

Chris Badger
Chief Inspector of Adult Social Care

Dear Chris,

Re: Clarification on the Implementation of the Oliver McGowan Mandatory Training

I am writing as Chief Executive of Care England regarding the Care Quality Commission's (CQC) approach to the implementation of the Oliver McGowan Mandatory Training on Learning Disability and Autism (OMMT). The sector strongly supports the aims of this training and is committed to ensuring staff are equipped with the right skills and understanding. However, providers need clarity from the regulator on how this will be inspected and applied in practice.

We are aware that the CQC will not endorse or require a specific named package but instead will assess providers against the requirements of Regulation 18 and the standards in the Oliver McGowan Code of Practice. While this distinction is important, providers remain concerned about inconsistency of application, lack of clarity on immediate evidence requirements, and the absence of defined expectations around phased implementation. To support consistency and transparency, we ask that the CQC publish clear timescales and a table setting out what it expects to see against each key area of the Code of Practice.

Attached to this letter is a detailed breakdown of the areas of concern identified by our Working Age Adult Policy Board, who have been consulted and fully support this approach. Beyond the general consensus regarding the rigidity of the current framework, the Board has concluded that several elements of the Code, in their present form, cannot be delivered effectively at scale.

We also believe it would be helpful for the CQC to make explicit that providers are not required to deliver the *Oliver McGowan* branded training itself, provided that their chosen approach demonstrably meets the standards set out in the Code of Practice. Such clarity would help avoid misinterpretation and reassure providers that they may continue to use equivalent, high-quality training that aligns fully with the Code's four standards.

These issues are not raised in opposition to the purpose of the training, but to support its successful and consistent implementation across the sector. Greater clarity from the CQC on the points below would give providers the assurance needed to deliver at pace and with confidence, while ensuring inspectors apply a consistent approach. We therefore seek clarification on the following five areas:

Q1. What training have CQC inspectors been given on OMMT, and how is consistency ensured across the country?

Providers' experience of inspection is shaped by inspectors' knowledge and understanding. If this differs regionally, providers risk being subject to inconsistent interpretations of compliance. We would welcome confirmation of:

- the training that all inspectors have completed Tier 2 training;
- the completion rates and quality assurance of this training;
- whether inspectors have been issued national guidance, job aids or lines of enquiry to ensure consistency;
- how calibration across inspection teams is being assured.

Without national alignment, there is a risk that compliance becomes dependent on the individual inspector, not the provider's actual practice.

Q2. How will CQC ensure that local authorities and their commissioning teams have sufficient awareness of the Code, and are working with providers to support delivery?

The Code of Practice explicitly states that commissioners should use it to set expectations in contracts, particularly where services are not CQC-regulated. Commissioners therefore play a central role in shaping provider practice. If commissioning teams are unaware of, or inconsistent in their interpretation of, the Code, this risks conflicting expectations between commissioning and regulation.

We ask how the CQC will test commissioner awareness and readiness through its local authority assurance work, and how it will ensure that commissioners are supporting rather than hindering provider compliance.

Q3. How will CQC take into account the structural challenges faced by providers of different sizes?

The scale of implementation differs significantly across the sector. Larger organisations are coordinating national roll-outs that take time to cascade across hundreds of sites, while smaller providers may face different challenges in sourcing accredited trainers or arranging cover.

For multi-site and group providers, much of the strategic oversight and assurance for implementation naturally sits within central governance structures rather than at individual service level. It would therefore be helpful to understand how inspectors will take this into account and how evidence from head-office planning and monitoring arrangements will be considered within the inspection process.

We also ask how inspectors will view credible national implementation plans, booked training, or phased delivery schedules, and whether these will be accepted as evidence of progress. Recognising the differing scale and complexity of providers is essential to ensuring inspections are proportionate and reflective of genuine progress.

Q4. What is CQC's immediate national expectation of providers in evidencing compliance?

The Code allows for providers to use either OMMT or equivalent training that meets the four standards. Yet many members are unclear what constitutes sufficient evidence during transition.

We ask for a published national checklist setting out what inspectors will accept now, for example:

- a role-mapping exercise showing allocation to tiers;
- an implementation plan with milestones and accountable leads;
- evidence of procurement or booking with accredited trainers;
- training matrices showing staff completion of Part 1 e-learning and scheduled Part 2 delivery;
- mapping documents demonstrating equivalence to the Code's four standards;
- evidence of lived-experience involvement in design or delivery.

Such clarity will avoid duplication, ensure proportionate inspection, and reassure providers that they will not be marked down while implementing credible plans.

We also recommend that the CQC formally recognises that the lived experience element of Tier 2 training can be co-produced and delivered remotely or via recorded video within face-to-face sessions. This practical and proportionate approach would resolve several of the structural challenges providers face, while maintaining the integrity and intent of the Code.

Q5. Will there be a grace period for providers to adopt and evidence compliance, and how will it be applied?

The scale of implementation is unprecedented, particularly given high workforce turnover and limited trainer availability. Without a defined grace period or phased milestones, providers fear that inspections may treat them as non-compliant before delivery is realistically possible.

We ask the CQC to confirm:

- whether a national grace period will apply, and for how long;
- how "proportionate" will be defined in practice;
- whether inspectors will accept evidence of active roll-out as compliant during transition;
- whether settings or staff groups should be prioritised.

Providers are fully committed to delivering training that improves outcomes for people with a learning disability and autistic people. The absence of clear national expectations risks

confusion, wasted effort, and inconsistent inspection outcomes. By clarifying the five points above, the CQC would provide assurance to providers and inspectors alike and help ensure the success of this important reform.

As a result of these questions, we draw attention to the flexibility within page 16 of the *Oliver McGowan Code of Practice*, which recognises that registered providers may have “good reasons” for adopting alternative approaches that nonetheless achieve full compliance with the underlying requirement.

The evidence and rationale set out in this letter and the accompanying document demonstrate the sector’s intention to implement the Code in a way that remains true to its purpose while ensuring deliverability and consistency at scale. Care England and its Working Age Adult Policy Board are therefore seeking to work with the CQC and DHSC to agree how this flexibility can be reflected in inspection and implementation guidance.

In particular, we encourage the CQC to acknowledge explicitly that compliance rests on meeting the *requirements* of the Code rather than adherence to any specific training brand, and to confirm that flexibility in the mode of delivery, including the remote or pre-recorded inclusion of lived experience, is permissible where outcomes are equivalent.

Providers are fully committed to delivering training that improves outcomes for people with a learning disability and autistic people. The absence of clear national expectations risks confusion, wasted effort, and inconsistent inspection outcomes. By clarifying the five points above, the CQC would provide assurance to providers and inspectors alike and help ensure the success of this important reform.

We would appreciate a written response which we can share with our members. We would also welcome a meeting with your team to explore how Care England can support communication and consistency across the sector.

Yours sincerely,



Professor Martin Green OBE

Chief Executive, Care England