCHS	Tier 1	585,000	41%
	Tier 2	860,000	59%
	Total	**1,446,000**	**100%**
General Practice	Tier 1	83,000	43%
	Tier 2	112,000	57%

	Total	**194,000**	**100%**
NHS dentists and DCPs	Tier 1	0	0%
	Tier 2	94,000	100%
	Total	94,000	**100%**
Independent HCHS	Tier 1	104,000	48%
	Tier 2	111,000	52%
	Total	**215,000**	**100%**
Independent dentists and DCPs	Tier 1	0	0%
	Tier 2	38,000	100%
	Total	38,000	**100%**
Public CQC-regulated ASC	Tier 1	113,000	63%
	Tier 2	66,000	37%
	Total	179,000	**100%**
Independent CQC-regulated ASC	Tier 1	602,000	63%
	Tier 2	354,000	37%
	Total	**956,000**	**100%**
Total combined workforce	Tier 1	1,487,000	48%
	Tier 2	1,635,000	52%
	Total	**3,122,000**	**100%**

Table 6c. Estimated size of health and adult social care staff groups in 2023/24, split by tier 1 and tier 2 participants under Option 1 (headcount or filled posts, rounded to the nearest thousand, and proportion). [And high cost workforce split]

Staff group	**tier**	**Headcount / Filled posts**	**Proportion**
NHS HCHS	tier 1	473,000	33%
	tier 2	973,000	67%
	Total	**1,446,000**	**100%**
General Practice	tier 1	64,000	33%
	tier 2	131,000	67%
	Total	**194,000**	**100%**
NHS dentists and DCPs	tier 1	0	0%
	tier 2	102,000	100%
	Total	102,000	**100%**
Independent HCHS	tier 1	79,000	37%
	tier 2	136,000	63%
	Total	**215,000**	**100%**
Independent dentists and DCPs	tier 1	0	0%
	tier 2	41,000	100%
	Total	41,000	**100%**
Public CQC-regulated ASC	tier 1	113,000	63%

	tier 2	66,000	37%
	Total	179,000	**100%**
Independent CQC-regulated ASC	tier 1	602,000	63%
	tier 2	354,000	37%
	Total	**956,000**	**100%**
Total combined workforce	tier 1	1,330,000	42%
	tier 2	1,803,000	58%
	Total	**3,133,000**	**100%**

Number of health and adult social care staff to receive Oliver's Training in each year

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

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

    for year one

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

    from year two onwards

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

    Using this method, we were able to find the percentage of staff that need to be trained each year so that all staff that remain employed in the health and care sectors at the end of year 3 are trained. Where possible, we set the percentage to be the same in each year to even the roll-out. Due to a lack of data, we have not made a specific assumption around staff who may change role but stay within health and social care. This could slightly reduce costs since some joiners would not be required to undertake training until their repeated training is required after 3 years.

148. These percentages were different across staff groups due to different growth and leavers' rates, they ranged from 34% to 40% of staff to be trained each year to reach the maximum number of trained and retained staff at the end of the 3-year roll-out period. Note that it is

not possible to reach 100% of staff in any given year, because there will still be turnover in the final year of the roll-out, meaning that some people who receive training that year will still leave and will be replaced by joiners who are new to the healthcare and adult social care sectors and, therefore, who have not had Oliver's Training. The maximum cumulative proportion of trained and retained staff is '100% - leavers' rate', which is 93% for healthcare and ASC.

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

- taking the number of staff who were trained and retained 3 years ago (e.g., in year one for year 4 calculations) and applying the annual leavers' rate for each year between first training and the repeated session to estimate how many are still employed in the health and social care sector and, therefore, need repeated training,
- finding the number of joiners to train by subtracting the cumulative number of staff trained and retained in previous years (e.g., after three years for year 4 calculation) from the estimated workforce size in the following year to arrive at the number of untrained staff (while following the same methodology as described in paragraph 147 to continue estimating the cumulative number of staff trained and retained).

150. Tables 7a, 7b and 7c below shows the number of staff that should receive training for each year of the appraisal period under Option 1.

Table 7a. Number of staff to receive training each year under Option 1 (rounded and expressed in thousands). [And low workforce split]

Staff group	23/24	24/25	25/26	26/27	27/28	28/29	29/30	30/31	31/32	32/33
NHS HCHS – T1	253	254	262	315	283	293	267	270	279	256
NHS HCHS – T2	267	266	264	324	287	287	270	270	270	256
GP – T1	35	36	35	41	37	37	34	35	34	32
GP – T2	33	33	33	40	35	35	33	33	33	31
NHS dentists and DCPs – T2	24	23	23	27	23	23	22	21	21	20
Independent HCHS – T1	47	47	48	58	52	54	49	50	51	47
Independent HCHS – T2	31	31	30	37	33	33	31	31	31	29
Independent dentists and DCPs – T2	10	11	11	13	12	12	11	12	12	11
Public ASC – T1	45	45	43	46	46	45	39	39	38	34
Public ASC – T2	26	27	25	27	27	26	23	23	23	20
Independent ASC – T1	237	239	227	243	244	236	206	208	203	180
Independent ASC – T2	139	140	133	143	143	139	121	122	119	106

Table 7b. Number of staff to receive training each year under Option 1 (rounded and expressed in thousands). [And central workforce split]

Staff group	23/24	24/25	25/26	26/27	27/28	28/29	29/30	30/31	31/32	32/33
NHS HCHS – T1	212	212	219	264	237	245	223	226	233	214
NHS HCHS – T2	299	306	313	364	331	338	304	311	318	288
GP – T1	28	29	28	33	30	30	28	28	28	26
GP – T2	39	40	40	47	42	43	39	40	41	37
NHS dentists and DCPs – T2	32	32	32	37	33	33	31	31	31	29
Independent HCHS – T1	38	38	39	47	42	43	40	40	41	38
Independent HCHS – T2	39	40	40	47	43	44	39	40	41	37
Independent dentists and DCPs – T2	14	14	14	17	16	17	15	16	16	15
Public ASC – T1	46	46	47	42	47	47	40	40	40	34
Public ASC – T2	27	27	27	25	28	28	23	23	24	20
Independent ASC – T1	243	245	247	221	248	250	209	211	213	182
Independent ASC – T2	143	144	145	130	145	147	123	124	125	107

Table 7c. Number of staff to receive training each year under Option 1 (rounded and expressed in thousands). [And high cost workforce split]

Staff group	23/24	24/25	25/26	26/27	27/28	28/29	29/30	30/31	31/32	32/33
NHS HCHS – T1	171	171	177	213	191	198	180	182	188	173
NHS HCHS – T2	338	346	354	412	374	382	344	352	360	326
GP – T1	22	22	22	26	23	23	21	21	21	20
GP – T2	45	46	47	55	50	51	46	47	48	43
NHS dentists and DCPs – T2	35	36	37	42	38	39	35	36	36	33
Independent HCHS – T1	28	29	29	35	32	33	30	30	31	29
Independent HCHS – T2	47	48	50	58	52	54	48	49	50	46
Independent dentists and DCPs – T2	15	16	16	19	18	18	16	17	17	16
Public ASC – T1	46	46	47	42	47	47	40	40	40	34

Public ASC – T2	27	27	27	25	28	28	23	23	24	20
Independent ASC – T1	243	245	247	221	248	250	209	211	213	182
Independent ASC – T2	143	144	145	130	145	147	123	124	125	107

Cost of providing training sessions under Option 1

151. Option 1 represents an optimal roll-out of Oliver's Training, with dedicated Government funding to aid the roll-out, with as many organisations as feasible becoming accredited providers of Oliver's Training to deliver training sessions in-house. Based on conversations with NHSE, we assumed that the vast majority of the public healthcare workforce (90%) would opt to receive training in-house. We have not consulted with independent healthcare providers; as they would not receive Government funding under this option and to avoid making assumptions that would artificially reduce the costs to business estimations, we assumed that 100% of the independent healthcare workforce would receive procured training from a third party. For ASC, we relied on the *'State of the adult social care sector and workforce in England: 2022'*[73] report from SfC, which showed that about half of ASC workforce are employed by small and micro businesses (SMBs) with fewer than 250 members of staff and about half are employed by large independent organisations. It is likely to be less feasible for SMBs to deliver Oliver's Training in-house. We, therefore, assumed that even with funding only 50% of independent ASC workforce (i.e., those working in large organisations) would be able to receive Oliver's Training in-house and that 100% of public ASC workforce would receive procured training from a third party.

152. To calculate the cost of training sessions for all staff groups in each year of the appraisal period, we multiplied the number of staff to receive training each year by the cost of tier 1 and tier 2 sessions, while adding venue hire and travel where applicable, as described in sections: 'cost of a tier 1 session', 'cost of a tier 2 session' and 'cost of repeated training sessions'. These costs are shown in table 8 below.

Table 8. Cost of training sessions per year under Option 1 (in £millions in 2022/23 prices, discounted).

Staff group	23/24	24/25	25/26	26/27	27/28	28/29	29/30	30/31	31/32	32/33
NHS HCHS – T1	2.0	1.9	1.9	2.3	1.9	1.9	1.7	1.7	1.7	1.5
NHS HCHS – T2	10.0	9.9	9.8	10.9	9.6	9.5	8.2	8.2	8.1	7.1
GP – T1	0.2	0.2	0.2	0.3	0.2	0.2	0.2	0.2	0.2	0.2
GP – T2	1.3	1.2	1.2	1.4	1.2	1.2	1.0	1.0	1.0	0.9
NHS dentists and DCPs – T2	1.1	1.0	1.0	1.1	1.0	0.9	0.8	0.8	0.8	0.7
Independent HCHS – T1	0.4	0.4	0.4	0.5	0.4	0.4	0.4	0.3	0.3	0.3

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

Independent HCHS – T2	1.5	1.4	1.4	1.6	1.4	1.4	1.2	1.2	1.2	1
Independent dentists and DCPs – T2	0.5	0.5	0.5	0.6	0.5	0.5	0.5	0.5	0.5	0.4
Public ASC – T1	0.5	0.5	0.5	0.4	0.4	0.4	0.4	0.3		0.3
Public ASC – T2	1.4	1.4	1.3	1.2	1.2	1.2	1.0	1.0		0.8
Independent ASC – T1	2.4	2.4	2.4	2.0	2.2	2.2	1.7	1.7		1.3
Independent ASC – T2	6.1	5.9	5.7	4.9	5.4	5.2	4.2	4.1		3.3
Total workforce	27.4	26.7	26.3	27.2	25.4	25.0	21.3	21.0		17.8

Costs related to in-house delivery of Oliver's Training tiers 1 and 2 under Option 1

153. After estimating the proportion of workforce in each staff group who could feasibly receive Oliver's Training packages in-house under Option 1 (see paragraph 143), we calculated the number of co-trainers and facilitating trainers needed for this option. This is based on the number of people that should be trained, divided by the number of working hours a co-trainer and facilitating trainer have in a year to deliver sessions and accounting for a 10% leavers' rate (i.e., assuming that 10% of recruited co-trainers or facilitating trainers would stop delivering Oliver's Training each year). To estimate the number of hours an co-trainer or facilitating trainer would spend on delivering sessions, we assumed that co-trainers, on average, would work at 0.5 FTE and facilitating trainers would work at 1 FTE, we allowed for 20% headroom (e.g., to account for sickness, professional development, and other such activities) and we accounted for the session preparation time (please see paragraph 85 for tier 1 and 91 for tier 2). Table 9 shows the number of co-trainers and facilitating trainers that need to be recruited each year to deliver Oliver's Training in-house sessions under Option 1.

