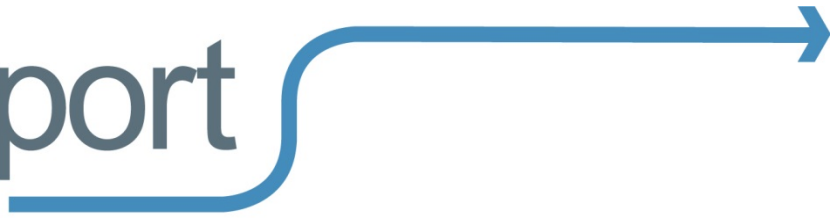


ies Report

Institute for Employment Studies



Review of Support for Disabled Students in Higher Education in England

Report to the Office for Students by the Institute for Employment Studies and Researching Equity, Access and Participation

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Executive summary

Introduction

This report presents findings from the second phase of a study to review models of support for disabled students in higher education (HE) in England. Phase one, undertaken in 2016/17, established a baseline of provision.

Phase two, the focus of this report, reviews progress by higher education providers (HEPs) over the subsequent two years to implement new models of support which reflect a more inclusive approach. It also assesses the impact of increased government funding to support these changes.

Background

The HE system in England continues to undergo considerable change in terms of funding, governance, delivery models, and access and participation. This study is set against a context in which:

- a. The numbers of disabled students accessing HE continue to climb. Over the past five years, the total number of disabled students in English universities and colleges (regardless of domicile) has increased by just under one third (31 per cent): from 190,000 in 2013/14, to almost 250,000 in 2017/18. In 2017/18 disabled students accounted for 13 per cent of all students in English HEIs.
- b. The number of new entrants with a disability (i.e., first-year disabled students) has grown from 68,000 in 2013/14 to over 94,000 in 2017/18 – an increase of 38 per cent. The most commonly reported disability is a specific learning difficulty (SpLD), followed by a mental health condition.
- c. As this suggests, there has been a marked increase in the numbers of students reporting a mental health condition. There have also been significant increases in students with social communication or autism spectrum disorders, and those with two or more conditions.
- d. There have been a number of changes in the approach to funding for disabled students. The allocation of the disabled students' premium, formerly the role of the Higher Education Funding Council for England (HEFCE), is now the responsibility of the Office for Students (OfS), the independent regulator of HE in England.
- e. There has been an overall increase in funding levels, and changes to the eligibility criteria for individual-level support via the Disabled Students' Allowance (DSA). The effect of these changes is to place greater responsibility on HE providers to fund certain types of support.

-
- f. The prevailing model of disability continues to move away from a medical model (a problem belonging to the disabled individual) to a social model (where it is society that disables individuals).

The increase in the numbers of disabled students is likely to be driven by a number of factors:

- Improved special educational needs and disability (SEND) support for children in the compulsory education system.
- Students' increasing willingness to disclose a disability, especially a mental health condition.
- Sustained efforts in the sector to widen participation to traditionally under-represented groups, including disabled students.
- Changes in legislation related to the requirements HE providers are expected to meet in providing support for disabled students¹.

Methodology

The 2016/17 baseline report identified a number of key indicators to measure providers' progress towards inclusive models of support. These included the existence of an accessibility plan; levels of student engagement; the extent to which students are encouraged to disclose their disability, to enable them to be properly assessed and supported; and evidence of regular review and evaluation of disability provision to ensure it remains effective and fit for purpose. Providers were asked to assess themselves against these indicators².

The indicators have been revisited and updated in this report, which analyses the results of an online survey of 67 publicly funded HE providers in England in receipt of at least £20,000 of Disabled Students' Premium funding³. Case studies with nine providers gathered detailed insights and feedback from staff and a small number of students. In addition, 14 responses were received from private or alternative providers registered with the OfS in the 'approved' category. These providers were not in the baseline study, and their results are presented separately.

The achieved sample size for both surveys is small. The study does not claim to capture the totality of provider activity in this area. In particular, the Phase two survey included

¹ Notably the Special Educational Needs Disability Act (2001), the revised Disability Discrimination Act (2005), the more inclusive Single Equality Act (2010), and the Public Sector Equality Duty (2010).

² The phase one report is available at:

<https://webarchive.nationalarchives.gov.uk/20180103173830/http://www.hefce.ac.uk/pubs/rereports/Year/2017/modelsofsupport/>

Section 1.3 presents the discussion of the key indicators and the progress that has been made since the baseline report.

³ The sample includes further education colleges (FECs) offering HE provision.

responses from only seven further education colleges (FECs) offering HE provision, one of which did not respond in full to the survey, but did provide sufficient responses to warrant inclusion⁴.

It is also important to note that the number and composition of providers differs between the baseline and Phase two surveys. A smaller number of providers responded to the Phase two survey (67 compared with 108 in Phase one). This means that changes between the two surveys may be attributable to the different profile of responding providers, rather than to changes in a particular provider's behaviour or to systemic changes in the sector.

Key findings

There is evidence of positive progress against the **key indicators** over the past two years:

1. Numbers of accessibility plans have increased. However, providers still face challenges in making their teaching and learning spaces, and particularly their student accommodation, fully accessible.
2. Providers' engagement with students in relation to disability issues – for example, in the co-design of student support services – has increased substantially.
3. The use and coverage of assistive technology (AT) is increasing. In particular, the vast majority of providers use 'lecture capture' (audio or video recording of lectures), with two in five HE providers using it to capture more than half of all lectures. This not only benefits disabled students but is an example of an inclusive strategy that benefits any student unable to attend or get all they might from a live lecture experience.
4. Providers' interaction with external agencies is increasing. A greater proportion of providers now buy in disability services from external suppliers, particularly non-medical helper (NMH) support. Only one in 10 providers now provides all services in-house.
5. Providers are continuing to evaluate the effectiveness of the support they provide or commission from an external provider. There appears to be a shift towards using hard outcome measures of effectiveness in line with developments in the Teaching Excellence and Student Outcomes Framework (TEF) and the new requirements around access and participation plans (APPs). These and other developments can act as drivers for positive change. They also generate data which can be used to review and evaluate services. However, the value of qualitative evaluative feedback to aid understanding of the issues and support future developments was frequently noted.
6. The activities of the alternative and private providers surveyed mirror those of publicly funded HE providers, with few exceptions. This group tended to have smaller, core disability support teams (reflecting their smaller student population), and less engagement with external services. They were also less likely to have an accessibility

⁴ One FEC gave a very partial response and so were not included.

plan or digital accessibility statement. However, they were fairly confident that they were making good progress towards a fully inclusive model of support.

A number of **broader messages** also emerged from the study:

1. Supporting disabled students and moving to an inclusive approach is not a short-term fix, but a long journey. HE providers across the sector are at various stages on this journey. All report that they are making progress towards greater inclusivity and an inclusive model of support covering all students. But they also acknowledge that there is further work to do.
2. There is evidence that providers are evaluating and reflecting on the effectiveness of innovative approaches involving different parts of their organisation (for example, support services and academic departments), or specific student groups. These approaches encourage greater collaboration⁵. They also allow for the development of effective mechanisms and processes for identifying implementation issues, potential unintended consequences, and likely impact. Many providers run pilot projects, which use limited resources and set time-frames, before rolling out initiatives more widely.
3. There is growing recognition of the issues and challenges of intersectionality and the multiple factors that influence students, including different equality characteristics, and issues relating to social class or other widening-access considerations. Each of these can, and does, combine with issues of disability. There is also growing awareness of the needs of international students with disabilities.
4. The approaches and experiences of HE providers appear to be influenced by their size and structure. The attitudes of senior staff are also a key factor. Senior leadership is pivotal, particularly where there are multiple agendas and competing demands. Where senior leaders prioritise support for disabled students, signal their commitment to a wider culture of inclusivity, and are actively working to integrate it across their institution, there is likely to be a better chance of success in bringing about the shifts required.
5. Training and staff development needs to be flexible and ongoing to enable colleagues to acquire role-specific and issue-specific knowledge. This will incrementally add to their awareness and support them in embedding inclusive practices from the start.
6. There is no one perfect model of inclusive support, and what works in one institution may not directly translate into another. However, there are some key elements that appear to align with positive change. These include strong leadership; a holistic approach covering all students, and involving shared responsibility across the institution; collaboration within institutions between core disability services and across all staff groups; balancing inclusive approaches with tailored support for individuals; encouraging disclosure across the student life-cycle; improving accessibility to services, digital resources and estates; giving students a voice and involving them in

⁵ Collaboration is one of the seven inclusive curriculum design (ICD) principles which were evident within many of the case study examples. For further details on the other ICD principles (which are anticipatory, flexibility, transparency, accountability and equity) see Morgan, H. and Houghton, A-M. (2011) 'Inclusive Curriculum Design in Higher Education', York: Higher Education Academy

the creation of services; focusing on mental health and wellbeing; ensuring adequate resources; and harnessing technology.

7. Sharing good practice is generally regarded as useful, and something that all providers would welcome. There is a strong desire to use evidence to understand and share what works, although individual provider context – its size, type, mission, the provision it offers, the make-up of its student population – is key: there is no ‘one size fits all’ solution.

Finally, the report recommends the **development of additional indicators** to reflect how providers think about inclusive practice. These indicators could cover both emerging practice – practice that is not yet widespread, or which has not yet been fully evaluated – and areas where practice is variable, and which may therefore benefit from a focus on improvement. They might include:

- Senior level commitment to the inclusion agenda.
- Wider staff involvement in encouraging disclosure of disability.
- Written policies describing inclusive support and taking a whole institution approach.
- Building considerations of inclusivity and accessibility into curriculum design and programme review.
- Building considerations of inclusivity and accessibility into purchasing of services and equipment (reflected in the tendering process).
- Extent of sharing good practice within institutions and across the sector.
- Provision of advice, guidance and good-practice examples to staff on meeting digital accessibility standards.
- Offering alternative formats as standard practice.

1 Introduction and background

1.1 Introduction

In 2019 the Office for Students (OfS) commissioned the second phase of a study to review models of support for disabled students in higher education (HE). This research was undertaken by the Institute for Employment Studies (IES), in partnership with Researching Equity, Access and Participation (REAP) in Lancaster University's Department for Educational Research.

Overall (across Phases one and two) the research explores the approach to supporting disabled students across the sector and particularly the use and experience of inclusive models of support. Phase one was undertaken by IES and REAP in 2016/17 and established the baseline of provision (at that time). This involved a review of the nature and levels of support, the understanding across the sector of inclusive approaches, and an assessment of progress towards inclusive models. The Phase one research involved an online survey of publicly funded HE providers who received at least £20,000 in disability funding. This was supplemented with 13 case studies: three early case studies to support the development of the questionnaire, and 10 main-stage case studies to gather more detailed insights into the issues of developing inclusive provision.

Phase two – the focus of this research report – reviews the progress made over the subsequent two years. It assesses the impact of the increased central funding to support disabled students and encourage HE providers to adopt an increasingly inclusive approach that reduces the need for reasonable adjustment. It also expanded the scope of the research to include alternative and private HE providers.

A number of different terms are used to describe the educational providers involved in the research and these are used interchangeably.

Higher education providers or HEPs refer to all institutions providing programmes of study at HE level. This is an umbrella term and is the broadest group of providers.

Higher education institutions or HEIs refer to those institutions that are publicly funded (through the Government and its bodies).

- This group includes **further education colleges (FECs)** offering HE programmes alongside further education (FE) programmes. These HE programmes can be offered through franchised or validation arrangements with another HEI or the college can have degree-awards powers in its own right. Sometimes this subset of providers are referred to as college-based higher education (CBHE), and individual institutions can be referred to as colleges.
- This group also includes **universities**, providers with the legal right to include 'university' in their title.

Private providers are institutions that offer HE programmes but do not receive annual public funding. Some students at private providers can however be eligible for public funding support such as student loans. Private providers can also be referred to as **alternative providers (APs)**, and this refers to the old regulatory system.

The terms ‘institution’ and ‘provider’ are used throughout but where used the subset referred to will be clearly indicated.

1.2 Background

1.2.1 Increasing numbers of disabled students accessing HE

The HE system in England continues to undergo considerable change in terms of funding, governance, delivery models and participation. A key and sustained trend has been the increasing number of disabled students accessing HE. This is likely to have been driven by:

- Sustained efforts in the sector to widen participation to traditionally under-represented groups including specific work targeting disabled students.
- Changes in legislation influencing the legal requirements HE providers are expected to meet⁶.
- Improved Special Educational Needs and Disability (SEND) support for children in the compulsory education system.
- An increasing willingness to disclose a disability, especially a mental health condition.

Over the past five years, the total number of disabled students in English HEIs (regardless of domicile) has increased by approximately one third (31 per cent) from 190,000 in 2013/14 to almost 250,000 in 2017/18. In 2017/18 disabled students accounted for 13 per cent of all HE students in English HEIs. Similarly the number of new entrants with a disability (i.e. first-year disabled students) has increased (by 38 per cent) from 68,000 in 2013/14 to over 94,000 in 2017/18. The most commonly reported disability is a specific learning difficulty (SpLD) followed by mental health condition:

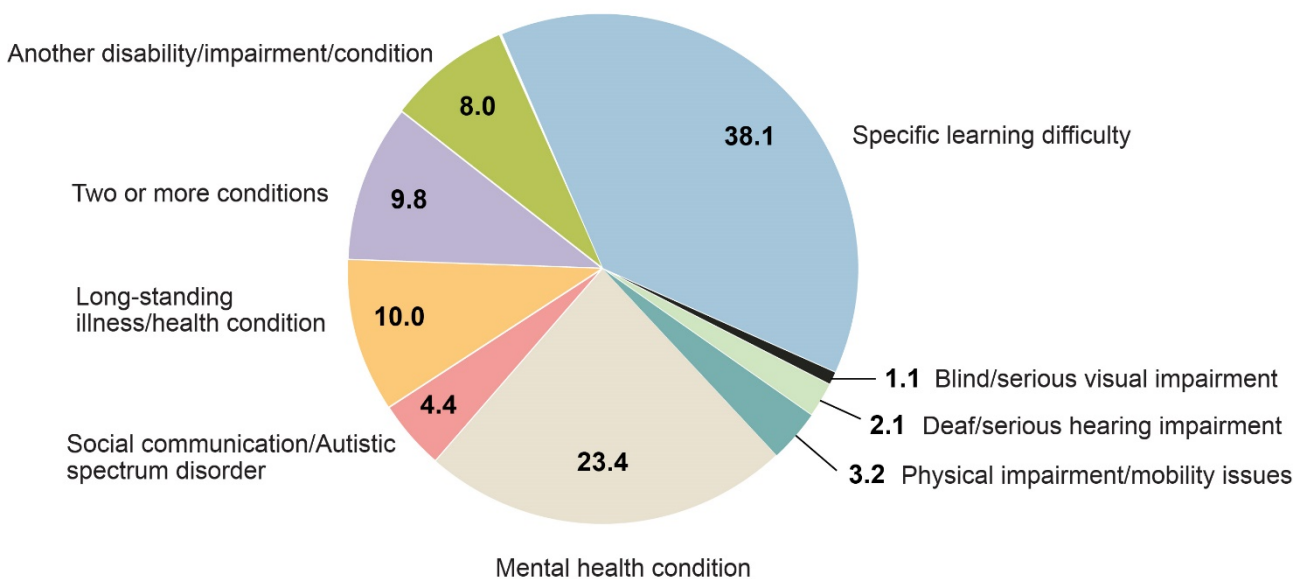
- Those who self-reported a SpLD accounted for at least 38 per cent of all UK-domiciled first-year students in UK HEIs in 2017/18 with a disability, and 5.2 per cent of all UK-domiciled first-year students.
- Those who self-reported a mental health condition accounted for at least 23 per cent of all UK-domiciled first-year students in UK HEIs in 2017/18 with a disability, and 3.2 per cent of all UK-domiciled first-year students.

