RCGP response to the Department of Health and Social Care consultation on the Oliver McGowan draft code of practice on statutory learning disability and autism training

(September 2023)

Dear Colleague,

The Royal College of General Practitioners (RCGP) welcomes the opportunity to comment on the Oliver McGowan draft code of practice on statutory learning disability and autism training. The online consultation form is more suited to individual respondents, so we appreciate being able to submit our organisational response in this format.

Our points are made below:

1. The RCGP is supportive of all health and social care staff receiving high quality training in learning disability and autism that is appropriate for their role. This is something that patients and carers should expect from their health and social care providers. Some skills learnt may benefit other patients, such as those with mental health, learning and communication difficulties.

2. Given workforce pressures, it is critical that staff groups feel able to manage the completion of training. If too onerous, they will fail to engage. If impractical to deliver, organisations may find ways to avoid providing training beyond Tier 1, when not justified in doing so.

3. The RCGP would support a competence-based, as opposed to time-based, approach to learning disability and autism training. This is more likely to achieve 'buy in' from the GP profession and would align with the model of the new Safeguarding standards for primary care, due to be published before the end of 2023.

4. There are many roles which function above Tier 2 and therefore have training requirements beyond that suggested in the Oliver McGowan Mandatory Training (OMMT). The role of GPs, who work with a high degree of autonomy and rarely have support from others in their healthcare of this population, is not clearly Tier categorised within the core capabilities framework. To comply with the Act, all professions, should be guided about appropriate training for their role. It is not clear whether training in learning disability and autism should be mandated in undergraduate medical training or specialty GP training.

5. By expecting the OMMT to be the only package used, the process is failing to adequately train Tier 2 staff, according to the core capabilities definition, in the training requirements of the framework. The training content fits more closely with Capability 1 of the framework for learning disability, which is designed for staff in Tier 1. In relation to GPs, the OMMT will cover the important attitudinal requirements but omit some very necessary clinical requirements to improve health outcomes.

6. Further clarity is required about funding and infrastructure required to deliver the training, as well as expected timescales for its delivery. It is also not clear whether training will be delivered at national or local level. Section 3, which explains that the CQC will take adherence to the code into consideration, must align with the training available to avoid unfair penalisation from the regulator.

7. The vast majority of staff employed in a primary care setting will fall into the category requiring a full day training after they have completed the e-learning. Referring to the impact assessment, the total number in the workforce requiring Tier 2 training is about 1.5million people (ref para 116). If these are trained for 1 day in groups of 30, it will take 50,000 days each with 2 experts by experience - 1 with autism and 1 with learning disability. The disruption to primary care would make this impossible to deliver, particularly so in the current health care, and in particular GP, workforce crisis. The code is not clear about how this challenge would be addressed. There is no evidence provided about the impact on service delivery of removing large numbers of the health and social care workforce for a full day training, and no reference to funding to backfill clinical roles. We would therefore, as stated in paragraph 3, not support a time-based training approach. Instead, we would encourage consideration of a confidence-based training model.

8. A phased approach to implementation is a potential option if higher level training isn't achievable immediately. An interim approach might be to ensure established GPs as well as students, trainees and nurses (etc) receive primary level training, as is required by all groups.

9. Alignment with the core capabilities framework is important. However, the core capabilities framework was published in 2019. Further competencies will inevitably become important as research and evidence development progresses (for example – expanding evidence in genomics) and also as the nature of the health and social care workforce changes (for example the burgeoning of new roles within the primary care workforce, some with no professional accreditation).

10. Standard 2 requires that training should help staff put learning into practice. The training package is a one-off training and therefore does not have any component of establishing outcomes of learning. There is no guidance about how organisations should be measuring the impact of any training in terms of putting learning into practice. There is no evidence provided that the evaluation of the training packages that have been approved has included this. There are many methods of potentially achieving this, for example - post training assessment, assessment of experience of

care by people with a learning disability or autistic people, clinical outcome reporting, reduction in acute hospital admissions, reduction in psychiatric hospital admissions, improved longevity.

11. In a primary care setting, the training will likely require to be delivered in a multi-disciplinary setting – i.e. all practice staff rather than separated into staff groups. As the details of the approved training packages have not been published, it is unclear how Standard 2 could be delivered for all staff types likely to be attending primary care training.

12. Although the guidance suggests that the mandatory training should be repeated every 3 years for all, and more frequently if an individual's job/role changes, there is no guidance about how this is to be achieved. Given the degree of change within the early working lives of junior doctors, including GP specialty trainees, the practicality of achieving this is not addressed. It would be more appropriate to develop a curriculum of updating and improvement that can be given regularly. Furthermore, there are established mechanisms that can be used for professionals to provide evidence of ongoing learning – for example the annual appraisal and five yearly revalidation.

13. It is absolutely appropriate and proven that experts by experience should co-produce and co-deliver training and that the impact of such training is much greater. However, it remains very unclear how an adequate workforce of experts by experience in learning disability and autism can be adequately trained and remunerated to deliver this extent of training.

14. The guidance gives no indication about who would be performing the accreditation of any developed training packages and with which organisation the accreditation sits. There is also no evidence about what is being accredited –the content, the level of co-production and delivery, the measurement of impact of training, the cost benefit analysis and the potential negative impact of removing people for a full day from the clinical setting. The nature of evaluation and accreditation of the training packages submitted to analysis from the trial has not been provided. It declares that any training commissioned must be independently evaluated and accredited but gives no indication of by whom this should be done.

15. The code stipulates that training should be evidence-based. It is not clear whether this means that the content of training should be evidence based or the mechanism of training evidence based. The core capabilities framework was completed already four years ago. The development of a clinical management evidence base in the field of learning disability is slow given the relative paucity of research funding and effort, in clinical outcomes and the management of complexity. However, the evidence base is constantly changing and renewed as understanding progresses. There is no clarity about the updating of the core capabilities framework in response to this or discussions about how the accepted evidence may be challenged in the light of future research.