Table 9. Number of co-trainers and facilitating trainers to recruit for delivering Oliver's Training in-house under Option 1 (FTE).

	23/24	**24/25**	**25/26**	**26/27**	**27/28**	**28/29**	**29/30**	**30/31**	**31/32**	**32/33**
Co-trainers	225	26	27	49	12	29	-	24	27	-
Facilitating trainers	102	12	12	22	5	13	-	11	12	-

154. After calculating the number of FTE co-trainers and facilitating trainers needed to be recruited in each year, we multiplied them by the costs of recruitment, 'train the trainer'

sessions and employment support sessions (see section 'Costs related to in-house delivery of Oliver's Training tiers 1 and 2'). The total costs are shown in table 10.

Table 10. Breakdown of costs related to the in-house delivery of Oliver's Training under Option 1 (in £ thousands, 2022/23 prices, discounted).

	23/24	24/25	25/26	26/27	27/28	28/29	29/30	30/31	31/32	32/33
Recruitment	309	39	39	65	18	38	-	30	32	-
Support into employment	54	6	6	11	2	6	-	5	5	-
'Train the trainer'	360	312	301	9	2	5	-	4	4	-

Staff time costs under Option 1

155. To calculate the staff time cost of undertaking Oliver's Training, we multiplied the number of staff in each staff group that would take either tier 1 or tier 2 by the hours they would spend on training and their mean annual earnings, as derived in the section 'Mean annual earnings for healthcare and social care staff groups'. It is not clear how much of Oliver's Training tier 1 and tier 2 packages can be absorbed under existing contractual allowances for training time. Based on conversations with programme leads from NHSE and SfC, we assumed that the 90-minute e-learning element would be absorbed by healthcare staff Continuing Professional Development (CPD) across all settings but that none of Oliver's Training would be absorbed in such provision for ASC. The staff time costs are presented in table 11 below.

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

Table 11. Staff time costs per year for each staff groups under Option 1 (in £millions in 2022/23 prices, discounted).

Staff group	23/24	24/25	25/26	26/27	27/28	28/29	29/30	30/31	31/32	32/33
NHS HCHS	70.7	69.8	69	77.7	68.1	67.3	58.6	57.9	57.2	50.0
GP	14.1	13.9	13.7	15.3	13.4	13.2	11.5	11.4	11.2	9.8
NHS dentists and DCPs	7.7	7.5	7.1	8.0	7.0	6.6	6.0	5.9	5.6	5.0
Independent HCHS	12.5	12.3	12.2	13.7	12	11.9	10.3	10.2	10.1	8.8
Independent dentists and DCPs	3.3	3.3	3.2	3.8	3.4	3.3	2.9	2.9	2.9	2.6
Public ASC	3.6	3.5	3.4	2.9	3.2	3.1	2.5	2.4	2.4	2.0
Independent ASC	28.1	27.3	26.6	23.0	24.9	24.3	19.7	19.2	18.7	15.4
Total workforce	139.8	137.6	135.2	144.5	132.0	129.8	111.6	109.9	108.0	93.7

Summary of all costs under Option 1

157. In summary, we estimate that Option 1 will cost £1,483.7m expressed in 2022/23 prices and discounted for future years of the 10-year roll out period. Table 12 below present a summary of all costs under this option.

Table 12. Summary of total costs for Option 1 (in £millions in 2022/23 prices, discounted).

	23/24	24/25	25/26	26/27	27/28	28/29	29/30	30/31	31/32	32/33	Total
Training sessions	27.5	27.0	26.5	27.3	25.7	25.2	21.5	21.1	20.7	17.8	240.1
In-house delivery costs	0.7	0.4	0.3	0.1	0.0	0.0	-	0.0	0.0	-	1.6
Staff time costs	139.8	137.6	135.2	144.5	132.0	129.8	111.6	109.9	108.0	93.7	1,242.0
Total	**168.0**	**164.9**	**162.0**	**171.8**	**157.7**	**155.0**	**133.0**	**131.0**	**128.8**	**111.5**	**1,483.7**

Opportunity cost of central funding under Option 1

158. Option 1 shows the optimal roll-out of Oliver's Training and assumes that funding will be provided to public healthcare and adult social care organisations over 3 years to support the roll-out period. Under this assumption, £82.3m (in 2022/23 prices, discounted) would be required to cover the costs of the training sessions and the in-house delivery route. There is an associated opportunity cost such that funding could be spent on other DHSC/NHSE programmes and in turn lead to further health impacts in the NHS or the wider health and social care system. To quantify this into Quality Adjusted Life Years (QALYs), we divided the cost by £15,000 (the cost per QALY in impact assessments). Therefore, the opportunity cost of funding Option 1 is estimated to be 5,486.6 QALYs, or a societal value of £384.1 million (the societal value of a QALY is valued at £70,000).

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

159. Option 1 is associated with the total costs of £973.6m for public healthcare, which cover training sessions and staff time costs across NHS HCHS, GP and NHS dentists and DCPs over the 10-year appraisal period (in 2022/23 prices, discounted). These costs can be converted to foregoing 64,907 QALYs (valued at £15,000) or £4,543.5m in societal value (where each QALY is valued at £70,000). This is an upper bound based on the assumption we are displacing clinical activity.

Benefits of Option 1

160. We expect a wide range of benefits from Oliver's Training including the saving and improvement of lives of people with a learning disability and autistic people. Stakeholder feedback has repeatedly informed us of the need for Oliver's Training and consultation feedback was overwhelmingly positive (see table 2), which makes the potential benefits of option 1 clear.

161. We have not included the monetisation of benefits associated with option 1 in the appraisal summary tables due to uncertainties surrounding the scale of the impact of Oliver's Training. No training programme of this size and scope, on learning disabilities and autism, has been rolled out before to the health and social care workforce. Whilst the rapid evidence review we conducted (detailed in table 14) does give an indication of the range of

potential impact of this training, we do not believe that this evidence is reliable enough to be confident about the precise impact resulting in the benefits of option 1.

162. We have instead included illustrative analysis within this section, which outlines the potential benefits of option 1, if we were to assume that Oliver's Training improves health and wellbeing outcomes by 6%. Further detail on the conceptualisation of this 6% and our rapid evidence review is outlined within paragraphs 180 to 183 and table 14.

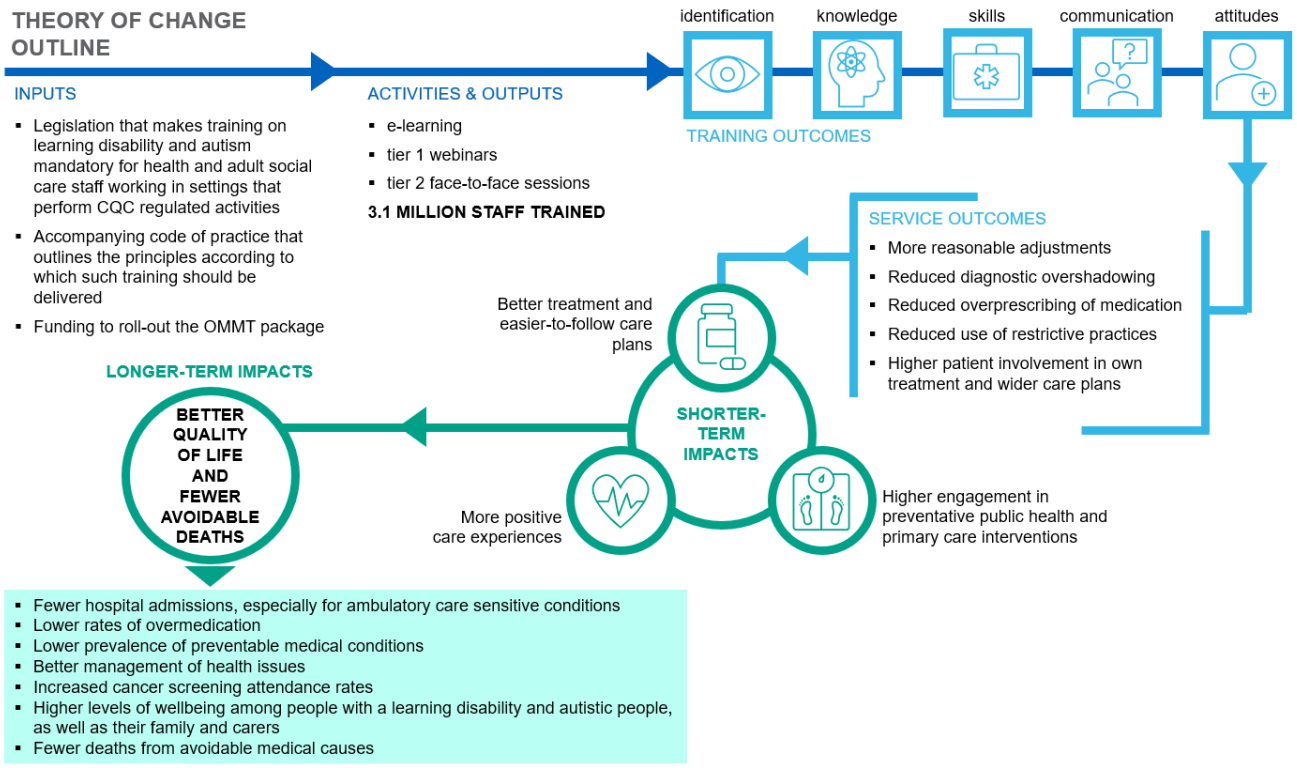
163. To estimate and quantify the benefits of option 1, we have considered the potential NHS cost savings and improvements in quality and length of life as a result of Oliver's Training. Based on the available data, within our illustrative analysis we have monetised (in 2022/23 prices and discounted over a 10 year period) the cost savings associated with: a reduction in the prevalence of preventable health conditions, namely chronic constipation and non-type 1 diabetes (£38.4m); a reduction in risk of deaths from cancer due to increased breast, colorectal and cervical cancer screening participation (£0.7m), and reductions in emergency acute and mental health hospital admissions (£13.9m and £310.4m respectively). For improvements in quality and length of life, we have monetised the societal value of reduced avoidable mortality and improved quality of life for people with a learning disability and autistic people using Statistical Life Years (£568.7m).

The overall monetised benefit of option 1 within our illustrative analysis, discounted over a 10 year period, is approximately £932.1m.

Theory of change

164. To illustrate our approach to estimating the potential benefits of rolling out Oliver's Training under the preferred option, we provide an outline of the theory of change for this intervention in figure 1 and summarised in text below. This is not intended to be comprehensive.