Figure 1.1 shows the breakdown by type of disability for 2017/18, and Figure 1.2 illustrates how the numbers of disabled students have increased in recent years. In particular it shows how the number of students reporting a mental health condition has

⁶ Notably the Special Educational Needs Disability Act (2001), the revised Disability Discrimination Act (2005), the more inclusive Single Equality Act (2010), and the Public Sector Equality Duty (2010).

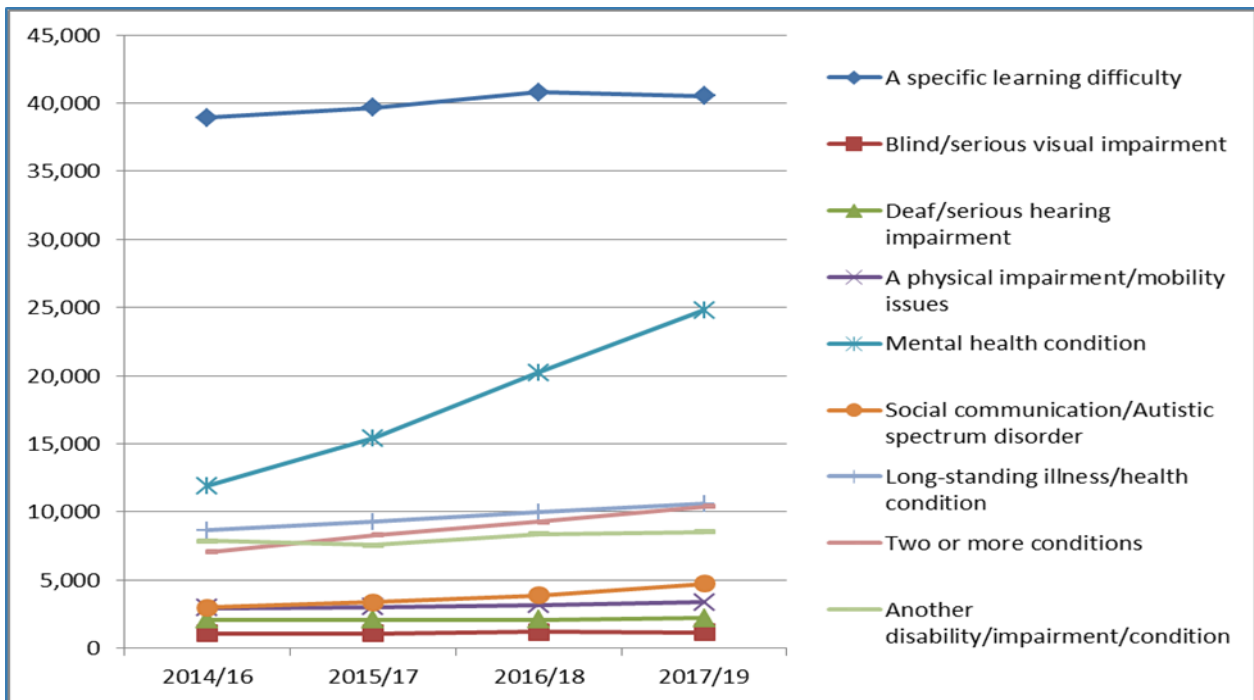
increased dramatically, more than doubling in the past four years. Also the number of first-year students with a social communication or autism spectrum disorder has increased by 59 per cent, and co-morbidity – having two or more conditions – has increased by 48 per cent. The latter could include students reporting mental health difficulties suggesting that the number and proportion of students reporting a mental health difficulty could be even greater than indicated on the chart.

Figure 1.1: UK-domiciled first years with a disability in academic year 2017/18 – by disability



Source: Table 15: UK-domiciled student enrolments by disability and sex 2014/15 to 2017/18, HE Student Data, HESA, <https://www.hesa.ac.uk/data-and-analysis/students/table-15#> (accessed 01/08/2019)

Figure 1.2: UK-domiciled first years by disability: Academic years 2014/15 to 2017/18



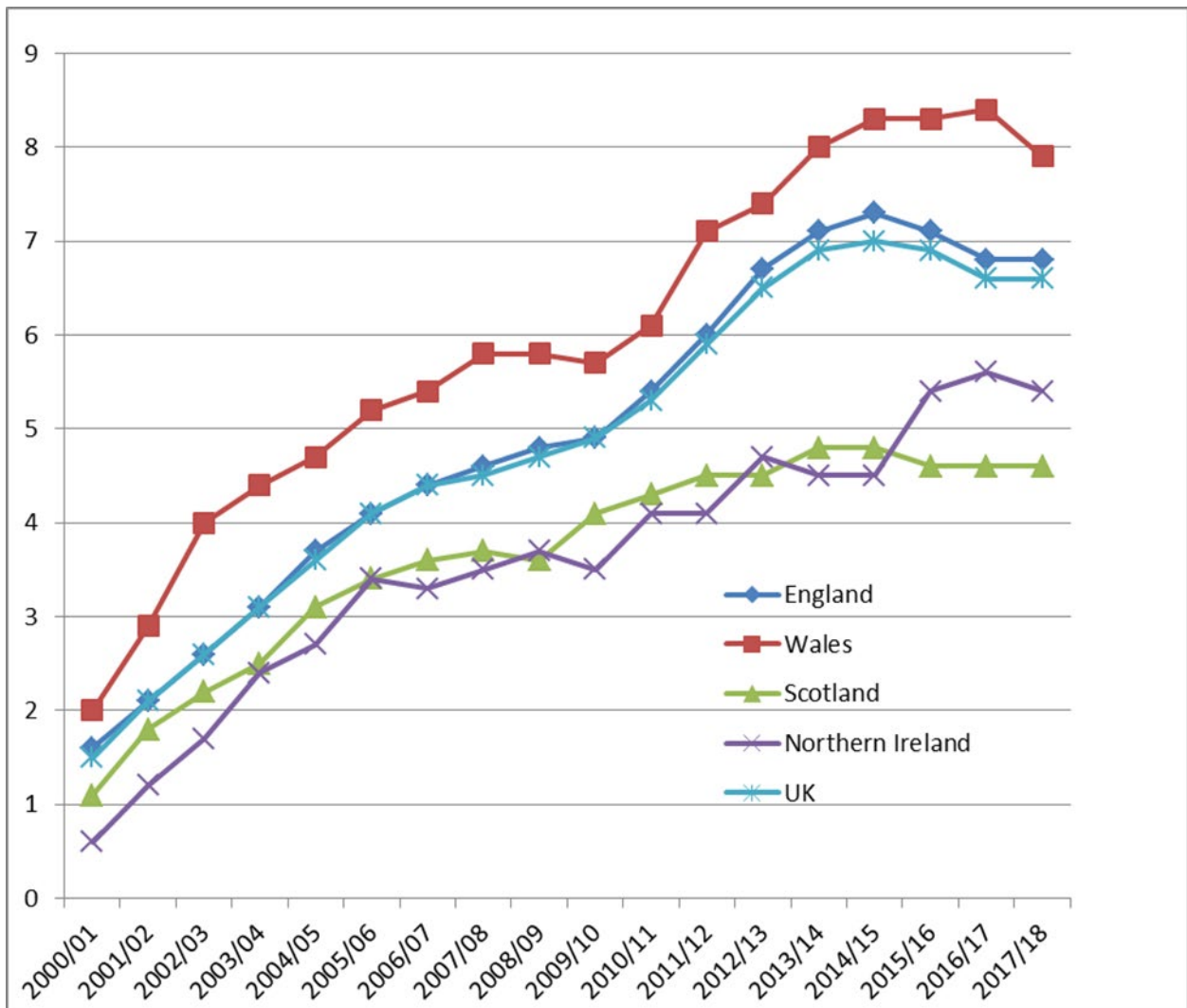
Source: Table 15: UK-domiciled student enrolments by disability and sex 2014/15 to 2017/18, HE Student Data, HESA, <https://www.hesa.ac.uk/data-and-analysis/students/table-15#> (accessed 01/08/2019)

The number of students accessing the Disabled Students' Allowance (DSA) – the primary individual-level source of funding for disabled students (see below) – is considerably lower than the number that self-report a disability. The number of full-time recipients in England and across the UK HE sector is increasing (although the proportion of all students this group represents has fallen from the peak in 2014/15). In contrast the number of part-time recipients has fallen (reflecting the general pattern of part-time student numbers):

- In 2017/18 the Higher Education Statistics Agency (HESA) widening participation indicators (T7⁷) found there were 71,490 full-time undergraduate students studying in England who were in receipt of DSA. This accounted for 6.8 per cent of students. The corresponding figures for those studying across the whole of the UK were 84,150 and 6.6 per cent.
- The numbers of part-time students in receipt of DSA are considerably smaller: 5,120 part-time undergraduates studying across the UK (3.4 per cent).

⁷ <https://www.hesa.ac.uk/data-and-analysis/ukpis/widening-participation/table-t7>, accessed 01/08/2019. Scope is all UK-domiciled undergraduates (not just entrants) and includes all full-time students, and part-time students who are at least 50 per cent full-time equivalent (FTE).

Figure 1.3: Proportion of full-time first-degree UK-domiciled students in receipt of DSA by location of HE provider and academic year: Academic years 2000/01 to 2017/18



Source: Table C: Percentage of UK-domiciled students in receipt of DSA by location of HE provider and academic year (2000/01 to 2017/18): Full-time first-degree students, Widening participation summary: UK Performance Indicators 2017/18, HESA, <https://www.hesa.ac.uk/news/07-02-2019/widening-participation-summary#>; (accessed 01/08/2019)

1.2.2 Changes in the funding for disabled students

Alongside increases in the number of disabled students accessing HE there have been important changes in recent years to the funding arrangements and allocations for supporting this group of students.

Notably, the body responsible for distributing government HE funding to providers has changed. The responsibility now lies with the OfS, formed from the merger of the Higher Education Council for England (HEFCE) and the Office for Fair Access (OFFA). The OfS became fully operational in April 2018. As the independent regulator of HE in England the OfS aims to ensure that English HE is delivering positive outcomes for students. The OfS' four regulatory objectives are to ensure that students from all backgrounds:

1. are supported to access, succeed in and progress from HE;
2. receive a high-quality academic experience;
3. are able to progress into employment or further study and their qualifications hold value over time; and
4. receive value for money.

The OfS works to achieve these aims by issuing guidance, identifying and promoting effective practice, developing and delivering funding, working closely with other agencies and sector practitioners and researchers, and through access and participation plans (APPs).

Also, the sources of funding for disabled students have changed. There are two key funding sources: the DSA and the Disabled Students' Premium. While these have been the primary funding mechanisms for several years, the arrangements and eligibility criteria for these have been subject to change.

The DSA has been available since 1974 and provides individual, tailored support to help pay for the extra costs a student might have as a direct result of their disability, and so provides support that is essential for a student to access their studies. DSA is not intended to assist with disability-related expenditure that a student would continue to incur if they were not following their course of study. Currently, it is available for undergraduate and postgraduate students studying full-time and for part-time students (as long as their course lasts at least one year and is at least 0.25 FTE). To be eligible for support an individual has to be UK domiciled, meet the definition of disability outlined in the Equality Act 2010, provide evidence of their disability, and will usually have to be assessed (via study needs assessment, which involves a charge) to identify the type of support required. DSA includes several types of support: general allowance for course-related costs, specialist equipment allowance, non-medical helper (NMH) allowance to pay for support workers such as British Sign Language interpreters, and a travel allowance. The amount received depends on assessed need and not on a student's (or their family's) income. The support is paid directly to the individual and/or to the organisation providing the service or equipment. The funding is distributed via Student Finance England and is funded from the Department for Education budget.

In 2016/17, after a government consultation on targeting funding for disabled students in HE, the DSA eligibility criteria were changed. The consultation focused on value for money and the balance between the help available for all students via HE providers (fulfilling their obligations under the single Equality Act and making reasonable adjustments⁸) and specific aspects of personalised support via DSA. Primary responsibility for funding of some NMH support (Bands 1 and 2⁹) was then transferred to

⁸ The duty includes making reasonable changes to practices, the physical environment and the provision of auxiliary aids and services.

⁹ Band 1 covers support assistants (providing practical support around the campus, library, laboratory or studio, reading aloud, scribing and text checking) and Band 2 covers enhanced support assistants (providing support for students to develop their independence and autonomy, support during exams).

HE providers (with some exceptions) and only specialist support (at Bands 3 and 4¹⁰, excluding transcription services) continued to be funded by the DSA. In addition, cost ranges were introduced for NMHs, with students expected to pay for any support that exceeded the maximum. Responsibility for meeting the additional costs of specialist accommodation was also passed to HE providers (where they or their agents owned or managed the accommodation) unless it could be considered to be out-of-scope for reasonable adjustment. The cost of purchasing standard computer equipment was also passed to the student, as in most cases the need for this equipment was not deemed to be solely due to a student's disability¹¹. These changes reflected a shift from the medical model of support that has influenced DSA and has focused on individual impairments and relevant adjustments, towards the social model of support. The social model assumes that barriers to success are a result of institutional processes rather than individuals' disabilities and therefore promotes the development of inclusive environments and practices including service provision, teaching, learning and assessment.

In contrast to the DSA, the Disabled Students' Premium (formerly part of the Student Opportunity Fund) is a funding stream directed at providers. This funding is now distributed by the OfS and is intended to support the costs of activities that will promote inclusion and remove barriers to participation and success for disabled students. Inclusive learning has been defined as:

*'teaching which engages students in learning that is meaningful, relevant and accessible to all, embracing a view of the individual and of individual difference as a source of diversity that can enrich the lives and learning of others'*¹²

Inclusive practice includes curricula, learning and teaching environments alongside structured support. Inclusive support has been identified as a priority for the sector¹³, and reflects findings from earlier research¹⁴. To support this aim, and in acknowledgement of the rapid rise in students reporting disabilities (particularly mental health conditions, as

¹⁰ Band 3 covers specialist enabling support providing expertise and training in a particular access area such as a Communication Support Worker, Specialist Note Taker, Specialist Transcription Services, and Band 4 covers specialist access and learning support such as Specialist Mentor, BSL Interpreter, Language Support Tutor for deaf students, Assistive Technology Trainer. See for example https://www.dsa-qag.org.uk/application/files/7214/8705/6024/DSA_Guidance_NEW_DSA_Students_in_AY_2016-17_0916.pdf

¹¹ See <https://researchbriefings.files.parliament.uk/documents/CBP-7444/CBP-7444.pdf>

¹² Adapted from Hockings, 2010 ??? Full reference needed and quoted in Department for Education, 2017 'Inclusive Teaching and Learning in Higher Education as a Route to Excellence'.

