RCN Response to the Department of Health & Social Care consultation on the draft Code of Practice for Mandatory Training in Learning Disabilities and Autism.

Introduction

With a membership of around 500,000 registered nurses, midwives, health visitors, nursing students, health care assistants and nurse cadets, the Royal College of Nursing (RCN) is the voice of nursing across the UK and the largest professional union of nursing staff in the world. RCN members work in a variety of hospital and community settings in the NHS and the independent sector. The RCN promotes patient and nursing interests on a wide range of issues by working closely with the Government, the UK parliaments and other national and European political institutions, trade unions, professional bodies and voluntary organisations.

RCN Member Engagement

Members' views have been collated for this consultation through a series of online engagement events. We circulated an online form for members to share their feedback if they were unable to make an online event, and the consultation has been shared with the 35 professional forums we have. Informal feedback has also been gathered through various meetings and email responses during the consultation period.

There has been consensus from members throughout that they have appreciated the confidentiality of sharing their thoughts on this consultation via the RCN. Members consistently reported barriers to providing feedback regarding this training as they had seen social media targeting and pressure from people with political influence when this had happened. A common theme members raised was that this training feels like it is being politically driven rather than being driven by the needs of services, but members felt unable to raise this. The RCN is in an advantageous position to represent these views in this consultation whilst protecting individuals and organisations anonymity.

General comments

1.1 The RCN welcomes the recognition of need to improve training in learning disabilities and autism, and is supportive of this being a statutory requirement in the Health & Care Act 2022, which states:

"... service providers to ensure that each person working for the purpose of the regulated activities carried on by them receives training on learning disability and autism which is appropriate to the person's role."

The RCN and its members fully support measures to improve training for health and social care staff in meeting the needs of people with learning disabilities and autistic people. However, it is important to highlight that staff training in learning disabilities and autism is only one of the contributing factors to the inequalities in health outcomes that people with learning disabilities experience.

It is also important to consider:

1.1.1 - There are often genetic and physiological causes to learning disabilities, and these conditions often come with multiple associated health needs.

1.1.2 - 90% of people with learning disabilities have one or more long term conditions, with 45% of people having 3 or more long term conditions (LeDeR, 2022).

1.1.3 - 85% of people with learning disabilities have a communication disorder that results in expressive and/or receptive communication needs (RCSLT, 2016). This will affect the person's ability to report health concerns, to seek help, and in understanding health information given to them.

1.1.4 - Intellectual disabilities may affect how the person's central nervous system processes pain and other health indicators, and there may be limited understanding that signs such as pain are reasons to seek support.

1.1.5 - There is a national shortage of learning disability nurses (RCN, 2021)

1.1.6 - The lifestyles of people with learning disabilities can be very different to the general population due to dependency on support, cognitive processing differences, limitations on mental capacity, community acceptance and barriers to inclusion.

1.2 Training is one part of the solution and will not be the panacea for the health inequalities people with learning disabilities experience.

1.3 This consultation is happening at an unprecedented time of pressure across our health and social care sector, with an estimated 300,000 vacancies across health and social care in England. The implications of this code will mean that any employee that has direct contact with people will need an additional day's training and backfill. The resources required for this training will further stretch an already stretched workforce.

1.4 The health and social care sector is extremely diverse, from "small supports" (NDTi, 2019) to national and international providers, providing a huge range of health and social care interventions. The code at present does not provide the flexibility this diverse workforce needs.

1.5 Whilst the progress in improving the training of health and social care staff is welcomed, further consideration is needed to this draft code of practice to ensure it is practical and applicable across all health and social care settings.

The consultation questions and the RCN's response

2 - Do you agree or disagree that the purpose of the code is clear?

2.1 The draft code needs to offer greater support for organisations that choose not to use the Oliver McGowan Training. Members felt that the draft code strongly supports the use of the Oliver McGowan Training or training that mirrors this and did not support providers in meeting the requirements of the Health and Care Act 2022 in other ways.

2.2 The RCN members voiced concern regarding clarity of what is mandatory. The code states that the code is not mandatory, yet the impact of the code upon CQC registration infers that it is. The Oliver McGowan Training is not mandatory unless an employer mandates it, yet it being referred to as the Oliver McGowan 'Mandatory' Training implies it is mandatory for all.

Section 1: standards for training and related guidance

3. Please share any other thoughts you have on Standard 1 r

3.1 The knowledge, skills and capabilities of Registered Nurses in Learning Disabilities (RNLDs), and other specialist learning disability workers, require greater recognition in the code. RNLDs are already meeting tier 3 of the competency framework and evolve their skills and knowledge through Continuing Professional Development which must be reported to the NMC for revalidation every three years. The impact assessment suggests that RNLDs will be exempt from this training but this is not stated in the draft code, which implies they must still complete Tiers 1 and 2.