Figure 1. Theory of change outline for Oliver's Training roll-out.



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

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

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

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

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

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

Longer-term impacts – reduced hospital admissions, especially for ambulatory care sensitive conditions;[74] lower rates of overmedication; reduced prevalence of preventable medical conditions; better management of morbidity rates; increased cancer screening attendance rates; higher levels of wellbeing among people with a learning disability and autistic people, as well as their family and carers; reduced mortality associated with avoidable medical causes of death.

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

165. In estimating the potential benefits, we account for the rising cumulative proportion of staff that receive training during the roll-out period. Table 13 below shows the percentage of trained staff in relation to the total workforce size across regulated health and adult social care.

Table 13. Proportion of trained staff across the appraisal period under Options 1 and 2.

	23/24	24/25	25/26	26/27	27/28	28/29	29/30	30/31	31/32	32/33
Option 1	34%	64%	91%	93%	93%	93%	93%	93%	93%	93%

166. 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.[75] 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 Oliver's Training will

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

[75] 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

decline by 10% (as the midpoint of 5% to 15%) after the first year of roll-out, with this fading over time.

Assessing the scale of training outcomes

167. The NDTi evaluation of Oliver's Training trial provides a direct assessment of learning outcomes among training participants. The report states that for both tier 1 and tier 2 packages "results indicated that, compared to before the training, people rated themselves significantly higher on the following domains after attending the training:

- People felt that they had more knowledge about working with people with a learning disability and autistic people.
- People felt they had the skills that they need to work with people with a learning disability and autistic people.
- People felt more confident working with people with a learning disability and autistic people.
- People felt more confident in communicating with people with a learning disability and autistic people." [76] (NDTi report pages 38 and 69)

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

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

- Knowledge increases were seen immediately post training in most studies, ranging from 11% to 71%.[77,78] Increases in knowledge were also maintained up to a year post-training.[73]
- Communication skills were reportedly improved, with 80% of participants using the skills learnt in practice up to 6 weeks post-training.[79]
- Confidence was regularly significantly increased post-training and was maintained over time. One study reported confidence increasing by 9% between immediate post-training assessment and 1 year follow up.[80]

[76] National Development Team for Inclusion (2022). Evaluation of Oliver's Training Trial in Learning Disability and Autism. Accessed here.

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

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

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

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

- Attitudes towards people with a learning disability also changed after training, with significant increases in positive attitudes towards people with a learning disability post-training.[81,82]

Assessing the scale of service outcomes

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

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

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

    These indicators for the effectiveness of training are further supported by qualitative evidence from interviews with training participants. Such evidence suggests training increased the provision of reasonable adjustments in some instances: "*I now regularly ask before my first visit if there are things they like or don't like so I can adapt my practice."* [83] (NDTi report page 75)

    In addition, the evaluation report shows that:

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

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

    Such evidence suggests that in some instances training can lead to organisational or culture change that can improve service provision, as supported in qualitative insights: "*Helped create a new pathway with more support for bowel cancer screening for people with a learning disability."*[84] (NDTi report page 76)

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

    - Increased understanding and confidence around a subject led to immediate changes in the way an individual communicated with families and patients in clinical environments.[71,85]

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

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

[83] National Development Team for Inclusion (2022). Evaluation of Oliver's Training Trial in Learning Disability and Autism. Accessed here.

[84] National Development Team for Inclusion (2022). Evaluation of Oliver's Training Trial in Learning Disability and Autism. Accessed here.

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

- Increased discussion with patients using skills, understanding and knowledge obtained from the training, including higher rates of inclusivity when making medical decisions and planning treatment.[86]

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

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

171. The NDTi evaluation of Oliver's Training 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.

172. 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, with those reported most frequently being the coordination of a person's care and deviation from recognised care pathways or organisational policy 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.[87] If Oliver's Training is fully capitalised upon and addresses the organisational system and process failures, it could potentially prevent these deaths, resulting in 16% reduction of avoidable deaths.

173. 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.[88] 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).

174. A pilot study of Sensory Adapted Dental Environment (SADE) intervention aimed to reduce sensory-related distress and anxiety in autistic children facing dental treatment.[89] The study tailored the experience, using multisensory environments and sensory integration theories, with the treatment environment adapted. The study found that SADE reduced sensory-related distress and anxiety in autistic children when measuring behavioural distress (effect size 0.2), pain (effect size 0.6), and sensory discomfort (effect size 0.7). Further, the trial found that SADE increased the duration of dental cleaning, which could be associated with increased quality of dental treatment, (effect size 0.8). The effect sizes associated with reduced pain and discomfort and increased quality of treatment are

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

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

[88] 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

[89] 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.

considered large. These findings demonstrate the high potential effectiveness of reasonable adjustments.

175. 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.[90]

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

177. A study of Identification and Referral to Improve Safety (IRIS) intervention training for GPs to help them refer women affected by domestic violence and abuse on the right pathway found that referrals to domestic violence and abuse workers from GPs were 30 times higher than before training had occurred in these boroughs. This was also compared to a comparator borough that showed no change. These findings show that training can help professionals identify problems easier and earlier.[91]

178. A study assessing the impact of health visitors attending training on post-natal depression found that the interventions for mothers presenting with a high postnatal depression score decreased their depressive symptomatology significantly. Six months post-intervention training, the number of high postnatal depressions scores had decreased by 8%.[92]

179. A long-term study measuring the outcomes of Sexual Health in Practice (SHIP) training for GPs on HIV testing rates found that, for each GP trained, HIV testing rates increased by 16%. Six months post-training, the 16% increase remained the same and GP practices reported a 17% increase in positive HIV tests.[93]

180. Table 14 below summarised the range of impact estimates found in the evidence review. Based on this review and the results from Oliver's Training trial evaluation to monetise the potential benefits of Oliver's Training, we have applied a small impact of improving health and wellbeing outcomes of 6% when the benefits are fully realised (the benefits are at their highest when the highest number of staff are fully trained and the fade in knowledge and skills is minimised, this fading is captured within the 6% estimate). The 6% is conceptualised as follows: we find the number of people with a learning disability or autistic people who experience a health inequality and assume that Oliver's Training can reduce this by 6%. For example, if 100 people with a learning disability experience a preventable health condition, we assume that Oliver's Training can reduce the number of people with a learning disability who experience this condition by 6 (100*6%). We have included an increase and decrease to this impact factor of 50% in our sensitivity testing to further capture the uncertainty of the figure (see paragraph 252).

181. A substantial limitation within our use of this 6% improvement as a result of Oliver's Training is that we are applying the same scale of change independent of outcome type.

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

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

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

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

This is because we did not have sufficient evidence to generate more nuanced estimate for different outcome types (e.g., engagement with public health interventions vs. reducing overall avoidable mortality). Based on limited findings, we also could not produce separate estimates of the range of uncertainty around the assumption for each potential benefit. We have therefore tested the same range across all potential benefits in our sensitivity testing, from 3% in our low benefit scenario to 9% in high benefit scenario (see paragraph 252).

182. During the consultation we asked respondents to submit any further resources to help improve our evidence base. Whilst we would have liked to improve accuracy around individual benefits, such as increased cancer screenings and reduced hospital admissions, there was no new specific evidence provided on expected benefits. The estimated impact of training found in the rapid evidence review ranged from 8 to 45% in 6 studies where the impact was quantified. However, two of the 8 studies found no significant effect of training on their outcome measures.

183. The 6% impact figure is not an NHSE commitment or target and impacts will be measured through commissioned monitoring and evaluation (see paragraph 281 for more information).

Table 14. Summary of studies from the rapid evidence review which measured impact of training on service users.

Size of impact	Number of studies	Description of evaluation study	Range of estimates against outcomes
No impact	2	• Positive Behaviour Support training for health staff working with adults with learning disability and/or autistic adults and challenging behaviour.[94] Method: cluster randomised trial. Sample size: small, 113 patients. Follow-up period: 12 months.	• Outcome measure: Aberrant Behaviour Checklist total score. Estimate: no significant effect of training found.
		• Oral health training programme for adult social care staff working with elderly care home residents.[95] Method: cross-sectional study. Sample size: small, 213 residents. Follow-up period: 12 months.	• Outcome measure: oral health examination. Estimate: no significant effect of training found.
Small impact	1	• Training in postnatal depression counselling for health staff. [96] Method: cross-sectional study. Sample size: small, 64 health visitors. Follow-up period: 6 months.	• Outcome measure: Edinburgh Postnatal Depression Scale. Estimate: significant 8% decrease in high depression scores.
Medium impact	5	• Self-help parent training programme for children with ADHD.[97] Method: randomised control trial. Sample size: small,	• Outcome measures: parental account of children's symptoms (PACs) and DuPaul ADHD rating scale. Estimate: significant

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

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

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

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

	43 children. Follow-up period: 6 weeks.	decrease in PACS (Cohen's d = 0.73) and significant decrease in number of children meeting clinical concern level on ADHD rating scale (45% of children had a reduced concern level).
	• Postgraduate training in psychosocial interventions for mental health staff.[98] Method: cross-sectional study. Sample size: small, 129 service users. Follow-up period: 6 months.	• Outcome measures: standardised measures of mental health and Life Skills Profile questionnaire. Estimate: mental health patients had fewer psychiatric symptoms (t = -3.74) and improved self-reported life skills (t = -7.43).
	• Take-home naloxone distribution and training on opiate overdose knowledge for opiate users. [99] Method: repeated-measure study. Sample size: medium, 525 participants. Follow-up period: 12 months.	• Outcome measure: overdose occurrence. Estimate: significant 32% reduction.
	• Domestic violence and abuse (DVA) training for general practice staff.[100] Method: observational time-series study. Sample size: large, 144 general practices. Follow-up period: 5 years.	• Outcome measure: daily number of referrals received by DVA workers per 1,000 women registered in a general practice. Estimate: significant increase in referrals (Incidence Risk Ratio = 30.24)
	• Sexual Health in Practice training for general practitioners.[101] Method: quasi-experimental time series. Sample size: medium, 52 general practices. Follow-up period: 8 years.	• Outcome measure: HIV testing rate. Estimate: significant 16% increase in HIV testing rates for every GP trained.

Overview of overall benefits of Oliver's Training

184. As explained in the theory of change outline (paragraph 164 and figure 1), the longer-term impacts of Oliver's Training are better quality of life and fewer avoidable deaths among people with a learning disability and autistic people. These can be expressed in terms of the societal value of reduced morbidity, better management of conditions and reduced mortality. There are also potentially benefits to the NHS in terms of cost savings, which can be realised when health conditions are prevented or diagnosed sooner, thereby reducing the need for more expensive and extensive treatment. We describe these two types of benefits under sub-headings below and explain where the 6% reduction in the health inequality applies (see paragraph 180).