¹³ As identified in the 2016 grant letter to HEFCE from the Department for Business, Innovation and Skills (BIS): *'We would like the Council to review the level and method of allocating grant funding provided to support disabled students. We would like to see this funding working to incentivise universities to establish an inclusive learning and supporting environment that is consistent with the broader reforms the Government has introduced here.'*

<https://webarchive.nationalarchives.gov.uk/20160702184211/http://www.hefce.ac.uk/news/newsarchive/2016/Name,107598,en.html>

¹⁴ See HEFCE reports 'Support for higher education students with specific learning difficulties' and 'Understanding provision for students with mental health problems and intensive support needs' 2015

illustrated above), the Disabled Students' Premium funding (one of its targeted allocations) was increased. It rose from £20 million in 2015/16 to £40 million in 2016/17. The allocation has remained at this £40 million level for the 2017/18, 2018/19 and 2019/20 academic years. This fund is then distributed to providers using a weighting that is calculated to reflect the proportion of their UK students who receive DSA or self-declare a disability, and to take account of geography (London-weighting).

1.3 Progress against the key indicators

The baseline research study developed a number of key indicators of providers' models of support and progress towards inclusive models of support. These embodied a range of good practice aligned with offering inclusive support: having a strong strategy embodied in clear policies, harnessing technology to reduce the need for individual adjustments, working to improve physical accessibility of estates for all students, engaging with students to plan services reflecting a student-centred approach, encouraging disclosure of a disability to plan for additional support requirements, and reviewing and evaluating provision to ensure it remains effective and fit for purpose in the changing context.

The changes since the baseline for each indicator are presented here, although it should be borne in mind that the number of providers who responded to the current survey is somewhat smaller than in the baseline survey, 67 compared with 108, and so small changes in the indicators may be due to the different profile of responding providers rather than systemic changes in the sector.

Key Indicator 1 – proportion of providers with written policies

- Baseline – 90 per cent of providers had written policies describing the support and provision for disabled students.
- Follow-up – 85 per cent of providers have written policies.

The proportion of providers with written policies describing the support and provision for disabled students has decreased slightly since the baseline survey, from 90 per cent to 85 per cent currently. This difference is not statistically significant and so we cannot say that the prevalence of written policies has fallen. The change may be a consequence of the different size and nature of the responding group of institutions between the baseline and current survey. However, one hypothesis is that some providers have incorporated standalone disability policies into overarching inclusivity policies reflecting the move towards inclusive approaches (highlighted in Key Indicator 2 below). There is some evidence from provider feedback that this might be case but it would be an area for further research. It may also require a change to the performance indicator moving forward to focus on whether providers have written policies describing inclusive support and taking a whole institution approach.

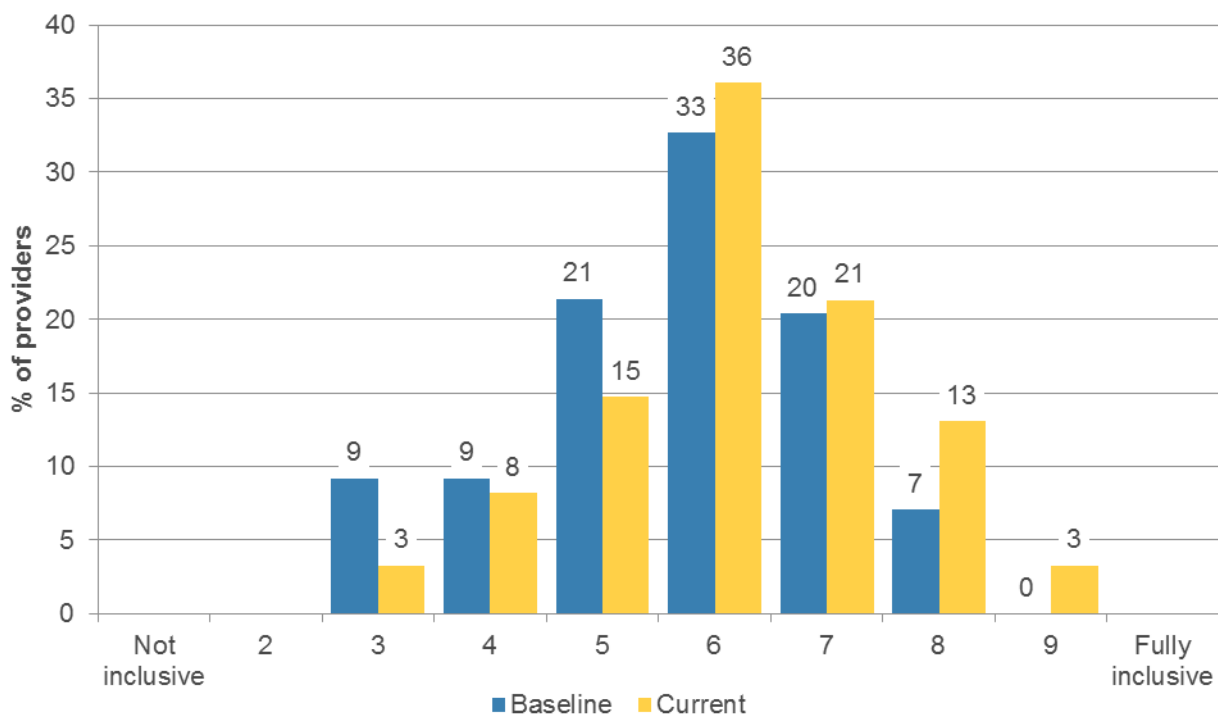
Key Indicator 2 – rating on inclusiveness scale

The current survey asked providers to rate how far along they felt they were in providing an inclusive model of support, using the same scale as used in the baseline survey. This scale ran from 1 to 10 where ‘1’ was ‘not inclusive’ and ‘10’ was ‘fully inclusive’.

- Baseline – 60 per cent of providers rated themselves at ‘6’ or higher, on an inclusiveness scale of 1 to 10, with a mean of 5.67 (just over the midpoint of 5.5).
- Current – 74 per cent of providers rated themselves at ‘6’ or higher, with a mean of 6.16.

Providers’ self-rated position in providing an inclusive model of support was significantly higher in the current survey than in the baseline, with the mean score increasing from below ‘6’ (out of 10) to slightly above ‘6’.

Figure 1.4: On a scale of 1-10 where 1 is not inclusive and 10 is fully inclusive, how far along do you feel you are in providing an inclusive model of support?



Source: IES surveys, 2017 and 2019; base = all respondents

Key Indicator 3 – use of audio/video recording of lectures (lecture capture)

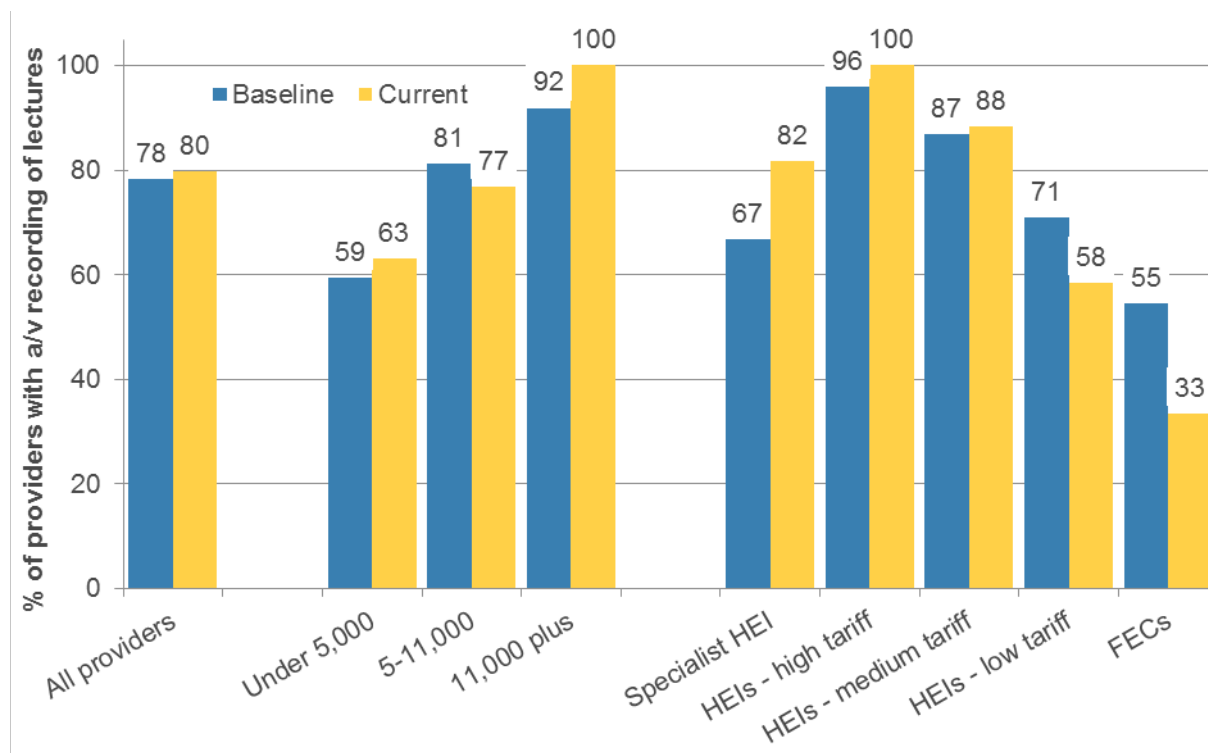
The third key indicator identified in the baseline study was the use of audio or video recording of lectures. This just refers to whether providers used it or not, and estimates of the proportion of lectures recorded, rather than data on actual take-up by students.

- Baseline – 78 per cent of providers used lecture capture (audio or video recording of lectures).

- Current – 80 per cent of providers used lecture capture.

All large providers and all high tariff providers who responded to the survey used audio/video recording of lectures.

Figure 1.5: Proportion of providers using audio/video recording of lectures



Source: IES surveys, 2017 and 2019; base = all respondents

Although the prevalence of audio/video recording of lectures was very similar compared with the baseline survey, the coverage of recording has increased.

- Baseline – 23 per cent recorded more than half of all lectures (four per cent all, 19 per cent 51-99 per cent).
- Current – 39 per cent recorded more than half of all lectures (eight per cent all, 31 per cent 51-99 per cent).

Key Indicator 4 – accessibility plan

The fourth indicator focused on the physical accessibility of the broader provider estate.

- Baseline – 52 per cent of providers had an accessibility plan.
- Current – 63 per cent of providers have an accessibility plan.

The proportion of providers with physical accessibility plans has increased since the baseline, although the difference is not statistically significant.

The patterns noted in the baseline survey were noted in the current survey in that providers were more likely to report that their social and recreational spaces were

approaching full accessibility (46 per cent), followed by their teaching and learning facilities (30 per cent) and then accommodation (8 per cent). The current survey also asked about library space, and 71 per cent reported that this was approaching full accessibility.

Key Indicator 5 – disclosure

In the current survey the vast majority of providers (at least 90 per cent) reported that they took steps to encourage disclosure of a disability or condition at each stage of the student life-cycle, while at the baseline survey at least 95 per cent encouraged disclosure at each stage. These differences are not statistically significant, however. Encouraging disclosure continues to be a core aspect of the work of disability services as it helps to normalise and de-stigmatise disability and helps institutions to plan their support. Feedback highlights how this is increasingly seen as a shared responsibility across the institution. Some providers therefore offer training for staff in dealing with disclosure and in sign-posting support and making referrals to the core team. Moving forward it may be more appropriate to focus this indicator on the extent to which staff from a wider range of departments/services are involved in encouraging disclosure.

However, it could be argued that with the move to more inclusive approaches to support, this will remove or at least lessen the need for students to disclose a disability. This could make this performance indicator much less relevant for the sector in measuring progress towards inclusive models of support.

The key indicator for disclosure focused on the proportion of providers encouraging disclosure at all of these measured stages.

- Baseline – 88 per cent of providers encouraged disclosure at all (measured) stages from pre-application to on course.
- Current – 76 per cent of providers encourage disclosure at all stages from pre-application to on course.

This difference was just outside the bounds of statistical significance at the standard five per cent level.

Key Indicator 6 – engagement with students' union/guild

This indicator focused on whether providers involve their students in the design and implementation of support.

- Baseline – 67 per cent of providers engage with their students' union/guild on issues around disability services.
- Current – 93 per cent engage with their students' union/guild on disability issues.

The questions were asked slightly differently in the two surveys – in the baseline survey it was asked as an open-ended question, whereas in the current survey a number of response categories were presented based on the baseline responses. However, it appears that engagement with students' unions/guilds has increased substantially

between the two surveys. This would align with the student-centred approach highlighted in the survey responses and case study feedback.

Key Indicator 7 – review of support

- Baseline – 85 per cent of providers are currently or have recently (last two years) taken steps to review their support for disabled students.
- Current – 65 per cent of providers are currently or have recently undertaken a review.

The drop in the proportion of providers undertaking a review is statistically significant but may well reflect the review cycle and changes in external context. For example, in the baseline survey reviews most commonly covered cuts to the DSA (which were introduced during the baseline year). It would be interesting to explore further the frequency of reviews and the factors that prompt them.

Among providers in the current survey that had not conducted a review and were not in the process of review, two thirds (67 per cent) planned to conduct a review in the next two years. This is above the proportion in the baseline survey of 53 per cent, although the difference was not statistically significant.

Key Indicator 8 – evaluation methods

- Baseline – 98 per cent of providers sought to evaluate the effectiveness/impact of their support for disabled students through surveys, comparison of academic results and satisfaction, or qualitative research with disabled students.
- Current – 98 per cent of providers used these methods to evaluate the effectiveness/impact of their support.

There has been no change in the key indicator, but given the very high level of usage of these methods there was little room for improvement.

1.4 Methodology

This new Phase two study updates the earlier Phase one research on how providers support disabled students, in particular looking at how they have:

- Progressed in their policy and practice towards embedding an inclusive learning environment (including physical and digital spaces, student services and teaching, learning and assessment)
- Responded to changes in funding (including new appointments or targeted projects and initiatives designed to embed inclusive practices)
- Responded to the increasing numbers of disabled students accessing HE and requiring support (with special consideration of the increase in students disclosing a mental health condition).

It explores how new models of support are working, the challenges faced and what changes providers have needed to make. It also broadens the scope taken in the Phase

one/baseline study to engage with a wider range of providers including private or alternative HE providers to understand their experiences.

The Phase one baseline report identified a number of key indicators which are revisited and updated in this current study. The indicators include:

- Existence of written policies on disability inclusivity/accessibility
- Level of student engagement
- Whether support for disabled students is regularly reviewed
- Extent to which disclosure of disability is encouraged
- Whether the provider has an accessibility plan
- Progress on lecture capture
- Overall self-assessed levels of inclusivity for disabled students.

1.4.1 Aims and objectives

The Phase two current research has two key objectives:

- To understand the progress made by universities and colleges (since the Phase one baseline report) to deliver an inclusive model of support for disabled students in HE in England, and to understand the impact of the OfS's increased funding to support disabled students for those providers registered in the approved (fee cap) category of the OfS register.
- To gain some insight into provision for disabled students in those providers registered in the 'approved' category of the OfS register (generally private or alternative HE providers).

1.4.2 Approach

The baseline study (Phase one) gathered quantitative and qualitative evidence from publicly funded HE providers about the support provided. It involved a comprehensive online survey of all English institutions who were in receipt of at least £20,000 in disability funding in 2016/17 and in-depth case studies with 13 institutions. The same approach has been adopted in this current (Phase two) study with one key exception: private and alternative providers in the 'approved'¹⁵ category of the OfS register have also been invited to participate in the research.