3.2 Specialist learning disability services, including learning disability social care providers, also require greater recognition. Services reported developing their own training that aligns to the competency frameworks based on individual's needs, local knowledge, and utilising local experts by experience. These services require more support from the code in evidencing and improving their existing training in meeting the Tier 1 & 2 requirements so as to avoid abandonment of established training packages or duplicating learning outcomes.

3.3 The content of Tier 2 includes understanding "Ask Listen Do" and "STOMP/STAMP". As these are NHS England initiatives rather than themes, it is suggested these topics are renamed. There was disagreement from members that 'diagnostic overshadowing' and 'STOMP' are relevant to all staff across all health and social care, and that 'culture' and 'communication' are not. A revision of what is mandatory and what is optional is recommended.

4. Please share any other thoughts you have on Standard 2

4.1 Employee welfare is an important consideration when tailoring training. Members reported that some employees have reported trauma after completing this training as it has reflected similar experiences that they have had personally.

4.2 Members felt that it has not been recognised that many nurses may themselves be neurodiverse or have close family members with learning disabilities. Having one expert by experience telling them what autism or learning disabilities is like when this may be very different from their lives was seen as devaluing their expertise in this area from their own experience.

5. Please share any other thoughts you have on Standard 3

5.1 Tiers 1 and 2 are not clear. It is read that a receptionist in an acute hospital setting needs the same level of training as a learning disability support worker.

5.2 There is not clear rationale why training needs to be a full day. This appears not comparable to all other training. The NDTi evaluation had insufficient evidence to support recommendations for Tier 2 (NDTi, 2021). This does not appear to fit with the Health and Care Act requirement that training is appropriate to different roles, or standard 2 that the training should be tailored. It seems inappropriate to standardise the length of training for all health and social care settings.

5.3 There needs to be more flexibility in the code regarding involving people with lived experience.

- 5.3.1 The requirement that all trainers must deliver the training in person will exclude some people with learning disabilities who participate better online, pre-recorded, or for shorter periods of time. This could lead to training not meeting the Equality Act and reduce inclusion.
- 5.3.2 The co-design and co-delivery of Tier 2 training requires further clarity. It is not clear if people with learning disabilities who are also autistic can facilitate both sessions, and if they cannot then why not. It is not clear if those co-delivering the training should be the same that co-design the training, and how lived experience can be delivered if that person is not involved in co-design. The level of involvement in co-delivery and co-design is also unclear.
- 5.3.3 Services that are for people with learning disabilities will usually not support an autistic person without a learning disability. They would therefore benefit from an autistic expert with learning disabilities. If the code is stating experts must be autistic only it is not clear what an autistic person without learning disabilities can share that an autistic person with learning disabilities cannot.
- 5.3.4 There are concerns about the reliance of one person's experience to present the diversity and complexity of experiences health and social care staff need to be aware when meeting the needs of people with learning disabilities, and that hearing the experiences of people with mild learning disabilities may provide conflicting view points to the lives of people with severe or profound and multiple learning disabilities.
- 5.3.5 Members raised concerns that family members were explicitly excluded from being an expert by experience for co-delivery of training. This prevents services the ability to tailor training appropriate to different roles, for example a children's ward may benefit from hearing from parents who receive their service to help them meet the needs of children with profound and multiple learning disabilities.

5.4 The draft code would benefit from an expected time difference between completing the e-learning and the one-hour session. The code requires clarity on what is expected from experts by experience if a provider does not choose the Oliver McGowan training and it is unclear whether services could continue asking people who use their services to volunteer their time to support training. Clarity is needed whether the e-learning is mandatory if providers are meeting the requirements of the code in alternative ways to the Oliver McGowan Training.

6. Please share any other thoughts you have on Standard 4

6.1 Further details are required regarding accreditation. Members reported that whilst all training has quality assurance in place, a significant amount of training does not go through an external accreditation process. There are concerns an accreditation process could add barriers to developing innovations and the existing training that has already been developed with local people with learning disabilities would be lost if it does not fit with the accreditation regime, and accreditation for this training does not have parity with other training. There are also concerns how small providers will adhere to accreditation requirements.

6.2 Other members shared that they had developed bespoke training on learning disabilities and autism and they had achieved accreditation through independent sources, such as through their local university. Members felt there should be choice regarding the accreditation they seek.