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

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

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

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

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

185. The Health and Care of People with Learning Disabilities is an annual publication reporting on the differences in health between people with and without a learning disability.[102] Data is collected from participating GP surgeries (55% of the GP surgeries in England) for different indicators looking at the prevalence of certain conditions, such as obesity and dementia, and participation in public health interventions, such as health checks and cancer screening. Based on this and other evidence, we know that people with a learning disability are more likely to experience preventable health conditions than the general population.[103]

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

    1. In 2016, a study of 343 GP practices in England found that deaths caused by respiratory diseases were nearly 7 times more common in adults with a learning disability than without (24.8 deaths per 10,000 compared to 3.9 deaths per 10,000)[104]. In particular, pneumonia and aspiration pneumonia as underlying causes of death were 10 times more common. Adults with a learning disability are also more likely to be admitted to hospital for a respiratory condition.[105] Admissions were more frequent, of a longer duration and had a higher likelihood of re-occurrence, in particular, influenza and pneumonia.

    2. In 2021/22, 25% of people with a learning disability were clinically obese, compared to 8% of people without.[106]

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

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

    5. People with a learning disability are at an increased risk of tooth decay, gum disease and edentulism (complete tooth loss). This is likely due to a decreased understanding of good oral health and its importance, and poorer access to dental services and preventative dentistry. All these conditions are preventable with good oral hygiene practices and regular oral health checks.[107]

187. In some instances, these conditions may be preventable or they may be managed to reduce detrimental effects to health, wellbeing and participation in daily activities. Oliver's Training 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. A 6% reduction in the health inequality (paragraph 180) would apply to all, such that the number of people who experience these preventable conditions would reduce by 6% in this analysis.

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[102] NHS Digital. The Health and Care of People with Learning Disabilities 2022-23. Accessed here.

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

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

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

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

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

188. The Health and Care of People with Learning Disabilities 2021/22 dataset[108] also tracks the rate of medication prescriptions, which may be used to manage behaviour that challenges among people with a learning disability and autistic people. We know that overmedication is an issue:

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

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

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

189. There are two national NHSE programmes targeting over-medication among children and young people: Stopping The Over-Medication of People with a learning disability, autism or both (STOMP) and Supporting Treatment and Appropriate Medication in Paediatrics (STAMP). We expect that Oliver's Training will raise awareness of these programmes among health professionals and support efforts in reducing the rates of medication prescription for behaviour that challenges. However, we do not assume that the 6% reduction in the health inequality (paragraph 180) would apply here, because the effect of Oliver's Training is indirect through raising awareness of other programmes.

190. Another health and care issue that affects people with a learning disability and autistic people is the use of restraint and restrictive practices in hospitals. In 2020, CQC published a report providing evidence of such practices[109] and recommending that "there must be renewed attempts to reduce restrictive practice by all health and social care providers […]." NHSE are committed to reducing inappropriate restrictive practice and we expect that Oliver's Training will raise awareness of this commitment. Through emphasising the use of reasonable adjustments, hospital passports, effective communication, and person-centred care, Oliver's Training should help health and care professionals better plan for instances when people with a learning disability and autistic people may experience stress, thus avoiding the use of inappropriate restraint. However, we do not assume that the 6% reduction in the health inequality (paragraph 180) would apply here, because, as with STOMP/STAMP, the effect of Oliver's Training is indirect.

191. From 2018 to 2020, the average rate of deaths from avoidable medical causes among people with a learning disability was 647 people per 100,000,[110] about 3 times higher than the general population (average of 221 avoidable deaths per 100,000 population in 2018 and 2019). Applying the avoidable death rate to the population of people with a learning disability, this suggests that there are around 1,827 deaths from avoidable medical causes among people with a learning disability each year. The 6% reduction in the health inequality (paragraph 180) would apply to all deaths of avoidable medical causes.

192. We monetise the societal value of avoidable mortality in the next section ('estimating the potential benefits of Option 1'). We were not able to monetise the societal value of reduced morbidity or better management of conditions among people with a learning disability and autistic people due to lack of available data. There is likely a high societal value to this, as

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

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

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

better health means a person could increase their participation in society, including social and economic activities. There is also a high value related to better experience of health and care provision, where individuals feel treated with respect and compassion.

NHS cost savings

193. The purpose of Oliver's Training is to improve how people with a learning disability and autistic people receive routine health and social care support. There are substantial cost savings that could be realised through the roll-out of Oliver's Training, most notably, from preventing an escalation of health needs among people with a learning disability and autistic people.

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

195. Other examples stem from better management of health disparities (as described in paragraph 186). Obesity is a particular health issue that could be de-escalated. With better access to healthcare services, especially primary care and annual health checks, obesity could be prevented by improving access to weight loss programmes. By preventing obesity, further health conditions, such as type 2 diabetes and hypertension, could be prevented. De-escalation of upper respiratory conditions, with people with a learning disability able to communicate their concerns with a healthcare professional and access primary healthcare sooner, could lead to earlier detection of developing conditions and, therefore, earlier treatment.

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

197. We apply a 6% reduction in health inequality (paragraph 180) to all of the above, and as a result NHS activity will also be reduced. We present a selection of examples where we could monetise such NHS cost savings in the next section.

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

Estimating the potential benefits of Option 1

199. In this section, we present a selection of benefits which we were able to estimate, given the available data. It is intended to give some scale to the benefits of Oliver's Training but does not represent the full spectrum of policy benefits. Whilst these estimations attempt to

calculate the monetised benefits of option 1, we are not presenting these in the appraisal summary tables due to a lack of confidence around the scale of benefits.

200. We were unable to monetise the benefits of Oliver's Training for autistic people to the same degree as for people with a learning disability due to lack of data on the health and care of autistic people. Data were available only for monetising the benefits of increased breast cancer and colorectal cancer screening among the autistic population[111], which has been included below. This is a substantial limitation and represents a large underestimation of the policy benefits. To give an idea of the scale of such underestimation, we considered the relative sizes of the populations of people with a learning disability and of autistic people[112]. Figure 2 below illustrates this.

201. Using the Health and Care of People with Learning Disabilities Experimental Statistics, 2021-22,[113] we estimate that there are 282,450 people with a learning disability in England (i.e., 0.5% prevalence in the population). The statistics also tell us that 30.7% of people with a learning disability have been diagnosed with autism, meaning that there are c. 86,700 people with a learning disability who are also autistic. According to the National Autistic Society,[114] there are 700,000 autistic adults and children in England. This suggests that there are c.613,300 autistic people without a learning disability.

202. Our benefits estimations are almost entirely based on the population of people with a learning disability (including those who are also autistic) based on the GP Learning Disability Registers. There are over twice as many autistic people without a learning disability, who will benefit from Oliver's Training but who have not been fully represented in our benefits estimation.

203. It is worth noting that the GP Learning Disability Registers may be underrepresenting the true number of people with a learning disability in the population. We recognise that Mencap use a different prevalence estimate[115], however, given that we do not have the health and care data of the population missing from the registers, we did not account for this underrepresentation in our monetisation methodology. Therefore, the population sizes we are using are likely to be underestimates, and since these are applied throughout our estimated impact of benefits, we believe that we could have significantly underestimated benefits of Oliver's Training in our illustrative analysis.

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

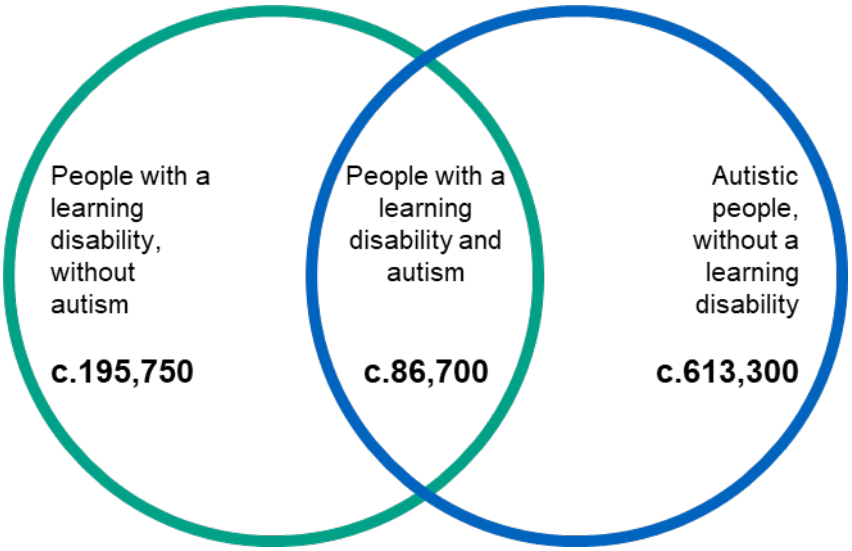
[111] The autistic population has been estimated using GP registered patient data. This is an underestimate of the entire autistic population and therefore may represent an underestimate in the total estimated benefits for this population.

[112] These populations are not identical, and as mentioned, the data available on the health and care of autistic people without a learning disability are more limited. However, we know that this group, similar to the learning disability population (see paragraphs 188 and 190), are more likely to experience chronic mental and physical health conditions, are less likely to attend cancer screenings, are overprescribed medication, and are more likely to face issues with healthcare access than the general population. This means our benefit monetisation is largely underestimated.

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

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

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



204. The following sections under dedicated sub-headings explain how we estimated some of the potential impacts of Oliver's Training. For all, we used a ten-year appraisal period from the point of implementation, because we think this will give a reasonable period to assess arising benefits, following Green Book guidance.[116]

Reduction in the prevalence of preventable health conditions

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

206. We identified which of the conditions measured in the Health and Care of People with Learning Disabilities data set were preventable and had a higher prevalence than in the population without a learning disability (a health inequality). We then assessed whether the savings to the NHS from the prevention of these conditions could be costed, from which we identified chronic constipation and non-type 1 diabetes.[117]

207. For chronic constipation, the annual cost of treatment was calculated by estimating the number GP appointments for those with a learning disability and chronic constipation, the number of people with a learning disability and chronic constipation and the annual cost of appointments and laxative prescriptions, more detail can be seen below in two parts:

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

        - To calculate the number of people with chronic constipation, the population of England from March 2021 (56,490,048[118]) was multiplied by the percentage of the general population with chronic constipation (1.3%) to equal 723,073. As 0.5% of the population has a learning disability[87], the population in England with

[116] HM Treasury (2022). The Green Book: appraisal and evaluation in central government. Access here.
[117] Non-type 1 diabetes can include type 2 diabetes as well as several other types including gestational diabetes. Type 2 is preventable and controllable through lifestyle and diet changes and medication. The other (rarer) types are less preventable and there is lack of data to be able to monetise them. As they equal around 1% of overall diabetes cases, it is assumed there will not be a large impact from the prevention of them.
[118] ONS. Census 2021. Accessed here

a learning disability is 282,450. This was multiplied by 13% (the proportion of people with a learning disability and chronic constipation)[87] to reach 36,719.

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

- The cost of laxatives prescriptions to the NHS in the 12 months between November 2021 and December 2022 was £114,267,550.[119]

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

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

2. Secondly, we calculated the cost of GP appointments per year per person with a learning disability and chronic constipation by multiplying the cost of one GP appointment (£34.04)[120] by the average number of GP appointments attended per year by someone with a learning disability and chronic constipation.