¹⁵ The register has two categories: 'approved' and 'approved (fee cap)'. The main differences relate to access to public grant funding, the fee levels that can be charged, and the levels of support students can receive. Approved providers can charge uncapped fees, but their eligible students can only access student support up to the basic level. Also, approved providers cannot access OfS grant funding. See <https://www.officeforstudents.org.uk/media/2287a9a2-2f61-4774-ae1a-3089ceff6424/ofs-registration-faqs.pdf>

Full details of the survey methodology are presented in the Technical Annex, although key points to note are:

- All publicly funded providers who received at least £20,000 in funding from the Disabled Students' Premium in 2018/19 were sampled.
- The design of the online survey was informed by the research team's experience of undertaking the baseline study (Phase one) and this was supplemented with stakeholder consultation involving the OfS and a small number of HE providers. A number of new questions were added to the questionnaire to capture information on:
 - Digital accessibility
 - Senior support for a culture of inclusivity
 - Assistive technology including captioning or transcribing lectures and training on AT software
 - Monitoring, review and evaluation of services, for example, the use of learner analytics, dissemination and use of evaluation findings.
- The sampled institutions were notified of the study by the OfS in May 2019 (in a letter sent to all vice chancellors and principals). The letter informed providers of the research, and asked them to identify a senior institutional contact to support the study.
- The survey was hosted on IES' online survey provider, SNAP surveys, and was set up so that only one response could be submitted per institution. However, respondents were able to complete the survey over several sessions and thus could consult with colleagues and gather factual data if required (and were provided with a Word/PDF version of the survey to support this endeavour).
- The survey was launched in June 2019, with reminders sent in June and July; the survey was closed at the end of July.
- Responses were gathered from 67 of the institutions contacted (this represented 61 completed responses and 6 partial responses). Provider-level data was added to the survey dataset to allow for an examination of responses by provider characteristics such as size, type of institution and proportion of disabled students (see Table 1.1).
- The survey responses were analysed in SPSS, and the follow-up (Phase two) responses were added to the baseline (Phase one) responses to allow for comparison (including significance testing to understand the strength of any changes over time).
- A small number of case studies took place in July and August 2019 to allow for more detailed insights into the issues around developing inclusive provision and the progress made in the past two years. In total, nine HE providers participated including four who had acted as case studies in the baseline study.

Table 1.1: Summary of providers involved in Phases one and two of the research by provider type

| | Baseline | | Current | |
|--|------------|------------|-----------|------------|
| | Number | % | Number | % |
| Tariff group | | | | |
| High tariff | 25 | 23 | 18 | 27 |
| Medium tariff | 24 | 22 | 17 | 25 |
| Low tariff | 24 | 22 | 13 | 19 |
| Specialist | 20 | 19 | 12 | 18 |
| FE college | 12 | 11 | 7 | 10 |
| Not known | 3 | 3 | 0 | 0 |
| Total | 108 | 100 | 67 | 100 |
| Size | | | | |
| Under 5,000 | 35 | 33 | 21 | 31 |
| 5,000-11,000 | 32 | 31 | 26 | 39 |
| 11,000 plus | 38 | 36 | 20 | 30 |
| Total | 105 | 100 | 67 | 100 |
| % in receipt of DSA | | | | |
| Less than 6% | 44 | 42 | 29 | 43 |
| Between 6 and 8% | 31 | 30 | 19 | 28 |
| More than 8% | 30 | 29 | 19 | 28 |
| Total | 105 | 100 | 67 | 100 |
| % with self-declared disability | | | | |
| Less than 6% | 41 | 39 | 6 | 9 |
| Between 6 and 8% | 35 | 33 | 19 | 28 |
| More than 8% | 29 | 28 | 42 | 63 |
| Total | 105 | 100 | 67 | 100 |

Source: IES Survey; base = all respondents (including partial responses)

It is important to note that the number and final composition of the Phase two responding sample differs in some ways from the responding sample achieved in the baseline survey (Phase one) – as indicated in the table above. The number of responding providers is lower than achieved in the baseline survey but this is likely to have been affected by the timing of the survey fieldwork (taking place in summer).

The proportion of responses for tariff group, size and percentage of students in receipt of DSA were broadly the same. However, there was a difference in the response rate based on institutions with a small proportion of their student body (less than six per cent) with a self-declared disability. In the current survey this group are under-represented when compared to the baseline survey. Similarly institutions with a larger proportion of their student body (more

than eight per cent) with a self-declared disability are over-represented in the current survey when compared to the baseline survey.

1.5 Report structure

This report presents anonymised, and in some cases aggregated, findings from across the survey responses and case study feedback. No individuals have been identified and institutions have only been identified in order to share good practice (with the text agreed with the lead institutional contact). The report is structured as follows:

- Chapter 1 (this chapter) sets out the background to the study, the aims and objectives and details of the methodological approach taken.
- Chapter 2 explores issues around governance, organisational structures and budgets to understand the strategic roles and responsibilities for supporting disabled students and the move to more inclusive approaches.
- Chapter 3 looks at the organisation of the day-to-day support for disabled students including core services, services bought in from external providers, and how providers encourage disclosure of disability to help plan and deliver support.
- Chapter 4 focuses on inclusive provision, what this means to institutions and how it is manifested in terms of use of technologies, inclusive practices, and physical accessibility.
- Chapter 5 looks at how institutions engage with internal stakeholders such as staff and students, but also with wider stakeholders such as external agencies to design and deliver support.
- Chapter 6 focuses on reviewing and monitoring planned action and intentions and actual practices.
- Chapter 7 provides findings from the small group of alternative/private providers who received OfS funding for the first time.
- Chapter 8 presents conclusions gathered through institutions' reflections on their provision/services overall, set against the key challenges they face, and their suggestions for areas of action that the sector, key agencies and HE providers could take to help move towards inclusive practice.

2 Governance, organisational structures and budgets

This chapter presents findings related to how the governance and organisational structures for the provision of support for disabled students are set up across the publicly funded providers who responded to the survey. It also covers budget setting and how providers determine their priorities for expenditure.

2.1 Governance and organisational structures

2.1.1 Responsibility for supporting disabled students

In around six out of 10 providers, the director of student services, or someone with a similar title, had overall strategic responsibility for supporting disabled students, while 14 per cent of respondents reported that strategic responsibility rested with a pro vice-chancellor (Pro VC) and 12 per cent said it rested with the vice-chancellor (VC) or principal.

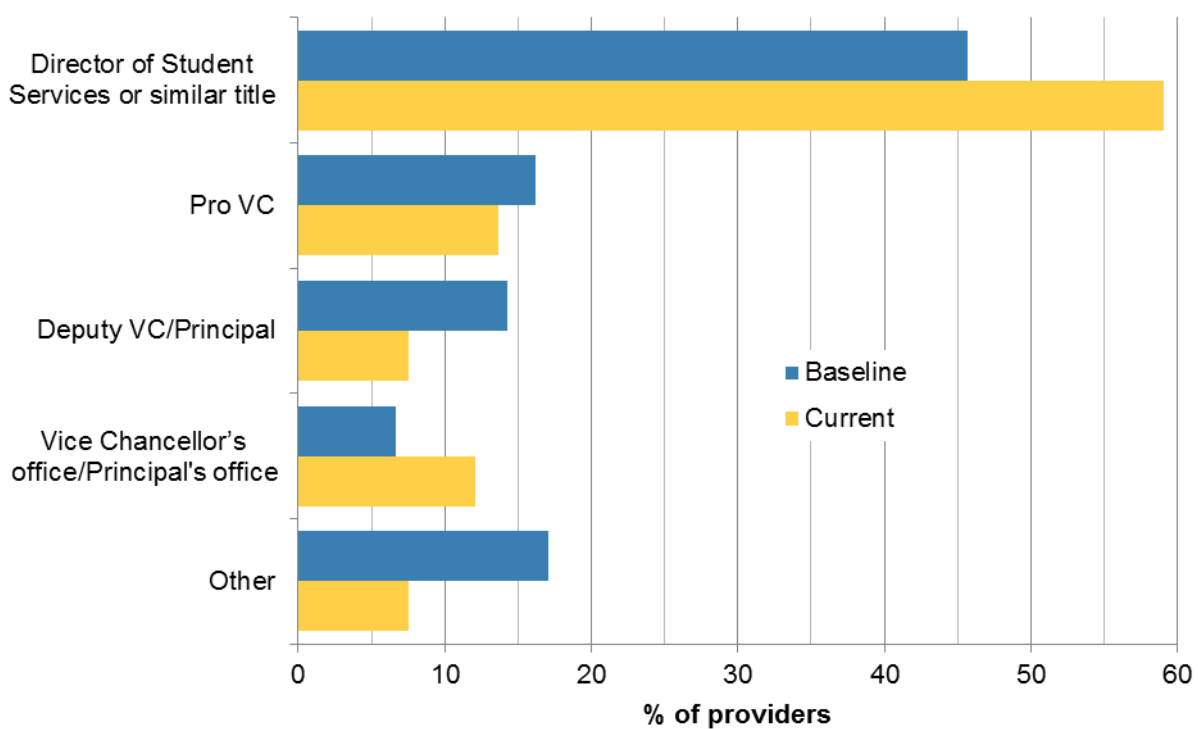
In comparison with the baseline survey, there has been a slight increase in the proportion of providers reporting that strategic responsibility lies at the top of organisational hierarchy – the proportion saying this lies with their VC/principal has increased from seven per cent to 12 per cent. However, as found in the baseline survey, it was most common for strategic responsibility for supporting disabled students to lie with the director of Student Services (or similar) (59 per cent: an increase on the baseline of 46 per cent).

For the current survey, in large providers, strategic responsibility was generally delegated to the director of student services (84 per cent of providers, and no large providers reported that the VC had responsibility). This is likely to reflect the larger management structure. In contrast, in medium and small providers, strategic responsibility was more likely to rest at Pro VC level or above (43 per cent of small providers, and 38 per cent of medium providers). There was a similar pattern by type of provider, with responsibility most likely to rest with VCs/principals in FE colleges (43 per cent, three out of seven responding colleges) and HEIs with low average tariff scores (15 per cent), while in 83 per cent of HEIs with high average tariff scores responsibility rested with the director of student services. These are similar patterns to those found in the baseline survey.

One case study provider described how governance is changing as part of the university-wide restructuring. They noted how governance has been led by the provost for learning and teaching but this is set to change and to move to the Pro VC for student experience in order to provide 'a clearer line of strategic responsibility and input'. The university are about to launch their new university-wide strategy to 2030 and mental health and wellbeing are embedded throughout this

new strategy. However, as yet they do not have a specific strategy around supporting disabled students or inclusive practice. They have instead a series of individual policies around supporting disabled students and supporting those with mental health needs. They would describe themselves as currently having a policy framework rather than an overarching strategy (but the latter would be their goal).

Figure 2.1: Where strategic responsibility for supporting disabled students rests in the institution



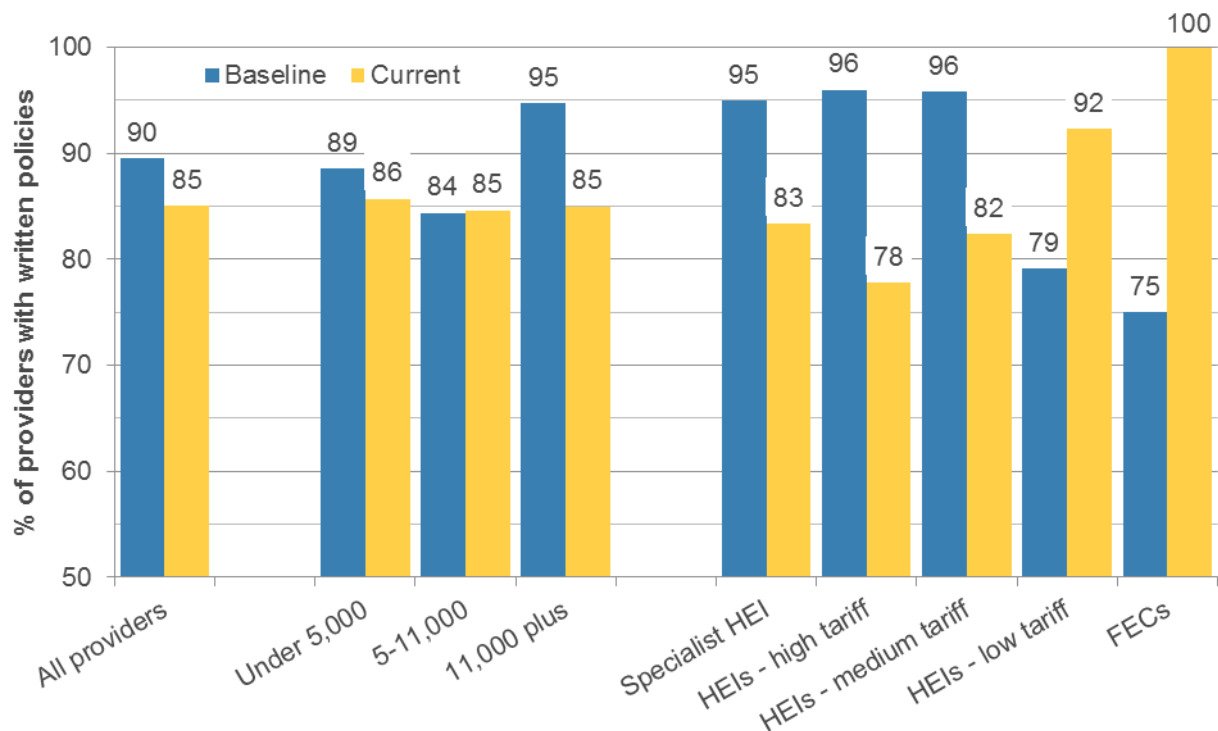
Source: IES Surveys 2017 and 2019; base = all respondents (Baseline n = 108 Current n = 67)

2.1.2 Written policies

A slightly lower proportion of providers in the current survey than in the baseline survey reported that they had written policies describing the support and provision for disabled students – 85 per cent (n=57) in the current survey compared with 90 per cent (n=97) in the baseline survey. However, a change of this magnitude is not statistically significant and may reflect the different composition of the responding samples rather than a systematic change in practice among providers.

Looking at the results by type of provider, the decrease in the proportion of providers with written policies was greatest among large providers (11,000 plus students), and among high tariff providers. However, there were increases in the proportions of specialist providers, low tariff providers and FE colleges reporting that they have written policies.

Figure 2.2: Proportion of providers with written policies describing support for disabled students



Source: IES surveys, 2017 and 2019; base = all respondents

However, feedback from respondents through the open text questions and from case study interviews suggests that there may be a move away from specific policies outlining the support for disabled students towards incorporating standalone disability policies into overarching inclusivity policies such as education strategy or estates policy. This reflects the direction of travel towards inclusive approaches and taking a holistic overview of support to encompass all students and also staff. This is highlighted in the following comments from survey respondents and case study interviewees:

“Disability/ inclusivity is threaded throughout all college policies. There are many procedures, frameworks and processes related to the policies that more specifically relate to support provision for disabled students.”

“The 2018 EDI [equality, diversity and inclusion] strategy. Specific areas such as support for accommodation provided to disabled students, the disability-related accommodation subsidy, additional examination arrangements. The aim is to have fully inclusive policies that anticipate the needs of all students rather than having exclusive policies for disabled students.”

“We might ask, what is the policy for new builds and how do we look at existing buildings? Can we think about toilets that take account of mixed gender with sanitary equipment to deal with gender reassignment and issues of access for those

needing more space? ... It's looking at accessible toilets, family rooms and baby change facilities etc. together instead of in isolation."