Further guidance on recruiting and supporting people with a learning disability and autistic people, procurement and record keeping

7. Please share any other thoughts you have on the section in the draft code on 'Further guidance on recruiting and supporting people with a learning disability and autistic people, procurement and record keeping'

7.1 Further consideration is required for the regular skills assessments mentioned. In general, members agreed that training should be repeated every 3 years, or more often if identified. However, it should also be considered if employees were able to demonstrate that they already meet the training requirements they could be excluded from this requirement. The care certificate is an example of where this approach is already in place, where support workers with experience can complete a questionnaire to demonstrate and self-certify that they meet these standards which their line manager can then validate. This would be useful for RNLDs who demonstrate they are maintaining competence through NMC revalidation.

7.2 Greater flexibility to involving people with lived experience, other than recruitment, needs greater consideration by the code. Many services already involve people they support, who volunteer their time, to provide real lived experience of people with learning disabilities who access their services. Making it necessary to recruit people with lived experience raises a number of challenges. There are conflicts of interest in recruiting a

patient or person you support, yet these people will likely give the most relevant lived experience.

Section 2: The Oliver McGowan Mandatory Training on Learning Disability and Autism

8. Please share any other thoughts you have on section 2 of the draft code

8.1 Further evaluation of this training is needed. Members raised that the code implies the Oliver McGowan training has been trialled with over 8,000 staff, but the training package that is in use now is different from the content of the pilots that were trialled.

8.2 The list of content in the tier 2 training given in this section requires further consideration for all health and social care staff. Rationale is needed for all staff working across health and social care requiring training that covers the application of DNACPR, and how the content listed here can be tailored for specific roles.

8.3 Greater flexibility is needed to ensure the Oliver McGowan Training is accessible. Further clarity is required on how the training is tailored to suit a variety of learners. Members reported the slide design and content must not be altered and there is not flexibility in what supporting materials are used. Members reported that the slide designs are unsuitable for people with dyslexia but they could not edit them. Members also described experts by experience being given scripted text which limits sharing their personal experience and restricts involvement of experts by experience to include only those who can read.

8.4 Consideration is required whether the experts sharing their experience will effectively reflect the lives of those most at risk of early mortality and avoidable deaths. Due to the abilities required for trainers (being able to read, present live face to face training, use verbal communication to share experience, understand and respond to questions) most trainers with learning disabilities will be people with low levels of support needs. Their lives and experiences will be very different to people with severe or profound and multiple learning disabilities who will have more complex health needs, difficulties communicating, and complex capacity issues relating to their care.

8.5 The wide audience across all health and social care settings requires greater attention. Members reported that the Oliver McGowan Training is focused on acute NHS services and that staff working in other settings may not see it as relevant to them. There were also concerns that the prescriptiveness of how this is delivered may make this training become resented by attendees.

Section 3: how to use the code to meet the training requirement

9. Do you agree or disagree that it is clear from the code how registered providers can ensure they are complying with duties to train staff to work with people with a learning disability and autistic people?

9.1 A stronger focus is needed on identifying the training needed in a service, and supporting services in meeting the standards. Members felt that the standards within this code are resource intensive, high cost, and may not be at the level they needed for their role. They felt as though the Oliver McGowan Training is being driven as the easiest way to meet these standards, with funding support for NHS providers, that the code would make it difficult to do anything different. Similar funding support has not been made available yet to non-NHS services. Members raised concerns that CQC would be judging adherence to the code when the code is not mandatory and the Oliver McGowan training is not mandatory, that CQC inspectors may not always recognise this and they could face enforcement action as a result. Adherence to the Oliver McGowan Training was felt to be being put at priority over mapping what training staff need and reviewing the quality of the training that is in place.

Impact assessment questions

10. In the impact assessment, we made an assumption about how much effect staff training will have on outcomes for patients and service users (for example, participation in cancer screening will increase by 6%). We are looking for evidence to refine this assumption.

If you have tried to link any staff training to the impacts on patients and service users or know of such attempts, please share the information with us

10.1 Concerns were shared that an over-reliance on training being the answer to health inequalities for people with learning disabilities. Whilst training will certainly improve access to health and social care for some it will not alleviate all the known causes why people with learning disabilities have greater health needs and experience poorer health outcomes.

10.2 The impact assessment also suggests that only 37% of Adult Social Care will need this training which appears to be an underestimate if the training is to reach all health and social care staff that may have a role in supporting people with learning disabilities or autistic people.

10.3 The overall costs for delivering option 1 of this training estimate costs to be £1.252 billion per year. As it appears some workforces have been underestimated the costs are believed to be significantly higher.

References

OMMT-final-report.pdf (ndti.org.uk)

Health and Care Act 2022 (legislation.gov.uk)

Connecting for Change: for the future of learning disability nursing | Royal College of Nursing (rcn.org.uk)

Small Supports - NDTi

Microsoft Word - RCSLT Good standards v 8 Nov 13

Learning from Lives and Deaths - people with a learning disability and autistic people (LeDeR) - King's College London (kcl.ac.uk)