   - By multiplying the number of GP appointments each week for constipation (218,000)[121] by the prevalence of people with a learning disability in the chronic constipation population (5%) we estimated that 11,070 GP appointments each week were for people with a learning disability and chronic constipation. This may be an over-estimate, since it may include GP constipation appointments for those with a learning disability, who do not have chronic constipation.

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

   - To find the annual cost of appointments per person, £34.04 x 16 = £533.60.

3. The annual cost was the cost of laxative prescriptions plus the cost of GP appointments per person with a learning disability and chronic constipation each year, which made £691.63.

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

209. To find the cost savings to the NHS associated with the prevention of chronic constipation, £691.63 x 2,203 (decrease in number of people with chronic constipation) = £1,523,748

210. For non-type 1 diabetes, we calculated the annual cost by finding the estimated lifetime cost of treatment and dividing this by the estimated lifetime of the condition in years. This

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

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

[121] As the available data relates to total constipation appointments each week, our analysis may overestimate the number of appointments related to chronic constipation. Bowel Interest Group. The Cost of Constipation 2019. Accessed here.

was calculated from three different sources from academic articles and averaged to find an estimated cost per year.

211. To estimate lifetime costs for all sources, the average life expectancy of 66.5 for people with a learning disability[122] was decreased by 1.7 years[123] (to 64.8) to account for type 2 diabetes lowered life expectancy. The average age of someone with type 2 diabetes was 50. This was subtracted from 64.8 to find an average lifetime of 15 years of type 2 diabetes.

    1. Firstly, the annual cost of diabetes (£8.8 billion in 2017/18[124]) was uplifted by GDP inflators to 2022/23 prices and divided by the number of people with type 2 diabetes (£3,368,115) in 2021/22[125] to find an annual cost to the NHS per person of £3,030. This was multiplied by 15 years to find an average lifetime cost of £45,455.

    2. A study of health care resources and costs for people with type 2 diabetes found annual costs per person to be £2,446 after GDP uplift to 2022/23 prices[126]. This was multiplied by 15 years to find an average lifetime cost of £36,692.

    3. Thirdly, a study of lifetime costs-effectiveness based on the EXSCEL trial found that it costs the NHS an average of £56,564 per person with type 2 diabetes across their lifetime[127].

212. After finding the average of all three sources and dividing by 15 years, the average cost to the NHS of treating type 2 diabetes per person per year was £3,099.

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

214. To find the cost savings to the NHS associated with the prevention of non-type 1 diabetes, £3,099 x 1,186 (decrease in number of people with non-type 1 diabetes) = £3,675,850.

215. The estimated overall cost savings to the NHS from a reduction in the prevalence of chronic constipation and non-type 1 diabetes are £1,523,748 and £3,675,850, respectively, making a total cost saving from a reduction in potentially preventable conditions of £5,199,598.

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

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

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

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

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

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

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

216. Oliver's Training intends to increase the participation of people with a learning disability and autistic people in public health interventions, such as cancer screening, by increasing accessibility and improving their experience. The Health and Care for People with Learning Disabilities publication also reports on the cancer screening rates for people with a learning disability compared to the general population rates. The publication includes data for the three key screening programmes in the UK: breast, cervical, and colorectal cancer. For breast and colorectal cancer screening, data is available within this publication for autistic people without a learning disability.

    1. The screening rate for colorectal cancer for people aged 60-74 is 50% for those with a learning disability and 58% for autistic people without a learning disability, compared to 67% in the general population.

    2. For breast cancer, there is a 47% uptake in females aged 50-69 years with a learning disability and 54% uptake in autistic females aged 50-69 without a learning disability, compared to 62% in females aged 50-69 in the general population.

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

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

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

    1. A study of cancer care costs in England found that early-stage colorectal cancer cost an average of £14,196 in a year, whilst the cost of advanced stage colorectal cancer cost an average of £15,411[128]. With GDP uplift to 2022/23 prices, the cost difference between early and advanced stage was £1,575.

    2. An economic evaluation of patient-level routine health system data for cancer care found that costs for stage 1 and stage 2 colorectal cancer in the first 12 months were £7,295 and £9,702 respectively, making an average cost for early-stage cancer of £8,499. Stage 3 cancer was costed at £13,306 per year. As the data did not cost for stage 4 cancer, advanced stage cancer was costed at £13,306[129]. After GDP uplift to 2022/23 prices, the cost difference for between early and advanced stage cancer for the first 12 months was £6,020.

    3. Data published by the Department of Health in 2011 found that the cost of stage 1 cancer was £9,121 and the cost for stage 2 colorectal cancer was £13,918. The average for early-stage cancer was therefore £11,520. Stage 3 cancer costs were £21,604 and stage 4 cancer costs were £13,344, therefore, the average cost for

[128] Laudicella, M., Walsh, B., Burns, & Smith, C. (2016) Cost of care for cancer patients in England: evidence from population-based patient-level data. British Journal of Cancer, 114, 1286-1292. Accessed here.
[129] Hall, P., Hamilton, P., Hulme, C., Meads, D., Jones, H., Newsham, A., Marti, J., Smith, A., Mason, H., Velikova, G., & Wright, P. (2015) Costs of cancer care for use in economic evaluation: a UK analysis of patient-level routine health system data. British Journal of Cancer, 112, 948-956. Accessed here.

advanced stage colorectal cancer was £17,474.[130] After GDP uplift to 2022/23 prices, the average cost difference between early and advanced stage colorectal cancer was £7,846.

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

218. We then calculated the number of autistic people and people with a learning disability who will have a reduced risk of dying from colorectal cancer following screening after Oliver's Training roll-out.

1. As only people aged 60-74 are eligible for colorectal cancer screening programmes, we calculated that the number of 60–74-year-olds in the general population in March 2021 was 8,820,114[95]. The prevalence of learning disability among people aged 60-74 is 0.5%, so the number of people aged 60-74 with a learning disability is 42,143[93]. The number of autistic people aged 60-74 with no learning disability has been estimated at 5,135 using GP registered patient data.

2. By multiplying 42,143 by 50% (colorectal cancer screening rates for people with a learning disability) and 5,135 by 58% (colorectal screening rates for autistic people without a learning disability), we estimate that 21,188 people aged 60-74 with a learning disability and 2,954 people aged 60-74 with autism and without a learning disability had colorectal cancer screening in 2021.[93]

3. We applied an impact of Oliver's Training in increasing the uptake of colorectal cancer screening of 6%. We multiplied the number of people aged 60-74 with a learning disability or autistic people with no learning disability who had a colorectal cancer screening by 6% - the additional number of people aged 60-74 with a learning disability or autism who are estimated to have a colorectal screening after Oliver's Training roll-out is 1,448.

4. The expected reduced relative risk of dying from colorectal cancer following screening is 23%.[131] Applying this to the 5-year colorectal cancer net survival rates within NHS Cancer Survival in England published data[132], we estimate that colorectal screening reduces the mortality rate for colorectal cancer by 9.5%.

5. We estimate the prevalence rate for colorectal cancer among the general population is 5.4%[133]. By multiplying the additional number of people having a colorectal screening after Oliver's Training roll-out (1,448) by the prevalence rate for colorectal cancer (5.4%) and by the expected decrease in mortality as a result of screening (9.5%), we estimate 7.4 people aged 60-74 with a learning disability or autism who will have a reduced risk of dying from colorectal cancer following screening.

219. By multiplying the average cost difference between early and advanced stage cancer (£5,147) by the number of people aged 60-74 with a learning disability who will have a reduced risk of dying from colorectal cancer following screening (7.4), we calculated that the

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

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

[132] NHS England. Cancer Survival in England, cancers diagnosed 2015 to 2019, followed up to 2020. Accessed here.

[133] 1 in 20 UK females and 1 in 17 UK males will be diagnosed with bowel cancer in their lifetime. Bowel cancer statistics | Cancer Research UK. Accessed here.

NHS cost savings due to a reduction in the risk of death from colorectal cancer in 2022/23 prices is £38,563.

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

    1. A study looking at the costs of early invasive breast cancer in the UK found that the annual cost for stage 1 cancer was £5,167 and for stage 2 cancer was 7,613, making the average cost of early-stage breast cancer £6,390. The paper had costs for stage 3 cancer only, so the cost for advanced stage breast cancer was £13,330[134]. The cost difference between early and advanced stage breast cancer in 2022/23 prices is £8,184.

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

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

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

221. We then calculated the number of autistic people without a learning disability and people with a learning disability who will have a reduced risk of dying from breast cancer following screening after Oliver's Training roll-out.

    1. As only females aged 50-69 are eligible for breast cancer screening programmes, we calculated the number of females aged 50-69 in the general population in March 2021 was 7,001,002.[95] The prevalence of learning disability among females aged 50-69 is 0.4%, so the number of females aged 50-69 with a learning disability is 30,471.[93] The number of autistic females aged 50-69 with no learning disability has been estimated at 4,470 using registered patient data published within the 2020-21 Health and Care of People with Learning Disabilities dataset.

    2. By multiplying 30,471 by 47% (breast cancer screening rates for people with a learning disability) and 4,470 by 54% (breast cancer screening rates for autistic people without a learning disability), we estimate that 14,382 females aged 50-69 with a learning disability[93] and 2,429 autistic females aged 50-69 with no learning disability had a breast cancer screening in 2021.

    3. We applied a 6% impact of Oliver's Training in increasing the uptake of breast cancer screening. We multiplied the number of females aged 50-69 with a learning disability

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

and autistic females with no learning disability who had a breast cancer screening by 6% – the number of females with a learning disability or autistic females who will have a breast cancer screening after Oliver's Training roll-out will be 1,009.

4. The expected reduced relative risk of dying from breast cancer following screening is 20%.[135] Applying this to the 5-year breast cancer net survival rates within NHS Cancer Survival in England published data[136], we estimate that breast screening reduces the mortality rate for breast cancer by 2.8%.

5. We estimate the prevalence rate for breast cancer among the female population is 14%[137]. By multiplying the additional number of people having a breast screening after Oliver's Training roll-out (1,009) by the prevalence rate for breast cancer (14%) and by the expected decrease in mortality as a result of screening (2.8%), we estimate 4 females aged 50-69 with a learning disability and autistic females with no learning disability who will have a reduced risk of dying from breast cancer following screening.

222. By multiplying the average cost difference between early and advanced stage cancer (£6,257) by the number of females aged 50-69 with a learning disability or that are autistic who will have a reduced risk of dying from breast cancer following screening (4), we calculated that the NHS cost savings due to a reduction in the risk of death from breast cancer in 2022/23 prices is £25,344.

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

    1. A report from Demos using data from Queen Mary's University London found that the cost of stage 1a cervical cancer was £1,379 and stage 1b cervical cancer was £8,164. As these stages are other non-invasive cancers, the average cost of non-invasive (early-stage) cancer is £4,772. The source defined the other stages of cervical cancer as invasive cancer (or advanced stage) and quoted an average cost of £19,261[138]. After GDP uplift to 2022/23 prices, the difference between early and advanced stage cervical cancer was £18,453.