Comparing the responses of those who completed both surveys, although a small number indicated that they now had policies whereas they did not in the baseline survey, a slightly larger number reported that they did not have policies currently but did in the baseline survey. Also there was little variation in the likelihood of providers having written policies by size of provider, whereas in the baseline survey large providers were most likely to have policies (95 per cent). This could also lend credence to the above hypothesis of movement towards inclusive policies, and suggest that larger providers might be leading this trend. This would be an area for further research to explore how providers are documenting (and naming) their policies.

Providers with written policies were asked to indicate which aspects of support for disabled students were covered by their policies (Table 2.1). Student support was the area most commonly covered by policies (93 per cent) followed by assessment (89 per cent) and teaching and learning (84 per cent). In the baseline survey, assessment was the most common area covered by policies (92 per cent), and only 80 per cent of policies covered student support. The current survey included additional response options (based on the main responses given by providers who ticked 'other' in the baseline survey). Of these additional aspects of support, three quarters (77 per cent) of providers said their policies covered a general commitment in principle to supporting disabled students, 61 per cent said their policy covered recruitment and widening participation, and 30 per cent said their policy covered transitions into and out of the institution. It is interesting to note an increased focus on the student experience and on inclusive curriculum design (including universal design for learning) in the current survey compared to the baseline survey.

Table 2.1: Areas covered by the policies supporting provision for disabled students (multiple response)

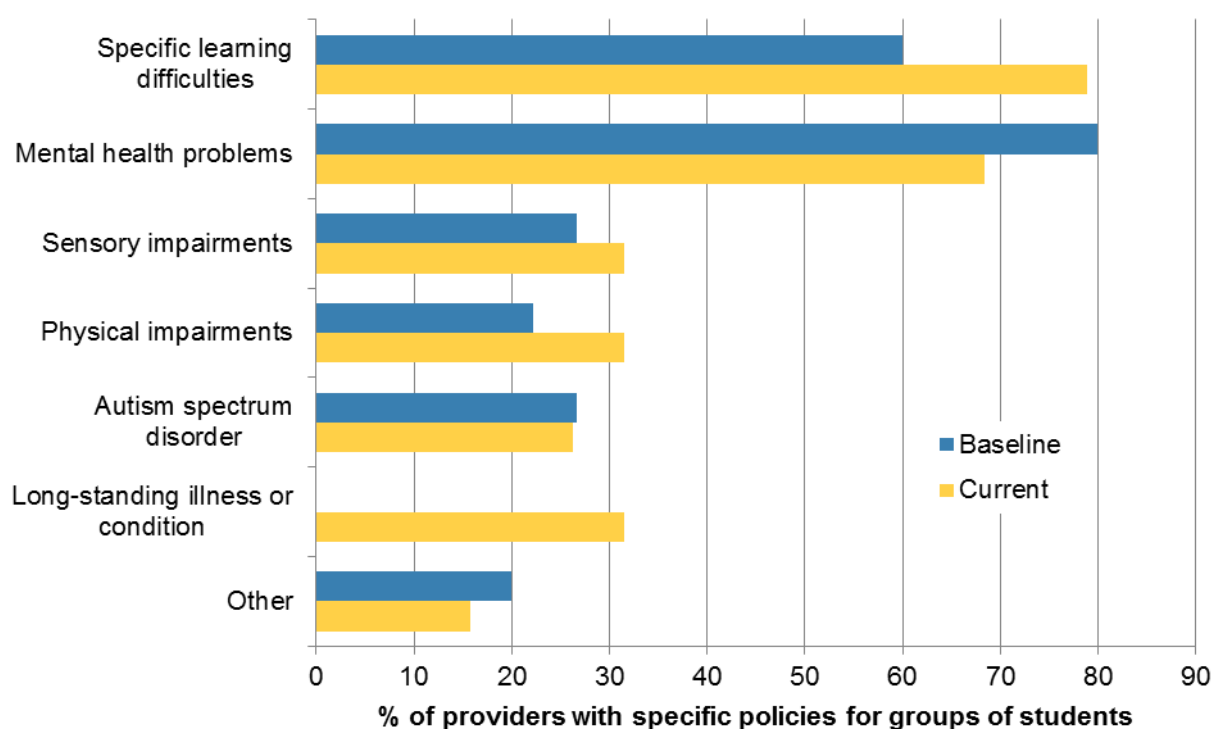
| | Current | | Baseline | |
|---|---------|------|----------|------|
| | Number | % | Number | % |
| Accommodation | 33 | 58.9 | 60 | 65.9 |
| Student Experience | 30 | 53.6 | 40 | 44.0 |
| Student Support | 52 | 92.9 | 73 | 80.2 |
| Teaching and Learning | 47 | 83.9 | 75 | 82.4 |
| Assessment | 50 | 89.3 | 83 | 91.2 |
| Inclusive curriculum design/Universal Design for Learning | 29 | 51.8 | 39 | 42.9 |
| General commitment in principle | 43 | 76.8 | - | - |
| Recruitment/widening participation | 34 | 60.7 | - | - |
| Transitions into and out of the institution | 17 | 30.4 | - | - |
| Other | 11 | 19.6 | | |
| N= | 56 | - | 91 | - |

Source: IES Survey 2019; base = all respondents with written policies

Around one in three providers with policies (35 per cent) said that they had specific policies for students with particular types of disabilities or conditions, down from around half of providers with policies (49 per cent) in the baseline survey. Small providers were least likely to have specific policies (17 per cent, compared with 46 per cent of medium-sized providers and 41 per cent of large providers), and no responding FE colleges had specific policies.

Specific policies most commonly related to students with SpLD (79 per cent) and mental health problems (68 per cent). These were the disabilities that were most commonly covered by specific policies in the baseline survey.

Figure 2.3: HE providers with specific policies for groups of students (multiple responses)



Source: IES Surveys 2017 and 2019; base = all respondents who had policies covering specific groups of students (Baseline n = 91 and current n = 56)

In the current survey, institutions with a written policy supporting disabled students most commonly updated their policies 'as required' (48 per cent), although one in four updated their policy annually (25 per cent); these proportions were broadly similar to those in the baseline survey (Table 2.2). Small providers were more likely to update their policies every two or more years (28 per cent, compared with nine per cent of medium-size providers and 12 per cent of large providers), while medium-sized providers were most likely to report updating their policy 'as required' (68 per cent).

When institutions were asked to provide more detail on the reasons for their latest update/review, the most common answer was that it was part of their regular review which was often carried out annually. Other common reasons to update the policy included

having an enhanced policy, provision or definition, and responding to wider sector developments including improved examples of good practice and current expectations.

Table 2.2: Frequency of policy updates

| | Current | | Baseline | |
|-------------------|---------|------|----------|------|
| | Number | % | Number | % |
| As required | 27 | 47.1 | 35 | 39.8 |
| Annually | 14 | 24.6 | 20 | 22.7 |
| Every two years | 6 | 10.5 | 9 | 10.2 |
| Every three years | 2 | 3.5 | 8 | 9.1 |
| Less frequently | 1 | 1.8 | 1 | 1.1 |
| Other | 7 | 12.3 | 15 | 17.0 |
| Total | 57 | 100 | 86 | 100 |

Source: IES Survey 2019; base = all respondents with written policies (Baseline n=86 and Current n = 57)

2.1.3 Factors influencing institutional response to inclusivity

The survey therefore indicates an increased focus on inclusivity in policies and the case studies suggest this may in part be driven by sector-wide issues. These include General Data Protection Regulation (GDPR), EU accessibility regulations, the APP requirements set by the OfS, the development of equality charter marks, and the broader wellbeing agenda; some, though not all, of these factors linked to the ‘crisis in mental health issues’. These factors were also having some influence beyond written policy to impact on the restructuring of committees, changes to roles and responsibilities, and the creation of targeted working groups. These external pressures were enabling providers to prioritise inclusivity, drive change and secure buy-in. As one case study participant noted:

“... people may like the concept of inclusivity for moral reasons but there is push-back and for change we needed the buy-in, we recognise this will have an impact on work processes if it’s done properly, it’s not just agreeing to produce a bunch of resources.”

The APP was mentioned by interviewees in several case studies. This was often described as a driver of increasing awareness of inclusivity, and enabling inclusivity to become more of a priority. One interviewee noted: *‘[gaps in attainment] have highlighted disabled students and mental health difficulties, it’s really pushed this up the agenda’*. The APP requirement has also led to a more integrated approach to monitoring and evaluating the effectiveness of current provision or targeted initiatives (see Chapter 7).

Interviewees also described how equality awards or recognition schemes with action plans, such as Athena SWAN, the Race Equality Charter, and Disability Confident, were enabling their institutions to adopt a more holistic approach. These schemes together with institutions’ own quality processes had led some institutions to restructure how services were managed and ultimately fitted into the organisational decision-making processes. In addition, several interviewees reported a greater emphasis on wellbeing which was a

more inclusive proactive banner under which to organise services as it was of relevance to all students and staff:

“The restructure of Wellbeing and Safeguarding was in response to our observations that there was some confusion regarding separate entry points, students and staff were uncertain about where to go, ... the student journey was fundamental to implementing the journey, ... it’s a new way of delivering the services, pulling things together into one service and working with that as a concept delivered a new way.”

2.2 Budget and expenditure

As in the baseline survey, providers were asked three questions in the online survey regarding the budget for disability services and how it is spent:

- Who in the institution has responsibility for deciding the budget for disability services?
- What information feeds into decision making about the size of the budget and how it is distributed?
- How are changes to the physical estate to improve accessibility funded?

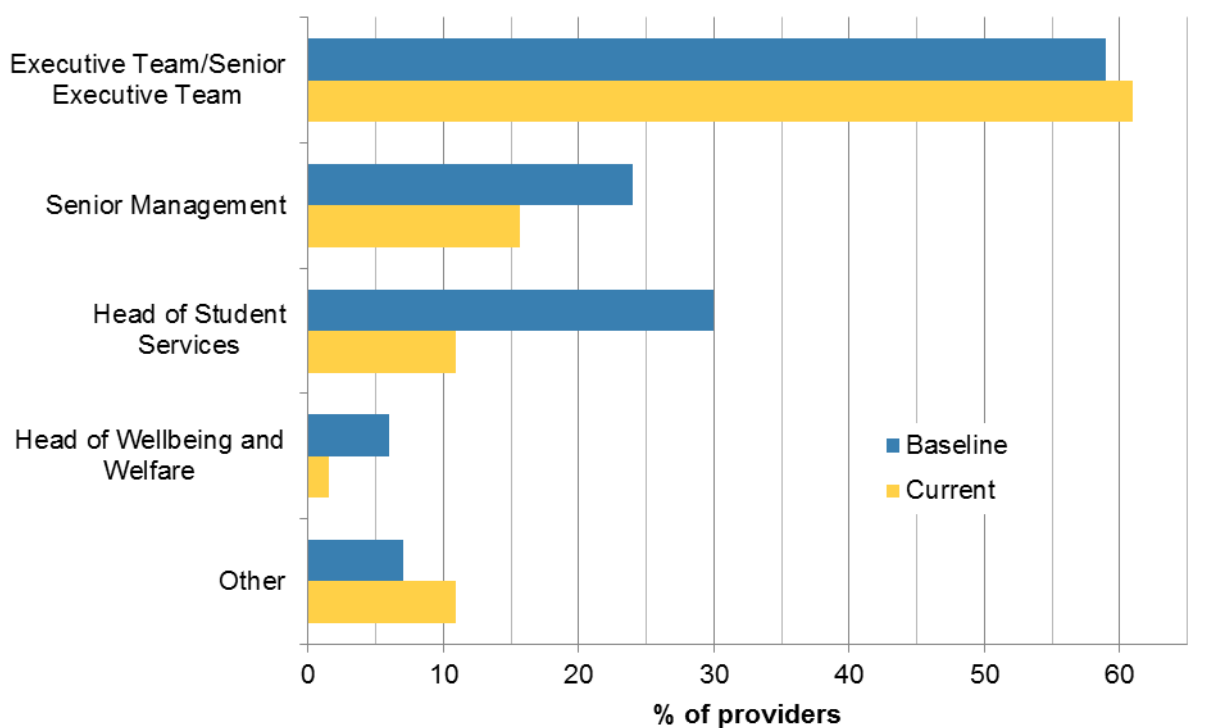
In the baseline survey, these were asked as fully open-ended questions, but for the current survey, response options were provided based on the common responses given by baseline survey respondents. In addition, the current survey asked how changes to improve digital accessibility (e.g. virtual learning environments (VLEs), library catalogues etc.) were funded.

HE providers were also asked how they have used the additional funding provided by the OfS to support them in developing inclusive models. This is discussed in Chapter 4 which focuses on inclusive provision.

2.2.1 Budget setting

Responsibility for deciding the disability services budget most commonly sat with the provider’s executive team or senior executive team, as it did in the baseline survey (Figure 2.4), while in a small proportion of providers, budget setting responsibility sat with senior management (16 per cent), the head of Student Services (11 per cent) or the head of Wellbeing and Welfare (two per cent). The proportions of respondents reporting roles below the executive team were lower than in the baseline survey, as the baseline survey allowed for multiple roles whereas in the current survey only a single option could be given. There were no significant variations in where budget setting responsibility rested by provider characteristics.

Figure 2.4: Where strategic responsibility for supporting disabled students rests in the provider



Note: In the baseline survey, the question was asked open-ended and multiple responses were coded, whereas in the current survey only a single response was possible

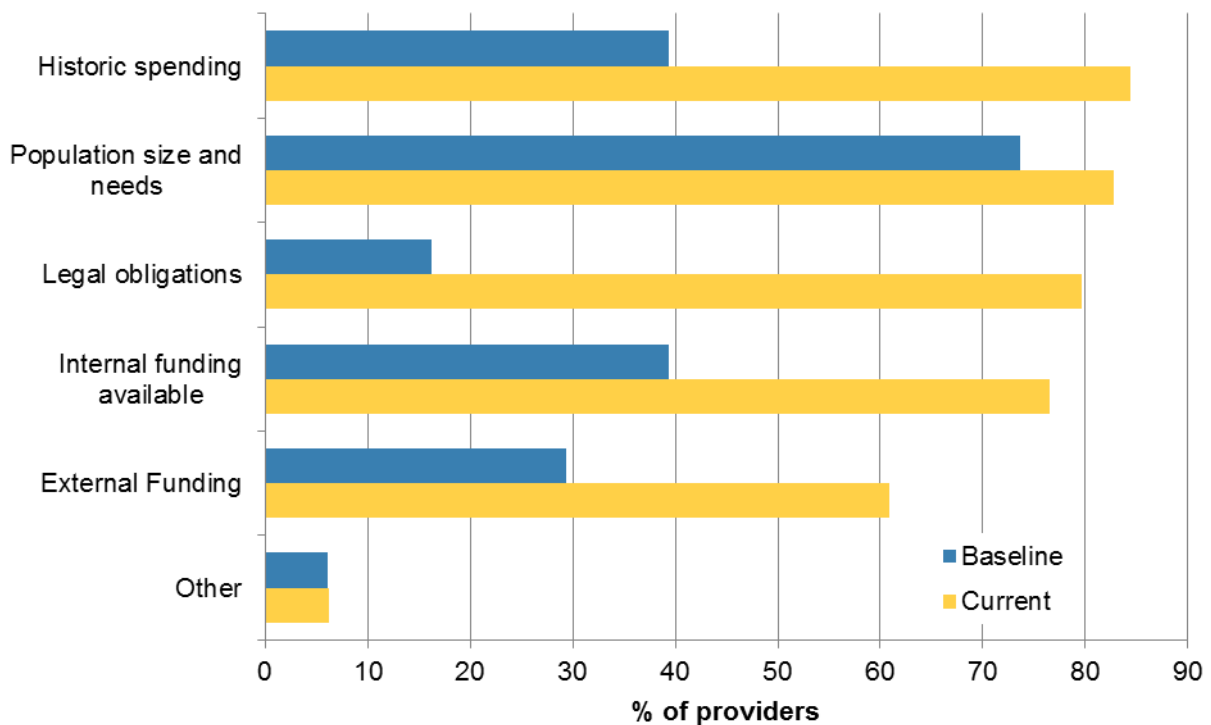
Source: IES Surveys 2017 and 2019; base = all respondents (Baseline n = 105 and Current n = 64)

Providers were also asked what information fed into their decision making about the size of the budget and how it is distributed. They were presented with a number of response options and asked to indicate all that applied. The most commonly mentioned source of information was historic spending (85 per cent), closely followed by the size and needs of the disabled student population (82 per cent), and internal funding available (77 per cent, see Figure 2.5). This followed patterns found in the baseline survey. However legal obligations (80 per cent) also commonly influenced budget setting, more so than was found in the baseline survey. There was no significant variation in the proportions mentioning each information source by provider characteristics.