    2. Using NHS reference costs and information from Cancer Research UK[139], the cost of each stage of cervical cancer was calculated from the costs of treatments. For stage 1 cancer, a patient receives either a cone biopsy or loop excision (£465), a simple hysterectomy (£1,230), or a trachelectomy (£5,486). An average was calculated from each of these costs to find the average cost for stage 1 cervical cancer (£2,394). For stage 2 cancer, a patient receives either a radical hysterectomy (£3,938), chemoradiotherapy (£24,168), or both (£28,105). An average was calculated from all three costs to find the average cost for stage 2 cervical cancer (£18,737). The average cost for early-stage cervical cancer (stage 1 and 2) was calculated at £10,565. For stage 3 cancer, a patient usually receives chemoradiotherapy (£24,168) so the average cost for stage 3 cancer was £24,168. Stage 4 cancer patients usually

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

[136] NHS England. Cancer Survival in England, cancers diagnosed 2015 to 2019, followed up to 2020. Accessed here.

[137] 1 in 7 UK females will be diagnosed with breast cancer in their lifetime. Breast cancer statistics | Cancer Research UK. Accessed here.

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

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

receive a hysterectomy, radiotherapy, and chemotherapy (£26,751) so the average cost for stage 4 cervical cancer was £26,751[111,140]. After GDP uplift to 2022/23 prices, the cost difference between early and advanced stage cervical cancer was £18,266.

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

224. We then calculated the number of people with a learning disability who will have a reduced risk of dying from cervical cancer following screening after Oliver's Training roll-out.

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

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

3. We applied a 6% impact of Oliver's Training in increasing the uptake of cervical cancer screening. We multiplied by the number of females aged 25-64 with a learning disability who had a cervical cancer screening by this 6%, and calculate that the number of females with a learning disability who will have a cervical cancer screening after Oliver's Training roll-out will be 1,287.

4. The expected proportion of people who will have a reduced risk of dying from cervical cancer following screening is 41%.[141] Applying this to the 5-year cervical cancer net survival rates within NHS Cancer Survival in England published data[142], we estimate that cervical screening reduces the mortality rate for cervical cancer by 15.9%.

5. We estimate the prevalence rate for cervical cancer among the female population is 0.8%[143]. By multiplying the additional number of people having a cervical screening after Oliver's Training roll-out (1,287) by the prevalence rate for cervical cancer (0.8%) and by the expected decrease in mortality as a result of screening (15.9%), we estimate 1.6 females aged 25-64 with a learning disability will have a reduced risk of dying from cervical cancer following screening.

225. By multiplying the average cost difference between early and advanced stage cervical cancer (£18,359) by the number of females aged 25-64 with a learning disability who will have a reduced risk of dying from cervical cancer following screening (1.6), we calculated that the NHS cost savings due to a reduction in the risk of death from cervical cancer in 2022/23 prices is £29,110.

Reduction in emergency acute hospital admissions

226. One of the intended outcomes of Oliver's Training 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

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

[141] Jansen, E. E. L., Zielonke, N., Gini, A., Anttila, A., Segnan, N., Vokó, Z., Ivanuš, U., McKee, M., de Koning, H. J., de Kok, I. M. C. M., Veerus, P., Anttila, A., Heinävaara, S., Sarkeala, T., Csanádi, M., Pitter, J., Széles, G., Vokó, Z., Minozzi, S., … Priaulx, J. (2020). Effect of organised cervical cancer screening on cervical cancer mortality in Europe: a systematic review. In European Journal of Cancer, 127, 207–223. Elsevier BV. Accessed here.

[142] NHS England. Cancer Survival in England, cancers diagnosed 2015 to 2019, followed up to 2020. Accessed here.

[143] 1 in 130 UK females will be diagnosed with cervical cancer in their lifetime. Cervical cancer statistics | Cancer Research UK. Accessed here.

engage in preventative and public health interventions. There is a lack of up-to-date data on the number and patterns of acute hospital admissions for people with a learning disability and autistic people. To estimate the scale of this benefit, we relied on two sources using Hospital Episode Statistics from 2005-2009[144] and from 2009-2013.[145] Given the review of broad evidence on health inequalities experienced by people with a learning disability (see section 'Problem under consideration and rationale for intervention') and continuing high rates of mortality from avoidable medical causes, we considered these sources valid for the purposes of estimating the benefits in this IA.

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

228. To monetise the benefit of reduced acute hospital admissions, we apply the 6% impact of Oliver's Training to the emergency admissions for ACSCs for people without a learning disability (9,767) – this arrives at 586 prevented emergency acute hospital admissions per year. We multiply this number by the average cost of a hospital admission (£3,162 per episode[146] in 2022/23 prices) and estimate that the NHS cost saving due to lower emergency acute hospital admissions is £1,879,124 per year in 2022/23 prices.

Reduction in mental health hospital admissions

229. In addition to reduced acute hospital admissions, Oliver's Training has the potential to reduce admissions and re-admissions to mental health hospitals, as better communication skills and improved healthcare support should prevent people from reaching a crisis point. Using data from Assuring Transformation,[147] we estimate the potential savings from hospital admissions of people with a learning disability and autistic people who are considered to require care in mental health hospitals.

230. In the last 12 months to December 2022, the total reported number of admissions was at 1,675 and the total number of reported re-admissions was at 335.[148] We applied a 6% impact of Oliver's Training on reducing mental health hospital admissions and re-admissions.

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

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

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

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

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

231. 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 £316,636 in 2022/23 prices.[149]

232. By applying the 6% impact of Oliver's Training to the October 2023 data on the total number of admissions and re-admissions (2,215) and the cost of an adult inpatient bed (£316,636), we estimate the saving from reduced mental health hospital admissions could be £42.1m per year in 2022/23 prices.

233. We believe the estimate above could be an under-estimate, since our methodology assumes that each of these admissions will require the cost of an adult inpatient bed for one year. However, NHS Learning Disability Services Statistics, Assuring Transformation suggests that the average length of stay may be over one year. Whilst the average length of stay is not provided, at the end of December 2023, 53% of people with a learning disability or autistic people in mental health hospitals have a total length of stay of over 2 years.[150]

Reductions in avoidable mortality

234. To calculate the estimated reduction in avoidable deaths, we multiplied an impact of 6% from Oliver's Training by the number of avoidable deaths each year among people with a learning disability. We therefore estimate 110 fewer avoidable deaths a year, if all staff are trained and there has been no skills fade in staff already trained.

235. 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.[151]

236. There is a lack of available data on the age at avoidable death for people with a learning disability. Our assumptions on the number of SLYs gained per avoided death have therefore been informed by the information available on deaths reported to the LeDeR programme. We assume that roll-out of Oliver's Training will result in a positive gain in life expectancy due to a reduction in the number of avoidable deaths.

237. The 2021 LeDeR report[152] suggests that deaths were more likely to be classified as avoidable with increasing age, peaking in the 25-49 age group before decreasing again for those who died over the age of 65 years. Therefore, whilst the median age of death in the LeDeR cohort was 60 for males and 59 for females, we believe the median age of death for those classified as unavoidable is likely to be younger.

238. Due to a lack of available data, we have made an estimate that the final expected additional SLYs brought by Oliver's Training per prevented death from an avoidable medical cause is 10. Assuming the median age of death for those with an avoidable cause of death falls in the 25-49 age group compared to the median age of death of 59.5 for the entire LeDeR cohort, we have used 10 years as a conservative estimate. Due to uncertainty around this figure, we included an increase and decrease to this impact factor of 20% in our sensitivity testing (see paragraph 252).

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

[150] Learning Disability Services Monthly Statistics, AT: December 2023, MHSDS: November 2023 - NHS Digital

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

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

239. Based on the above, by multiplying the estimated number of SLYs gained per death avoided (10), the monetary value of a SLY (£70,000) and the number of avoided deaths related to Oliver's Training (110), we estimate the societal value of reduction in deaths to be £76,753,028 per year (in 2022/23 prices).

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

240. Overall, our illustrative analysis of benefits shows that by applying a 6% reduction to health outcomes across a 10-year appraisal period, Option 1 could be associated with £984.8m in monetised benefits (table 15).

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

Total benefits (£m)	23/24	24/25	25/26	26/27	27/28	28/29	29/30	30/31	31/32	32/33	Total
Prevention of non-type 1 diabetes	1.3	2.3	3.2	3.2	3.1	3.0	2.9	2.8	2.7	2.6	27.1
Prevention of chronic constipation	0.6	1.0	1.3	1.3	1.3	1.2	1.2	1.2	1.1	1.1	11.2
Increased rate of cancer screening	0.0	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.7
Reduced emergency acute hospital admissions	0.7	1.2	1.7	1.6	1.6	1.5	1.5	1.4	1.4	1.3	13.9
Reduced mental health hospital admissions	15.2	26.5	37.2	36.5	35.2	34.1	32.9	32.0	30.9	29.9	310.4
Reduced avoidable mortality	27.8	49.3	70.5	70.7	69.4	68.5	67.5	66.9	65.9	65.0	621.4
Total	**45.6**	**80.3**	**114.0**	**113.4**	**110.5**	**108.4**	**106.0**	**104.3**	**102.1**	**100.0**	**984.8**

241. Option 1 is associated with estimated cost savings to the NHS of £363.3m, which cover prevention of non-type 1 diabetes, prevention of chronic constipation, increased rate of cancer screening and reduced emergency acute and mental health hospital admissions over the 10-year appraisal period (in 2022/23 prices, discounted). These savings could be converted to delivering 24,220 QALYs (valued at £15,000) or £1,695.4m in societal value (where each QALY is valued at £70,000).

Net present value of Option 1

242. The net present value of Option 1 is negative over a 10-year appraisal period – this is shown in table 16a below. However, due to uncertainty of the scale of the impact of Oliver's Training we were not able to include monetised benefits.

243. Table 16b shows the net present value of Option 1 over a 10-year appraisal period with partial benefit monetisation, where a 6% impact on health outcomes has been applied. The monetisation is partial, because we could only monetise a small selection of benefits related to autistic people (see paragraph 202), because we could not monetise the societal value of improved morbidity and better management of morbidity for people with a learning disability, and because we could only monetise a selection of NHS cost savings. As a result, the estimate of net benefit does not represent a complete picture of the net benefit of the option to society.

244. In addition, the largest component of our estimated costs are economic staff time costs of staff undertaking training in place of other activities. This component is sensitive to the assumptions that Oliver's Training will displace other activities, rather than be integrated as part of contractual headroom for mandatory training. We show how this assumption affects costs in the best-case and worst-case scenarios in our sensitivity analysis (see paragraph 252) and breakeven analysis (see paragraphs 255-258).

245. In the final Impact Assessment, we are only considering one option and, therefore, the NPV for Option 1 reflects the highest chance of bringing about the intended outcomes and impacts, as described in the theory of change outline (see paragraph 164 and figure 1).

Table 16a. NPV summary for Option 1 (in £millions in 2022/23 prices, discounted).

	Option 1
Total monetised costs across 10 years	1,483.8
Total monetised benefits across 10 years	0
Net present value	-1,483.8

Table 16b. NPV summary for Option 1 with partial benefit estimation (in £millions in 2022/23 prices, discounted).

	Option 1
Total monetised costs across 10 years	1,483.8
Estimated partial benefits across 10 years	984.8
Net present value	**-499.0**

Indirect benefits of Oliver's Training

246. We discussed the direct benefits of Oliver's Training in terms of societal value and NHS cost savings. There may also be other indirect benefits, which are summarised below.

Improvement in the wellbeing of family and carers

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

Reduction in clinical negligence claims

248. Oliver's Training 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.

249. 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 Oliver's Training.

LeDeR review cost savings

250. 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.[153] 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.

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

Sensitivity analysis

Scenario testing for both options

252. This section outlines which key assumptions and variables in the cost and benefit model (central scenario) could feasibly change to represent alternative scenarios: the best- and worst-case scenarios. For all benefits, the central scenario refers to the mid-point estimates used in the illustrative analysis of monetised benefits, but these are not included in the appraisal summary tables due to a lack of uncertainty around the scale of impacts.

253. The assumptions tested in this section are limited to those we think will have material impact on the NPV of the policy option, or scenarios that could potentially occur, which we gauged through engaging with stakeholders. We present two scenarios where key assumptions are varied simultaneously to provide estimates of the best and worst cases. Table 17 presents a summary of all variations that were used in our sensitivity testing.

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 training in-house for total NHS	90% (in-house) and 10% (procured)	80% (in-house) and 20% (procured) (10% pts increase)	100% (in-house) and 0% (procured) (10% pts increase)
Proportion of staff receiving training in-house for private ASC	50% (in-house) and 50% (procured)	40% (in-house) and 60% (procured) (10% pts increase)	60% (in-house) and 40% (procured) (10% pts increase)
Proportion of staff receiving training in-house for private healthcare	0% (in-house) and 100% (procured)	N/A	50% (in-house) and 50% (procured) (50% pts increase)
Proportion of staff requiring tier 1 and tier 2 training NHS	41% tier 1 and 59% tier 2	33% tier 1 and 67% tier 2	48% tier 1 and 52% tier 2
Proportion of staff requiring tier 1 and tier 2 training GP	43% tier 1 and 57% tier 2	33% tier 1 and 67% tier 2	53% tier 1 and 48% tier 2
Proportion of staff requiring tier 1 and tier 2 training NHS Dentists and DCPs	100% tier 2	100% tier 2	19% tier 1 and 81% tier 2

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

Proportion of staff requiring tier 1 and tier 2 training Private HCHS	48% tier 1 and 52% tier 2	37% tier 1 and 63% tier 2	60% tier 1 and 40% tier 2
Proportion of staff requiring tier 1 and tier 2 training Private Dentists and DCPs	100% tier 2	100% tier 2	19% tier 1 and 81% tier 2
Proportion of staff requiring tier 1 and tier 2 training public and private ASC	63% tier 1 and 37% tier 2	63% tier 1 and 37% tier 2	63% tier 1 and 37% tier 2
Number of non-clinical staff per dental location	3	4	2
Content and format of repeated training sessions	tier 1 – same as original package tier 2 – same as original package	N/A	tier 1 – same as original package tier 2 – e-learning plus shorter (3.5 hour) face-to-face session
The margin on private healthcare staff salary over NHS salaries	34%	54% (20% pts increase)	14% (20% pts decrease)
ASC staff - parts of Oliver's Training that can come under Continuous Professional Development / headroom	None	N/A	tier 1 – e-learning only, none of webinar tier 2 – e-learning only, none of face-to-face session
Healthcare staff - parts of Oliver's Training that can come under Continuous Professional Development / headroom	tier 1 – e-learning only, none of webinar tier 2 – e-learning only, none of face-to-face session	N/A	tier 1 – all comes under CPD / headroom tier 2 – all e-learning and half (4 hours) of face-to-face session
Potential impact of Oliver's Training on health outcomes	6%	3% (-50%)	9% (+50%)
Statistical life years (SLY)	10 years gained per death avoided	8 years gained per death avoided (-20%)	12 years gained per death avoided (+20%)

254. Table 18 below shows an illustrative comparison of NPV that includes our partial benefit estimations. The table shows cost and benefit estimates for the central, high, and low-cost scenarios for Option 1. In this table, the central scenario for benefits is based around a 6% impact of Oliver's Training on health outcomes, with 3% in the worst-case scenario and 9% in the best-case scenario. However, we are not indicating that 6% is the most likely scenario, and this comparison is just for illustrative purposes, to highlight how our partial benefit estimations compare to the monetisation of costs. All high, and low-cost assumptions are combined simultaneously in their respective scenarios.

Table 18. Summary of monetised costs and illustrative benefits under the best- and worst-case scenarios for Option 1 (in £millions, 2022/23 prices, discounted).

	Central scenario	Worst-case scenario	Best-case scenario
Training costs	240.1	253.8	222.6
In-house delivery costs	1.7	1.7	1.6

Staff time costs	1,242.0	1,386.3	563.4
Total costs	**1.483.8**	**1,641.8**	**787.7**
Reduced NHS costs	363.3	181.6	543.8
Societal value of reduced avoidable mortality	621.4	181.6	1,116.2
Total benefit	**984.8**	**430.2**	**1,660.0**
Net Present Value	**-499.0**	**-1,211.6**	**872.4**

Breakeven analysis for Option 1

255. This section summarises the breakeven analysis if the NPV we were to include quantified costs and illustrative benefits. (see section 'Net present value of Option 1'.

What would the expected impact of Oliver's Training need to be for a breakeven NPV under central scenario

256. We estimate the figure needed for the expected impact of Oliver's Training to be 9.04% for Option 1 to allow the option to have a breakeven NPV (zero). Given evidence from the rapid evidence review shows some similar packages have results ranging from no impact to a 45% improvement in outcomes, alongside the scale of expected roll-out and stakeholder feedback, we believe that this is plausible.

What parts of Oliver's Training would need to be absorbed under Continuous Professional Development / headroom for NHS staff for a breakeven NPV under central scenario

257. Under the central scenario, we assumed that all time taken by healthcare staff to complete Oliver's Training tier 1 webinars and tier 2 face-to-face sessions will have an economic staff time cost, as staff take training instead of performing other activities. However, in conversations with NHSE 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 Oliver's Training will be absorbed under CPD / headroom and will not pose an economic staff time cost.

258. We calculated that, under Option 1, all of tier 1 webinars (1.5 hours) and about a third of tier 2 face-to-face sessions (2.5 hours) would need to be absorbed under CPD / headroom for NHS staff to reach a breakeven NPV (zero). This is equivalent to 2.5 hours and 4 hours of NHS staff time, on tier 1 and 2 respectively, and may not be feasible given other mandatory training requirements.

Direct costs and benefits to business calculations

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

260. Staff time costs have been included in the Equivalent Annual Net Direct Cost to Business (EANDCB) calculations, however we have separated direct training costs and staff time costs in tables 19 and 20 respectively. More detailed staff time costs have been shown in table 11. Whilst we can estimate direct training costs with some degree of certainty, staff time costs are more uncertain since we do not know what proportion of training can be absorbed within CPD or displace other existing training, therefore we present direct training costs and opportunity costs separately.

261. Under Option 1, we assume that DHSC funding will be available to cover training costs for staff working in registered health and adult social care services and that this will include those in independent organisations. As set out in the 'Affordability Analysis' below, the decisions about the level of funding available and how any central funding will be accessed are in development. Therefore, for EANDCB purposes we have separated direct training costs and staff time costs for independent healthcare providers and independent ASC providers – these are shown in tables 19 and 20. After applying relevant discount and deflation factors to bring the costs to 2019 prices, 2020 base year, direct training costs become £91.2m for Option 1. Under a ten-year appraisal period, these costs' annual equivalent becomes £10.6m. Applying the same discount rates and deflation factors, staff time costs become £373m for Option 1. Under a ten-year appraisal period, these costs' annual equivalent becomes £43.3m. Including direct training costs and staff time costs as relevant costs to businesses, this gives a discounted cost of £464.2m and a costs' annual equivalent of £53.9m.

Table 19. Summary of direct training costs relevant for businesses under Option 1 (in £million in 2023/24 prices, not discounted).

Costs (£m)	23/24	24/25	25/26	26/27	27/28	28/29	29/30	30/31	31/32	32/33	Total
Private HCHS	1.9	1.9	2.0	2.3	2.1	2.1	1.9	2.0	2.0	1.8	20.0
Private dentists	0.5	0.5	0.5	0.7	0.6	0.6	0.6	0.6	0.6	0.6	5.8
Private ASC	8.5	8.6	8.7	7.8	8.7	8.8	7.3	7.4	7.5	6.4	79.7
Total	10.9	11.1	11.2	10.7	11.4	11.5	9.8	10.0	10.1	8.8	105.5

Table 20. Summary of staff time costs relevant for businesses under Option 1 (in £million in 2023/24 prices, not discounted).

Costs (£m)	23/24	24/25	25/26	26/27	27/28	28/29	29/30	30/31	31/32	32/33	Total
Private HCHS	12.5	12.7	13.0	15.2	13.8	14.1	12.7	13.0	13.3	12.0	132.5
Private dentists	3.3	3.4	3.5	4.2	3.9	4.0	3.6	3.8	3.8	3.5	36.9

Private ASC	28.1	28.3	28.5	25.5	28.6	28.9	24.2	24.4	24.6	21.0	262.1
Total	43.8	44.5	45.0	44.9	46.3	46.9	40.5	41.1	41.7	36.6	431.4

Affordability Analysis

262. Option 1 represents the optimal roll-out of Oliver's Training and pre-supposes that central funding will be provided to support delivery of the training package to the health and adult social care sectors. For the purposes of the modelling used in this IA, we have assumed that £82.3m would be required to support training delivery over a 3-year roll-out period beginning in 2023/24. Table 12 provides further information on this assumption.

263. In 2023/24, we developed and consulted on the draft Code of Practice. Whilst the Code was in draft form, we have been making progress on building training capacity and commencing roll out through provision of £17m to Integrated Care Boards. Further information on activities to support roll-out is set out under the section 'Preferred option with description of implementation plan'.

264. We expect for further central funding for 2024/25 to be afforded within outline budgets and are in the process of agreeing appropriate delivery models. This funding will not include staff-time costs in line with the approach taken on funding provided to Integrated Care Boards in 2023/24, and other central funding initiatives of workforce training and qualifications. Funding to support roll-out beyond 2024/25 will be subject to decisions in a future Spending Review.

Key Assumptions

265. This IA was prepared in advance of specific details on the roll-out of Oliver's Training 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 and Skills for Care (SfC) as the representative skills bodies for the health and care workforce and the key organisations who supported development of Oliver's Training. For example, this was the case for estimating the cost of recruiting the co-trainers and facilitating trainers to deliver Oliver's Training.