In the baseline survey, the question asked was fully open-ended, and so comparisons are not exact, yet there appears to be a large increase in the proportion of respondents mentioning legal obligations. However, this may reflect a degree of social desirability bias, in that respondents may feel they should be taking legal obligations into account. Furthermore, respondents ticked on average four of the six response options, whereas in the baseline survey, two options on average were extracted from the open-ended response given by each respondent, and so the proportion of respondents citing each information source will be larger in the current survey than in the baseline survey.

One case study provider described the budget process. They noted that the budget for student support is determined centrally by the university and is based on the previous year's budgets plus anticipated numbers of students requiring support. Despite significant restricting, the resources for supporting disabled students and the accessibility agenda have been protected and increased in recognition of the importance of this aspect of delivery and the growing demand for support/services. Thus their budget has increased over the last three years as the numbers of disabled students has increased. They use their budget to provide interim support for those waiting for DSA support, for those needing support on top of the DSA support (excess DSA), and for those not covered by the DSA (e.g. international students). The decisions about how to use the funding are made within the student support department/team which means they can be responsive and flexible.

Figure 2.5: Information used to feed into decision making on disability budget (Multiple response)



Note: In the baseline survey, the question was open-ended and multiple responses were coded, whereas in the current survey all response options were presented and respondents were asked to tick all that applied

Source: IES Surveys 2017 and 2019; base = all respondents (Baseline n = 105 and Current n = 64)

2.2.2 Funding for improvements to physical and digital accessibility

The vast majority (95 per cent, n=61) of the current survey respondents said changes to the physical estate to improve accessibility was funded through the providers' central estate budget, while around two thirds of respondents (64 per cent, n=41) also cited capital infrastructure as a source of funding. One in five respondents (19 per cent, n=12) reported that they used a specific pot of money for improving accessibility, and a similar

proportion reported that physical accessibility improvements were funded through the disability budget. The pattern of responses was broadly similar to that in the baseline survey, with the central estates budget most commonly mentioned, followed by capital infrastructure spending.

Institutions were also asked how changes to improve digital accessibility, such as VLEs, software and the library catalogue, were funded. The majority of respondents said these improvements were generally funded through department budgets e.g. using IT, library services or education and teaching budgets. To a lesser degree, institutions also funded their digital accessibility changes through central or capital infrastructure budgets. Only a small minority of institutions (10 per cent, n=6) reported that they had a specific budget for improving digital accessibility. There was little relationship between having specific budgets for both physical and digital accessibility, with only one respondent reporting specific budgets for both types of improvements.

3 Organisation of disability support services

This chapter looks at how the day-to-day support for disabled students in institutions is organised, the make-up of the core team and their responsibilities, and the services which are purchased externally. It also covers location of services, how they work with external providers, and explores how they encourage disclosure of a disability.

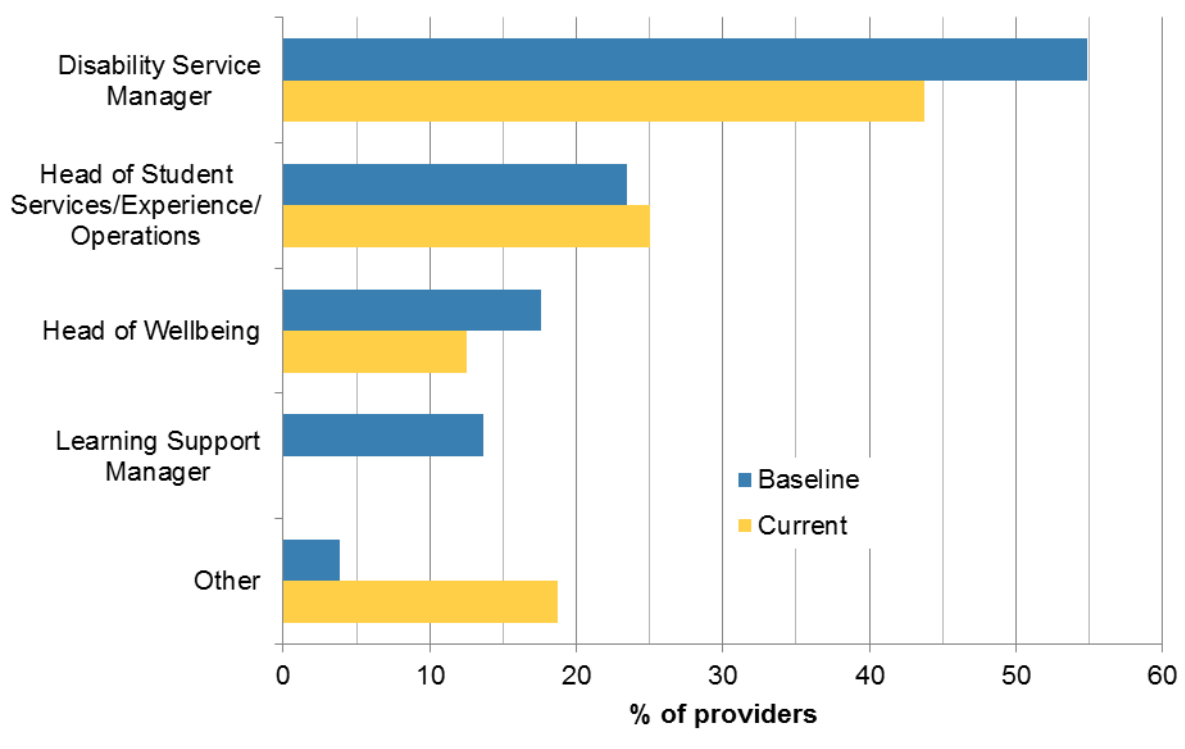
3.1 Day-to-day responsibility for disability services

In just under half of providers who responded to the current survey (44 per cent), the disability service manager had day-to-day responsibility for disability services, while in a quarter (25 per cent) responsibility sat with the head of student services or similar job title – head of student experience, or head of student operations. These results are broadly in line with those from the baseline survey, when the question was open-ended (Figure 3.1).

There was significant variation by provider characteristics in where day-to-day responsibility for disability services rested.

- In small providers, responsibility was most likely to sit with the head of student services/experience/operations (45 per cent) or in another job role (30 per cent), with only one in four providers reporting that the disability service manager had day-to-day responsibility.
- In half of medium-sized providers, and 56 per cent of large providers, day-to-day responsibility for disability support rested with the disability service manager, with only 15 per cent of medium-sized providers and 17 per cent of large providers saying the head of student services/experience/operations had responsibility. One in four medium-sized providers (24 per cent) reported that responsibility sat with the head of wellbeing.
- In four fifths of FECs (83 per cent, five out of six responding colleges), and 30 per cent of HEIs with low average tariff scores, responsibility sat with the head of student services/experience/operations, compared with 18 per cent of specialist HEIs and HEIs with medium-tariff scores, and 12 per cent of HEIs with high average tariff scores.

Figure 3.1: Individual in provider with day-to-day responsibility for disability support



Note: In the baseline survey, the question was asked open-ended and multiple responses were coded, whereas in the current survey only a single response was possible

Source: IES Surveys 2017 and 2019; base = all respondents Baseline n = 108 and Current n = 64

3.2 Central support for disabled students

3.2.1 Composition of central team

Alongside the service manager, institutions also employ other staff members to support the delivery of disability services. The most commonly cited roles among survey respondents are disability officers (97 per cent), disability administrators (84 per cent) and support tutors (55 per cent). However, Table 3.1 indicates the wide range of staff who are considered to be part of the core team for delivering disability support services. These include counselling staff, in-house NMHs, wellbeing support workers, mentors and those supporting specific aspects of the HE journey (e.g. transitions and careers).

One case study institution described how they were extending their mental health counselling support by working collaboratively with another institution who trained counsellors, by offering trainee counselling placements. This provides useful experience for the trainees and expands the support on offer at the institution.

Table 3.1: Staff roles involved in the core team for delivering disability support services

| | Number | % |
|--------------------------------------|--------|------|
| Disability advisers/officers | 62 | 96.9 |
| Administrative staff | 54 | 84.4 |
| Support tutors | 35 | 54.7 |
| Counselling staff | 30 | 46.9 |
| In-house NMHs (not NMH via DSA) | 24 | 37.5 |
| Wellbeing support worker | 22 | 34.4 |
| Support worker (not NMH via DSA) | 21 | 32.8 |
| Library staff | 18 | 28.1 |
| Disability mentors (not NMH via DSA) | 15 | 23.4 |
| IT technician/specialist staff | 12 | 18.8 |
| Careers staff | 9 | 14.1 |
| Inclusive learning staff | 9 | 14.1 |
| Transitions staff | 8 | 12.5 |
| Learning development staff | 8 | 12.5 |
| Student success staff | 6 | 9.4 |
| Other | 15 | 23.4 |
| N= | 64 | - |

Source: IES Surveys 2019; base = all respondents

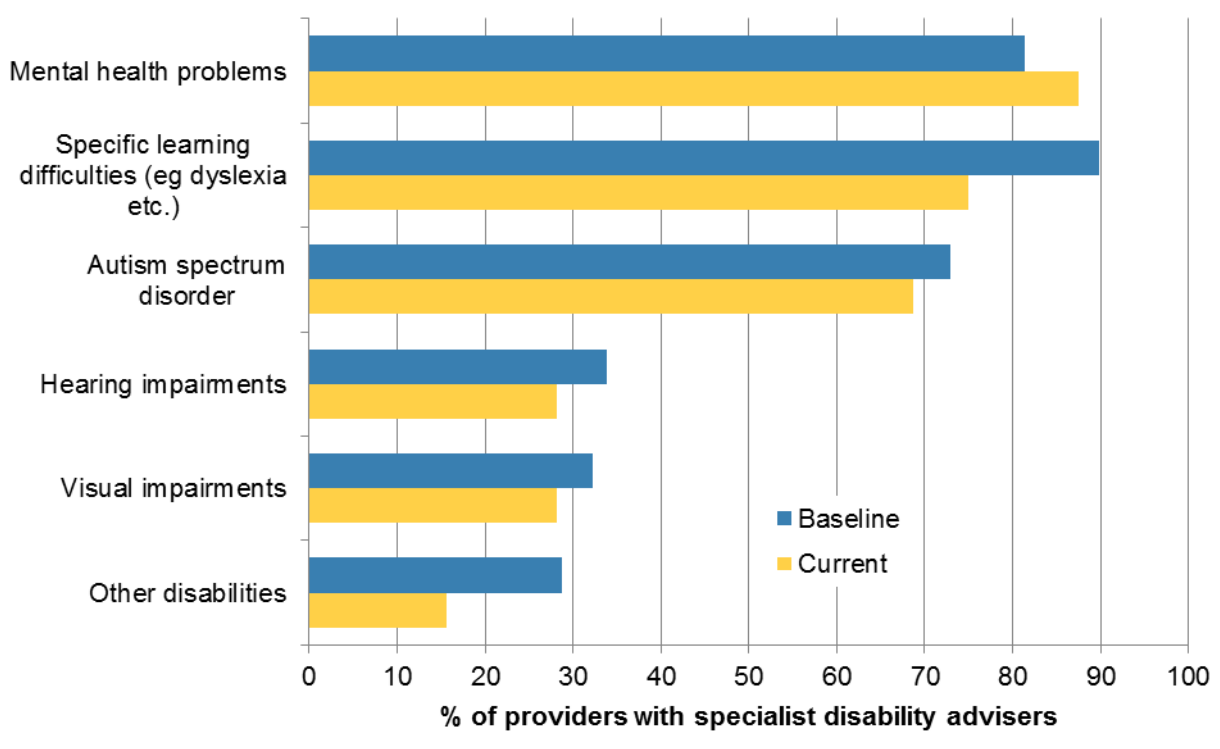
Respondents were also asked what proportion of NMHs they employed were not funded by the DSA. There was quite a wide range of answers. Four out of 10 providers reported that very few of these staff (less than 10 per cent) were not funded by DSA, while 20 per cent said the vast majority of their NMHs (80 per cent or more) were not funded by DSA. There was no clear variation by provider characteristics.

Providers were also asked whether they had advisors who specialised in providing support to students with particular types of disabilities. There was an even split between providers in terms of whether they had specialist disability advisers, or whether advisers were generalist staff who support students with all types of disabilities. In the baseline survey, a small majority of providers, 57 per cent (n=58), had advisers who specialised. In the current survey, there were some statistically significant differences between providers, with small providers (70 per cent), specialist HEIs (82 per cent) and HEIs with low average tariff scores (67 per cent) being most likely to have generalists in the roles, while medium-sized providers (65 per cent) and HEIs with medium average tariff scores (82 per cent) were most likely to have staff specialised in different disability types. This is likely to reflect the overall size of the team and the size of the student population. Larger teams supporting a large student population are more likely to be able to support specialist roles.

Looking at the type of students for which providers had specialist advisers, Figure 3.2 shows that nearly nine out of 10 providers with specialist advisers (88 per cent, n=28) had specialist advisers for students with mental health problems, 75 per cent (n=24) had

specialist advisers for students with SpLD, and 69 per cent (n=22) had specialist advisers for students with autism spectrum disorders. In comparison with the baseline survey, a lower proportion of providers had specialist advisers for students with SpLD, which may reflect a reduced need for specialist staff as a result of increased inclusive support for these students. In contrast, a higher proportion now have mental health specialist advisers which reflects an increasing sector-wide policy concern for the mental health and wellbeing of HE students.

Figure 3.2: Types of students covered by specialist advisers/officers (multiple response)



Source: IES Surveys 2017 and 2019; base = all respondents with specialist disability advisers. Baseline n = 59 and Current n = 32

Among providers that had specialist staff supporting students with mental health problems, a majority said that staff worked in both a counselling and advisory role (61 per cent) rather than just an advisory role (39 per cent).

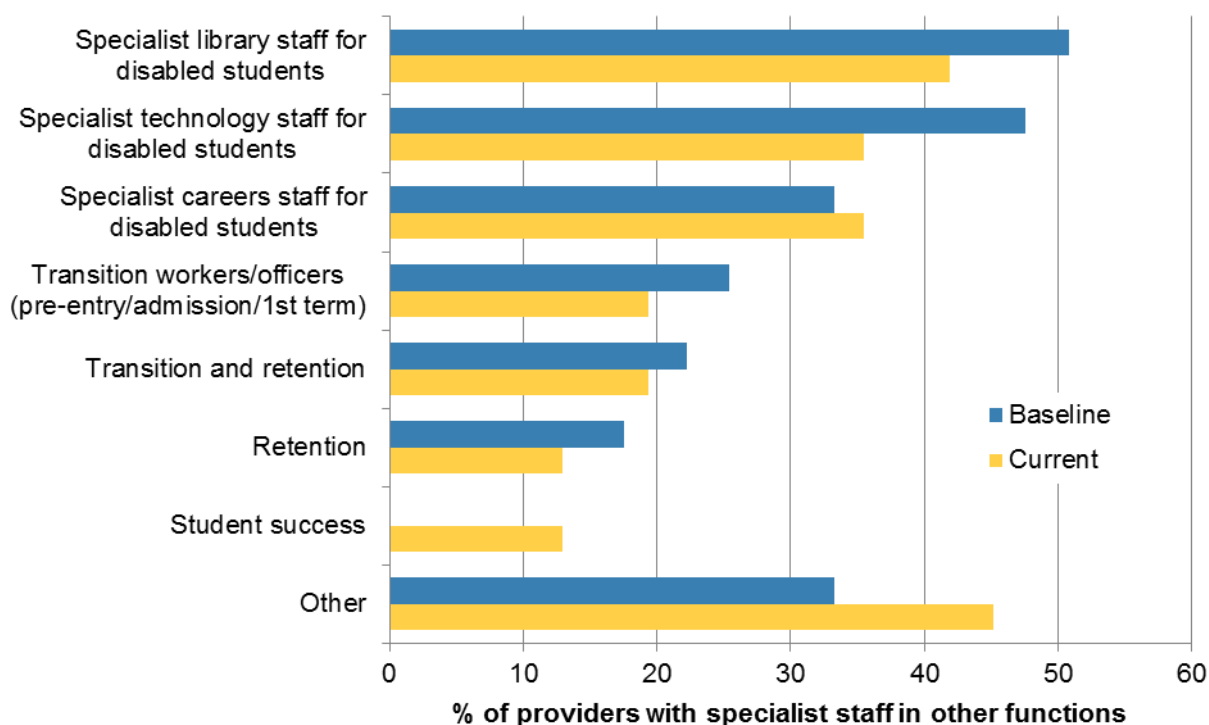
One case study described how they had specialist advisers. They have a mental health support team with a manager and currently one full-time mental health practitioner. This will be increased to two full-time staff from next academic year (to include a full-time psychotherapist). This reflects the growing need for mental health support. The team is also supported by a number of part-time/hourly paid mental health counsellors which helps them cope with the high demand. They also have an accessibility services team which has a manager, and four additional staff each with their own specialism and case load: autism, mental health conditions and difficulties, long-term medical conditions (e.g. diabetes, epilepsy, Crohn's etc), and SpLD. The services (mental health and accessibility) are housed together on campus (main campus) with a main reception and a GP practice.

Half of all providers (51 per cent) reported that there were, in addition to the central disability team, other functions within the provider in which there were specialist staff to support disabled students. How the core team works with and supports other professional services and academic faculties/schools/departments is discussed further in Chapter 5.

This is slightly below the proportion in the baseline survey of 61 per cent. There was significant variation by type of provider as would, perhaps, be expected. The proportion reporting other support functions increased from 25 per cent of small providers, to 54 per cent of medium-sized providers and 77 per cent of large providers, while 82 per cent of HEIs with high average tariff scores had specialist staff in other functions, compared with around half of HEIs with medium or low average tariff scores, 33 per cent of FECs (two out of six responding colleges), and 18 per cent of specialist HEIs.

Among the providers with specialists in other services, 42 per cent had specialist library staff, 36 per cent had specialist technology staff, and 36 per cent had specialist careers staff. These were also the most common types of specialist staff in the baseline survey.

Figure 3.3: Roles of specialist staff to support disabled students (multiple response)



Source: IES Surveys 2017 and 2019; base = all respondents with specialist disability staff in specific functions Baseline n = 63 and Current n = 31

3.2.2 Location of services

The majority (56 per cent, n=35) of disability services were co-located with other student services or within a 'one-stop-shop' for all services. A quarter (24 per cent, n=15) said they were based in multiple locations, including co-located with other services. Few respondents, just 13 per cent (n=8) said that disability services were located separately

from other student services. These proportions are very similar to those in the baseline survey, when 60 per cent (n=65) of services were co-located, and 10 per cent (n=11) were located separately from other student services. This suggests a continuation of the ‘joined up’ approach to supporting students whatever their need.

Case study interviews highlighted the diversity of teams and their locations. Where services were and with whom services were located was influential in how services were advertised to students. Co-location also offered opportunities for closer collaboration and easier referral of students to known colleagues. One case study talked about recent plans to co-locate and provide a more centralised service which could be more easily signposted for staff and students. Another case study institution described how they were trying to move away from having separate disability and mental health services, and to work more collaboratively which would bring benefits:

“pulling altogether as ONE service and work with that as a concept ... we have a new case management system and enquiry and communication system.”

Institutional location also influenced how services would interact with external NHS and voluntary services. This was particularly important for those not located on a campus where emergency services might be available 24 hours a day. As one student services colleague explained:

“We have to manage students’ and parents’ expectations. We are a 9.00 to 5.00pm service, Monday to Friday, we’ve worked hard with departments to publicise out-of-hours emergency contact information ... I know discussion at AMOSSHE conference that it’s widely recognised we need to manage expectations, doing too much is not going to help students in the long run.”

3.3 External support

Institutions typically also access external support to help support disabled students. The online survey asked providers which services for their disabled students they bought in from external providers. Overall, three-quarters of providers (75 per cent) said they bought in services (e.g. DisabledGo), while 60 per cent said they bought in equipment and adaptations, 54 per cent used external agencies for disability assessments and 52 per cent used them for NMHs and in-class support. The proportion of providers who did not buy in external support and provided all services in-house has fallen from 19 per cent in the baseline survey to 11 per cent in the current survey.

Table 3.2: What services for disabled students does the provider buy in?

| | Current | | Baseline | |
|----------------------|---------|------|----------|------|
| | Number | % | Number | % |
| Assessment | 34 | 54.0 | 44 | 44.9 |
| NMH/in-class support | 33 | 52.4 | 43 | 43.9 |
| Service equipment | 38 | 60.3 | 17 | 17.3 |

| | | | | |
|--------------------------------|----|------|----|------|
| Services (software, support) | 47 | 74.6 | | N/A |
| All services provided In-house | 7 | 11.1 | 19 | 19.4 |
| Other | 12 | 19.0 | 4 | 4.1 |
| Total | 63 | - | 98 | -- |

Source: IES Surveys 2017 and 2019; base = all respondents Baseline n = 98 and Current = 63

Although all institutions provide at least some services themselves i.e. in-house, the baseline survey suggested a preference for operating, as far as possible, an entirely in-house model of support. This was felt to offer greater flexibility to respond to students' needs, better quality assurance, improved consistency and continuity of provision, and increased networking across the institution. The current survey would suggest that providers are having to move away from an entirely in-house model. This could reflect the nature of the responding sample as in this current survey a much larger proportion of institutions have a high proportion of students with a self-declared disability.

However, feedback from providers in relation to changes they have made suggests that, for some, moving services in-house has helped them improve their services and take-up. One provider described a project they had undertaken which led to a change in approach:

"We worked hard over the last three years to identify barriers to the take-up of disability support. Through this research we have identified these barriers and removed them, improving access to support for disabled students. Many of these barriers were around students initiating the support journey, in particular obtaining medical evidence and meeting various individuals for assessments. Much of this activity happened off campus and was provided by individuals not connected with the university. We have now brought in-house: the diagnostic services, DSA assessment centre and in-house NMH support. This means that the entire disabled student support journey can take place on site. This has reduced additional costs to students, streamlined the process adding to ease of understanding and reduced the time such processes take."

Another talked about the radical step they had taken to improve access to support:

"The introduction of the 'Reasonable Adjustment Fund' and opting out of the DSA has revolutionised how we support students and the time it takes to have that support put in place. Students now can access mentoring and specialist study skills support within days of approaching the disability advisory service now that we no longer have to wait for approval of student finance that a student is eligible for support. Our model of support values the expertise of our disability advisors in making recommendations for support and these advisors no longer feel that they are just administrators of the DSA. We have quality control over our in-house non-medical helpers and service level agreements with suppliers of specialist support that we cannot manage in house. This has resulted in a very high class fast-acting service which supports students' needs. In addition as we have in-house non-medical helpers, we are able to initiate support even when the evidence of disability

is pending or a condition does not meet the Equality Act definition. This has ensured that students are supported before a crisis in study arises.”

The survey showed that, in general, providers' interaction with external agencies has been increasing on the whole over the last two years. Two thirds (64 per cent) of survey respondents said that their interaction with external agencies had increased. This compares with 30 per cent who said it had stayed the same, and six per cent who said it had decreased. Large providers, and HEIs with high average tariff scores, were more likely than others to say that their interaction with external agencies had decreased, perhaps reflecting a greater degree of inclusive support, reducing the need for external provision.

Looking to the future, around a third of providers (35 per cent) felt that their interaction with external agencies would increase as they moved to a more inclusive approach, 41 per cent felt it would stay the same, and 24 per cent felt it would decrease. Small providers were most likely to feel their interaction with external agencies would increase (58 per cent), while 35 per cent of medium-sized providers and 28 per cent of large providers felt their interaction with external agencies would decrease as they progressed towards inclusive support.

3.4 Encouraging disclosure

A key aspect of the work of disability support services is to encourage disclosure of a disability. As one case study institution noted, this can be essential in supporting their planning and budget process.

“We have learned to do as much planning up-front as possible. To put in place support before a student arrives. Plus crucially the need to put in place agreed principles and criteria for accessibility-support funding so we can be transparent about the decisions we make, and not always have to make decisions on a case-by-case basis.”

In the current survey, the vast majority of providers, at least 90 per cent, reported that they took steps to encourage disclosure of a disability or condition at each stage of the student life-cycle. This was very similar to the proportion in the baseline survey where at least 95 per cent encouraged disclosure at each stage. During application appeared to be a particularly key stage at which to engage with students and work to encourage disclosure of any existing disability. However, it was important to providers that they continued to provide opportunities for disclosure throughout the student journey, as issues could manifest themselves later on (after entry).

Table 3.3: Proportion of providers encouraging disclosure at different stages of the student lifecycle (%)

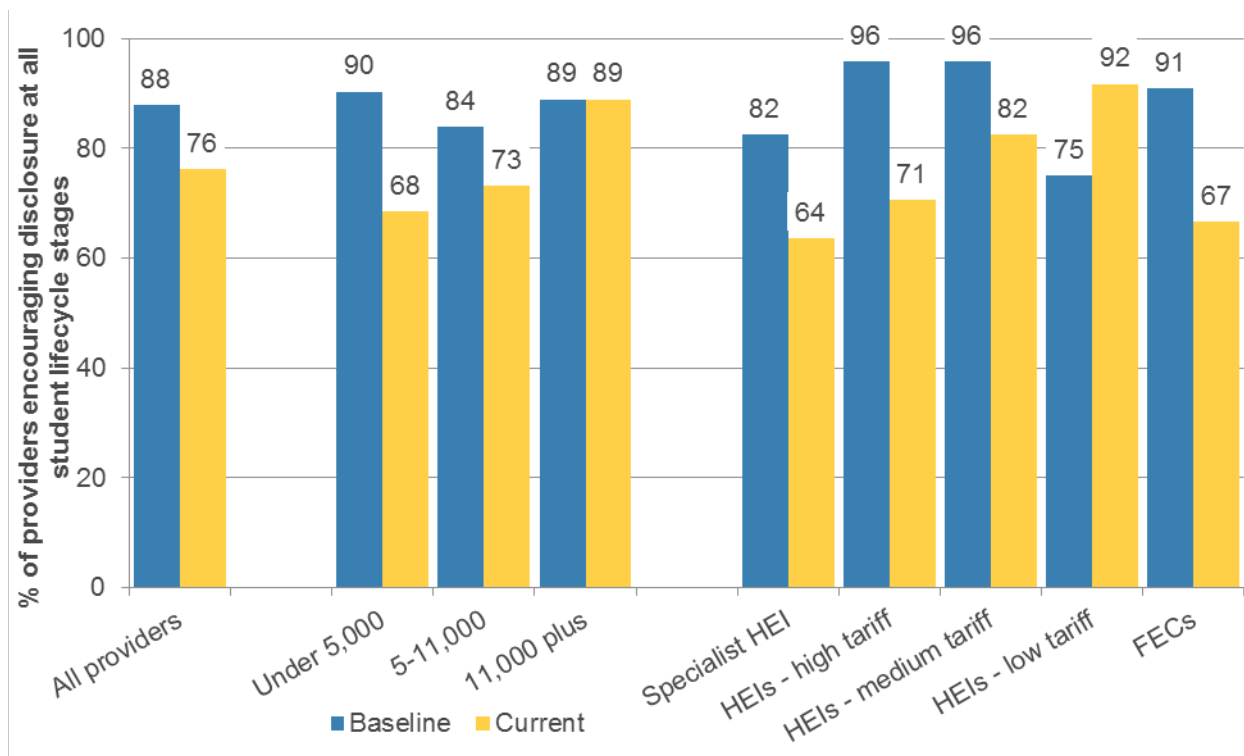
| | N | Current % | Baseline % |
|--------------------|----------|------------------|-------------------|
| Pre-application | 58 | 92.1 | 95 |
| During application | 61 | 96.8 | 96 |
| Pre-entry | 57 | 90.5 | 97 |
| At entry/induction | 59 | 93.7 | 99 |
| On-course | 59 | 93.7 | 95 |
| All stages | | 76 | 88 |

Source: IES surveys, 2017 and 2019; base = all respondents Baseline n = 98 and Current n = 63

Looking across all stages, 76 per cent of providers in the current survey encouraged disclosure at **all** (measured) stages from pre-application to on course. This is slightly lower than was found in the baseline survey (88 per cent) but the difference is not statistically significant. It is likely therefore to be due more to the different respondents in the two surveys rather than an overall reduction in measures to encourage disclosure (Table 3.3). The survey also found that two thirds (67 per cent) of providers have automated systems where disclosure on digital forms or platforms will automatically trigger signposting to support (and/or notify disability support services).

Large providers, and low tariff HEIs, were most likely to encourage disclosure. In the baseline survey, there was little variation by size of provider, but in the current survey there appears to be a strong relationship to size. The survey found that two thirds (68 per cent) of small providers encouraged disclosure at all stages of the student journey compared with 89 per cent of large providers (Figure 3.4)

Figure 3.4: Proportion of providers who encourage disclosure of a disability or condition at ALL stages of the student life-cycle



Source: IES surveys, 2017 and 2019; base = all respondents

Methods to encourage disclosure at the **pre-application stage** were commonly made through disability support teams being present at open days, taster days and other recruitment events such as outreach work with schools to reduce stigma. At these open days/recruitment events, advisers would be on hand to describe the support available, provide support and advice around making an application, and to encourage disclosure. Similarly providers could ‘market’ their disability support on their general website and in prospectuses. This could help to encourage individuals to make contact as soon as possible and provide prospective students with contact details for any enquiries (enabling individuals to be able to make direct contact with specialist professionals).