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

- In our illustrative analysis of potential benefits, we assumed that the 6% impact size calculated using table 14 is the same for all outcomes brought by Oliver's Training. However, given that Oliver's Training is expected to influence a wide range of outcome types, there may be variation in the actual size of the impact, for example, cancer screening attendance may be more easily amenable to change, while avoidable mortality may be harder to change due to larger variation and complexity of its determinants. We have not accounted for this in our benefit calculations (see paragraph 181).

- There is uncertainty around the feasibility of recruiting and training the co-trainers required for delivery. It is possible that in practice there is greater variability than what we have accounted for in the analysis. This is 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 of Oliver's Training, 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.[154] Therefore, workforce numbers could fluctuate more than we expect and have accounted for in our analysis, potentially leading to differences in estimated costs and benefits.

- We assume the potential benefits brought by Oliver's Training are equivalent 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 2021 LeDeR reports to inform several assumptions. This does not account for autistic people, although it will in future reports. The recently published 2022 report has limited data on autistic people, but the sample size is too small to inform assumptions. Therefore, the monetised benefits we have calculated in our illustrative analysis (for example, those related to SLYs) have been underestimated in this regard in our analysis.

267. 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 Oliver's Training. 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.

Key risks with the preferred option

268. There is a key risk that the roll-out of training in the ASC sector is not complete within 3 years, due to difficulties accessing training packages in year 1 to ASC providers. If roll-out was lower than expected in the first three years, then costs and benefits would likely be reduced in that time period. DHSC are working to facilitate access to improved quality and capacity of training to the ASC sector through the development of an endorsement scheme for training providers delivering Oliver's Training to ASC. Alongside the intention to provide central funding to subsidise the costs of roll out and continued work to promote and embed training uptake in the sector, it is expected that the practical challenges to roll out Oliver's Training in year 1 will be mitigated in subsequent years. Further detail is set out under the implementation plan for Option 1.

269. There is a potential risk to businesses surrounding the direct costs of the running and procurement of training packages, as well as the staff time costs of the time spent on training by the workforce, whether that be the cost of lost working time or via procuring agency staff to cover care.

[154] 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).

Impact on small and micro businesses

270. The new legislation that introduces mandatory training on learning disability and autism applies to all staff working in CQC-regulated settings, independent of their size. This means that all small and micro businesses that perform CQC-regulated activities will need to provide training on learning disability and autism appropriate to their staff roles. Across the adult social care sector in England, approximately 90% of domiciliary care providers and 78% of residential care providers are SMBs.[155] For the healthcare sector across the UK, 97% of providers are SMBs.[156] In line with the Regulatory Policy Committee's guidance for departments, we have considered whether any exemptions or mitigations would be appropriate for SMBs.

271. We do not anticipate that there will be disproportionate burdens on SMBs as a result of the preferred policy option outlined in this IA. Anecdotal feedback from businesses, including analysed responses through the consultation on the draft Code, suggests that all businesses will face the risk of meeting the direct costs of training (see paragraph 265). 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.[157] Therefore, SMBs should already be equipped in managing the requirements for Oliver's Training in line with the approach taken to manage requirements for other core training for staff. It is possible that there will be additional costs to SMBs in the future, if the 5-year code of practice review leads to changes in the model of delivery and content of training, however it is difficult to predict this at this stage.

272. Overall, as SMBs comprise most of the markets, we would expect to lose a sufficiently large part of desired benefits if they were made fully or partially exempt from this policy and therefore this has not been pursued. There is also a potential unintended consequence of incentivising businesses to reduce their size or staff to move to SMBs if they were exempt from this policy, to avoid meeting its costs, which would increase the risk that desired benefits are not realised.

273. It is also assumed that direct costs to businesses would be relative to the number of staff employed that are eligible for mandatory training. With this in mind, larger organisations are likely to have higher financial burdens given their larger workforce even if this amounts to a smaller proportion of their overall business costs compared to SMBs. Therefore, a targeted mitigation for SMBs has not been deemed necessary. However, we expect central funding to be accessible to SMBs in scope of the statutory requirement which should help reduce any burdens of delivering training to their staff. We will ensure that any provision of central funding is supported by clear communications to organisations in the health and social care sector.

274. Following advice from SfC, there is a potential risk of destabilising SMBs in the social care sector who deliver training, especially those who deliver specific learning disability and autism training, if they are not able to become accredited providers of Oliver's Training or offer training that meets the code of practice standards. We intend to mitigate this through clear communications on how to become accredited.

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

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

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

Impact on medium sized businesses

275. Similarly, to small and micro businesses, we do not anticipate that there will be disproportionate burdens on medium sized businesses as a result of the preferred policy option outlined in this IA. We have received anecdotal feedback from businesses, including analysed responses from the consultation on the draft Code, that suggests that all businesses will face the risk of meeting the direct costs of training (see paragraph 265). Therefore, we do not deem exemptions or mitigations necessary for medium sized businesses. However, we expect that central funding will also be accessible to these medium sized businesses that fall in scope of the statutory requirement to help reduce burdens of delivering training to their staff.

Wider impacts

Equalities

276. 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.

277. The public sector equality duty (PSED) has been considered as part of developing this intervention and an Equalities Impact Assessment has been carried out.

Unintended consequences

278. 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.

279. 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.[158,159,160] Therefore, there is a risk that this potential unintended consequence could exacerbate such regional variation issues.

Competition and innovation

280. We do not foresee any impact on competition and innovation as a result of this intervention. If training providers can demonstrate compliance with the standards in the Code of Practice, they would be able to provide the training.

Monitoring and Evaluation

281. 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 is described in the legislation).

282. The code of practice provides guidance about the nature of the training, including provisions about monitoring compliance and evaluating the impact of the training. Registered providers should continue to use their existing staff record management systems to record and monitor their staff's completion of learning disability and autism

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

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

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

training unless otherwise specified by the training provider. Registered providers and training providers are expected to make training data available to the relevant monitoring body (for example, their Integrated Care Board or local authority) and collaborate in any future impact evaluation activity. Registered providers and commissioners should also monitor uptake and analyse the impact of training within their organisations.

283. Our assessment of the success of the new legislative requirement takes a long-term approach in recognition that any behavioural and cultural changes take time to yield changes.

284. 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 Oliver's Training and the number and proportion who complete Oliver's Training 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.

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

286. 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.

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

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

289. 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.

290. The trial of Oliver's Training has been evaluated and the learning from this evidence has been used to inform roll out and amendments to the training packages to best meet our objectives. The training has begun to be rolled out, with the e-learning launched in November 2022, the interactive webinar sessions launched in January 2023, and roll out of tier 2 face to face 1 day training beginning in 2023 and continuing to present.

291. We are aiming to have an independent evaluation of Oliver's Training roll-out to understand the impact on learning outcomes for health and social care staff. We will use a two-stage evaluation, the first being a process evaluation to understand how Oliver's Training is implemented in practice, and the second being an impact evaluation to understand the impact Oliver's Training has on staff, people with a learning disability and autistic people, and trainers. The process evaluation will also evaluate the use and

effectiveness of the code of practice, which we expect will be published in advance of when we expect this research to begin. Early findings from the evaluation will inform changes to the code of practice when it is reviewed 5 years after publication. The evaluation will also help to inform policy decisions for Oliver's Training in the future, including changes to the training and future funding bids to continue delivery.

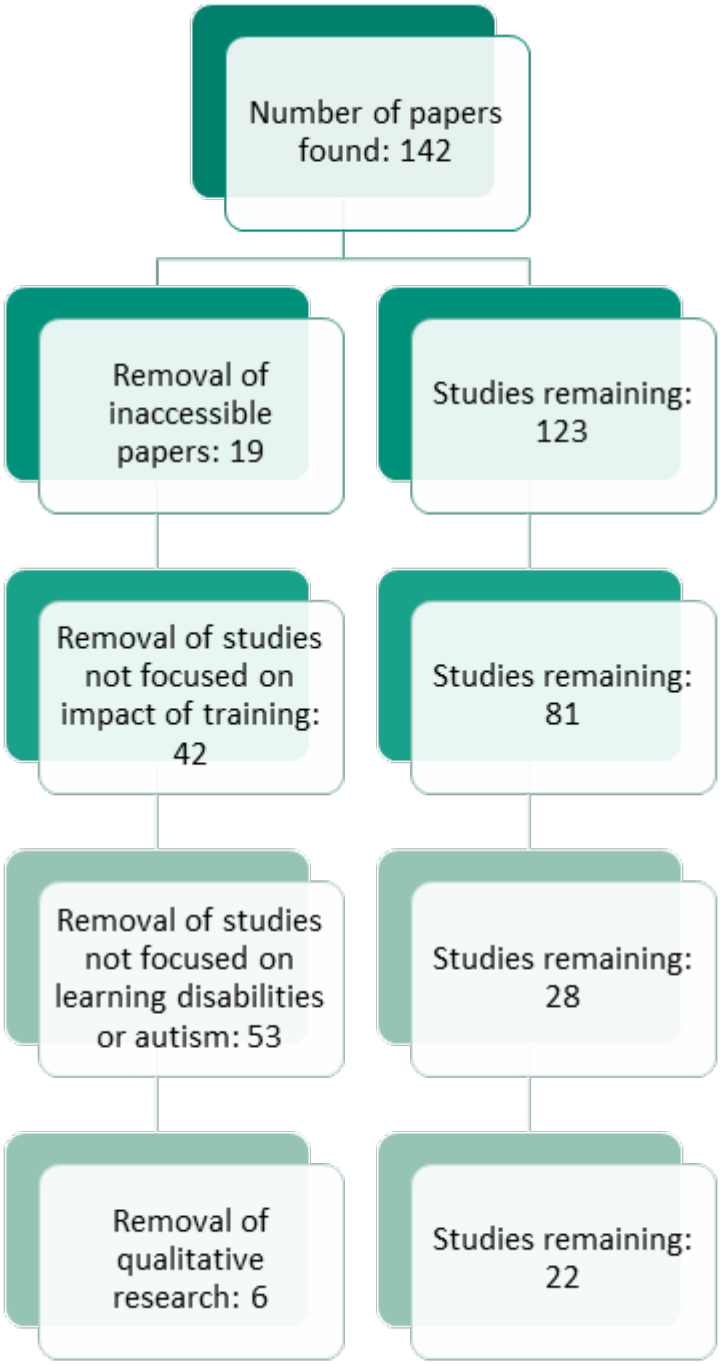
292. NIHR have published further detail covering key research priorities for each strand of the evaluation, details on the budget and duration of the evaluation process, and desired methodologies and outputs.[161]

293. As of February 2024, there are three research bids for monitoring and evaluation which have reached the second stage of the evaluation process. These bids were all deemed to be successful at Stage 1 of the evaluation process and will be reviewed by the independent committee to consider how they meet the policy objectives. As part of this stage, the applicants have been asked to link their evaluation to the Theory of Change, which was provided as part of the research specification.

Annex

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

[161]National Institute for Health and Care Research (2023). Policy Research Programme – (36-01-06) An Evaluation of the Oliver McGowan Mandatory Training on Learning Disability and Autism. Accessed here.


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