During the application process and pre-entry, providers often send all applicants emails to make them aware of the support available and also of the benefits of disclosing a disability. In addition, individuals are encouraged to disclose or declare any disability in the standard suite of application forms (including those from UCAS). When an individual has declared a disability, the support teams can proactively contact these individuals to build rapport and build up a profile of needs (often using an ‘additional requirements’ questionnaire). This can be especially important for students coming for interview or audition. Some providers offer applicant visit days (‘insight days’ or ‘transition days’) to help prospective students make up their mind about the institution, and to provide a further opportunity to encourage disclosure and promote the range of support and ethos/approach to supporting disabled students. Disability advisors can also have a presence at clearing days/events. Providers also re-contact students who are holding an

offer or have accepted an offer of a place to remind them of the support (and funding) available and to give them further opportunities to disclose a disability or condition. Providers stressed the importance of good, consistent and regular communication throughout the application and entry process.

Some providers offered specific events for those who have disclosed a disability to support their transition to the institution. These can focus on helping students to familiarise themselves with the environment/campus, and providing help with study skills. Additionally those who disclose are often encouraged to visit the institution and meet the team to discuss support before they start. One provider noted how they run a 'welcome campaign' for disabled students via telephone and email.

At **entry, during the registration and induction phase**, providers continue to disseminate the support offered and encourage disclosure. They often give talks and presentations at induction and welcome events (including freshers' fairs), and include information about the support available in the student handbook or welcome pack. Students can also disclose to the admissions team, accommodation services or to those in academic departments. Some providers talked about screening students for specific learning differences during the enrolment process.

To continue to encourage disclosure **across the student journey**, providers deliver ad hoc talks, run specific campaigns, events or road-shows, offer drop-in sessions, have a visible presence in student open areas, and ensure their web-presence is up-to-date. Many also use social media, leaflets and posters to promote the services available. Providers also noted the importance of raising staff awareness of the support available to students and having an effective referral process in place. This requires providing staff with relevant training on dealing with disclosures.

The case studies also highlighted how encouraging disclosure was embedded throughout institutions' processes from initial enquiry and throughout the student journey. However, disclosure was not always a straightforward process and several individuals raised concerns around confidentiality and data protection, and sharing information that students had shared in confidence.

One institution talked about the training given to staff involved in responding to prospective student enquiries to raise staff awareness of when a student might be disclosing information that would constitute a disability. The importance of raising staff awareness of what constituted disclosure and how they should respond, and where and to whom they should refer students was important:

"to enable our students to best access our service ... It is a process allowing one to disclose a disability of any kind at any point in their studies. Staff development events help to raise staff awareness, and training around mental health and information advice and guidance make sure staff are as well-equipped as possible."

Good practice example – South Essex College

Supporting transitions

The college has considerable experience of supporting disabled learners' progression from FE to HE provision – within their own college or to other HE providers. They find that as disabled FE learners are familiar with the college buildings, tutors and fellow students many do choose to stay on with them, as this can offer them continuity and familiarity with the environment and staff. However, the disability advisers work with identified disabled FE students to show them that they can progress to HE, and give impartial advice about their options for accessing support and reasonable adjustments in HE allowing them to make informed choices decisions about their university choice.

A key issue in supporting the transition is through the annual review process of education, health and care (EHC) plans that students have while studying at FE level expire when students enter HE. During this process where learners identify their intended progression is to HE, the dedicated HE disability adviser meets with them to explain FE-to-HE transition and that although their EHC plan expires when students enter HE, this will provide their evidence for their needs assessment. The college therefore works hard to identify the key aspects within students' EHC plans that they are able to take forward with support from FE to HE level as best they can. The advisors have considerable knowledge about the support students receive while studying at FE level, and note this is likely to be very different in universities where the disability support service might have little information about what support students were receiving at school or college.

4 Inclusive provision

This chapter focuses on inclusive support, what it means to institutions and how it is manifested in terms of the use of technologies for inclusive practices, and physical accessibility. The chapter ends with institutions' perspectives on their overall progress towards inclusive provision and how the additional funding from the OfS has helped them.

4.1 Characteristics of inclusive provision

In the online survey, providers were asked to give their views about what characterises an inclusive model of disability support. Respondents gave full answers that covered a number of themes and concepts. The open-text responses were coded into categories to provide an overview of what an inclusive model was felt to cover. Each response was assigned independently to one of six core themes identified in the survey's open responses.

As the survey responses were anonymous at an individual level, the origin of the responses is unknown. However, it is worth noting that within the case studies the definitions or views about inclusivity predominantly related to the role or responsibility of the interviewee. This is not surprising and probably reflects interviewees' priorities and the way in which they and their work connected with the inclusivity agenda. Interestingly, there were a few exceptions where an individual explained how a previous workplace, role or collaboration with colleagues working in another service influenced their views. Several interviewees referred to these additional insights as beneficial, and a result of inclusivity moving up the institutional and sector agenda.

Table 4.1: How would you define inclusive practice? (Open-ended; multiple responses coded)

| | Number | % |
|-------------------------------------|--------|------|
| All student approach | 34 | 51.5 |
| Curriculum and assessment | 27 | 40.9 |
| Teaching and learning | 26 | 39.4 |
| Collaborative approach | 13 | 19.7 |
| Physical accessibility | 9 | 13.6 |
| Social model of disability approach | 8 | 12.1 |
| Total | 66 | - |

Source: IES Surveys 2019; base = all respondents

4.1.1 Overview of inclusivity

“the dream would be that we wouldn’t need a disability service... That all the work we do ensures that all students have the same capacity to succeed or fail, and to be safe.”

Across all the comments was the belief that an inclusive model or approach would reduce (but not remove) the need for specific or ad hoc adjustments, and would allow all students to work towards independence. It was felt to be about building in flexibility (and choice), anticipating need and being proactive, offering a wide range of provision as standard and this becoming the normal approach. Some noted how this would lead to fewer students needing to access DSA support.

“An inclusive model of disability support is one which looks to move away from models based on individual reasonable adjustments for individual disabled students (noting that there will always be some students who do require individual adjustments) to one where the design of the curriculum and assessment (based on the principles of Universal Design for Learning - UDL) seeks to include as many students as possible across all protected characteristics. This is based on the social model of disability (M. Oliver¹⁶) but also on the affirmative model of disability (Cameron, French and Swain¹⁷) which seeks to normalise disability. This requires disability services to work closely with academic and support staff, and library, IT and academic development staff to develop inclusive practice as a shared institutional responsibility rather than one which is seen mainly as being the responsibility of the disability service.”

“An inclusive model of support is one that ensures full and seamless integration into mainstream learning and teaching, yet is capable of striking a balance between enabling people to be fully independent whilst ensuring that individuals are fully supported. In other words, an inclusive model should reduce the need for individual adjustments, but some students may require support over and above the inclusive model to ensure that they genuinely have full and equal access. For example, a blind student may require a sighted guide and/or braille, even if there are tactile markings and accessible notes; a hearing-impaired student may require a BSL interpreter, even though the material is all provided and video material is captioned.”

“An inclusive model recognises that there is no ‘one size fits all’, it must be flexible and adaptive, continually reviewed and challenged to ensure that it meets the multiple identities that each disabled person has. We should be looking at a model where the disability teams are concentrating on supporting only those students with

¹⁶ p. 45 Oliver, Michael (1983). *Social Work with Disabled People*. Basingstoke: Macmillan; and Oliver, Michael (1990). *The politics of disablement*. London: Macmillan Education

¹⁷ p. 45 Swain, John & French, Sally (2000). *Towards an Affirmation Model of Disability*, *Disability & Society*, 15:4, 569-582

complex disabilities but also operationally focusing much more on proactive work rather than reactive.”

More specific themes to emerge from the responses are discussed below.

4.1.2 All student (or institution) approach

An ‘all student’ approach was mentioned by over half (52 per cent) of providers and was the most common conceptualisation of inclusivity. This was often mentioned alongside having a student-centred approach and a recognition of the importance of the student experience. Respondents also tended to talk about helping students to succeed along the whole student journey, and often mentioned ‘co-production’ in terms of working with students to design and deliver support. Respondents noted:

“An inclusive model should anticipate the diverse needs of all students, wherever possible ... There should be a student-centred approach which includes growth in personal effectiveness and improved career and life opportunities.”

“A truly inclusive model of disability is one where students are able to study and succeed without impediment – where the environment is such that adjustments are in place either without request or with very simple procedures in place. An inclusive model will benefit all students regardless of disability or not and will provide an environment where all students can achieve their potential.”

“An inclusive model of disability support is a strategic, whole institution, holistic approach which values equality and diversity. An inclusive model of disability support removes barriers to learning, enhances experience, increases participation and enables all students to fully engage with all aspects of university life. Furthermore, it improves student satisfaction, aids retention, progression and achievement.”

“An inclusive model of disability support recognises and values the diversity of the student body, and works with them to optimise the learning experience for everyone. It moves away from the model of making reasonable adjustments for individual disabled students towards the principle of making all aspects of provision as accessible as possible. By doing so, the provider complies with the legal duty to anticipate the needs of disabled people at large across all of its provision and services. For example, we previously required lecture hand-outs to be provided in advance to dyslexic students only. Making them available to all students ensures that any students in the group who may have undiagnosed dyslexia are not disadvantaged.”

The distinction between trying to respond to all students and taking a whole university approach is important. The whole university approach was described as having a shared institutional responsibility for supporting disabled students rather than the responsibility of just one part of the institution (i.e. the disability service). This is often mentioned alongside the importance of changing the culture of the institution around disability.

“[inclusive approach is] One in which we are able to change the culture around disability with a whole university approach, provide the right support to individuals requiring it and diversity is celebrated.”

“A whole HEI approach, all academic and other provision provided with disabled people in mind to minimise the need for individual adjustments. Disabled people (staff, students and visitors) should feel very much at home and included.”

“Disability support should be joined up across the institution and the student considered holistically when entering university so that all needs are considered and supported rather than fragmented approaches to different aspects of a student’s experience.”

The case study interviewees confirmed a commitment to respond to all students. However, they felt that responses across institutional services were often ‘patchy’ or ‘uneven’ and ‘something we are only just beginning to work towards’. Many felt that a holistic strategic and institutional response was what would be required to bring about real change that would represent a whole university approach. They felt this was dependent on senior management commitment.

4.1.3 Curriculum and assessment

Curriculum and assessment was the second most commonly mentioned characteristic of an inclusive approach. This was mentioned in the responses of 41 per cent of providers. Here respondents described the importance of ‘designing inclusivity in’ when developing curricula. They also described the importance of offering a range of assessment approaches:

“Thinking about this [inclusive approach] as part of curriculum design rather than making adjustments later.”

“Curriculum and assessment [should be] inclusive by design thereby reducing the need for disabled students to identify themselves and require support. It requires commitment from senior management. There needs to be a training commitment.”

“Assessment needs to be flexible whilst still retaining the learning outcomes and overall there should be less reliance on ad hoc adjustments.”

“Our approach to student support is to be, as far as is practical, inclusive by design. We have 10 curriculum design principles that inform the development of all programmes within the university, number one of these is ‘inclusivity’. We seek first and foremost to remove barriers to success, where this is not possible we take reasonable steps to support students to be able to overcome the barriers that remain. At validation or review, each programme team is challenged to describe how they make all aspects of their programme accessible and inclusive to all potential learners. In addition, equality impact assessments are completed for all new programmes to ensure that all relevant steps have been taken to ensure our provision is inclusive. Where further adjustments are required, students with a self-declared disability are supported by our disability and learner support service to

create a reasonable adjustment plan. Outcomes of this process are reviewed regularly to determine whether such adjustments should be incorporated into institutional policy as standard practice.”

There were several explicit references to Christine Hockings’ work¹⁸ on inclusive teaching and learning and specific mention of institutional commitment to UDL, for example the extract below:

“ ‘...pedagogy, curricula and assessment are designed and delivered to engage students in learning that is meaningful, relevant and accessible to all...’

“An inclusive model of support embraces the concept of universal design for learning rather than relying on an exclusive disability support model, [which is] predominantly used at present, which relies on providing individual reasonable adjustments.”

“An inclusive approach means that what is good for one is good for all so an approach such as universal design is ideal as it does not stigmatise those with disabilities and recognises that everyone has different needs.”

4.1.4 Teaching and learning

Teaching and learning was mentioned by 39 per cent (similar to the proportion referring to curriculum and assessment). Here respondents tended to talk about removing barriers to learning and about making learning more accessible (‘levelling the playing field’). They also talked about learning approaches/strategies and the learning environment (both physical and virtual). This was also often linked to the wider student experience and lifecycle.

“An inclusive model of disability support removes barriers to learning, enhances experience, increases participation and enables all students to fully engage with all aspects of university life. Furthermore, it improves student satisfaction, aids retention, progression and achievement.”

“Teaching and learning environments (virtual and physical) which are accessible to all students, where the experiences and contributions of all students are equally valued and considered. Providing different ways that students can access learning and demonstrate competence. Soliciting the opinions of disabled students when designing teaching and learning environments and activities.”

“An inclusive model of disability support is characterised by inclusive teaching strategies, which refer to any number of teaching approaches which address the needs of students with a variety of backgrounds, learning modalities, and abilities. These strategies contribute to an overall inclusive learning environment in which students feel equally valued. One output of such strategies could be the building of

¹⁸ from Hockings, Prof. C (2010) ‘Inclusive learning and teaching in higher education: a synthesis of research’ Higher Education Academy”

inclusive classrooms. This is part of our wider 'inclusive curriculum' programme... IC as a shorthand for inclusive approaches to education and student support more generally. An inclusive curriculum is attentive to gender, race, class, sexuality, disability, age and faith in terms of teaching practice related to module content, the approach to teaching, learning and student support, and to the accessibility of learning resources. A commitment to inclusion means being aware of the diversity of your students and the ways in which an inclusive approach can enhance their success, engagement and enjoyment while at university."

"An inclusive model of disability support is about creating a culture which is dynamic, diverse and accessible to all; one where all students are facilitated in maximising their academic potential, irrespective of background or situation. Integral to this is the need to adopt and embed a consistent, inclusive approach to learning, teaching and assessment. This involves considering ways in which our institutional structures, practices and processes may create barriers to equitable experiences and exploring how these barriers may be dismantled through the implementation of best practice."

Teaching and learning was often framed as making reasonable adjustment for students within a group (this contrasts with considerations of curriculum and assessment which tended to be linked to quality assurance as discussed above). The following examples show how for some this also meant a movement toward the more pro-active anticipatory approach:

"One where barriers to learning are removed by: making lectures and teaching materials accessible such as visual, auditory and kinaesthetic ways of teaching to cater for all learning styles; using a variety of teaching methods; making reasonable adjustments where necessary to e.g. assessment methods, placements etc.; fostering an inclusive learning environment where accessibility is increased to minimise need for individual adjustments and a positive accepting culture."

"When we see a sharp reduction in the lists of reasonable adjustments required from teaching and assessment teams. Reasonable adjustments become the norm, rather than the exception e.g. sympathetic marking, additional time in class tests. Fewer students requiring DSA support."

4.1.5 Collaboration and sharing good practice

One in five providers (20 per cent) referred to the adoption of a collaborative approach. This emphasised a way of working, and indicated the range of stakeholders who might feature within the process of developing and delivering inclusive provision. Typically the collaborative relationship mentioned was between centralised disability services and academic departments (see also Chapter 5). This builds relationships that can provide mutual benefit but can feel a little uncomfortable at first. This internal collaboration also helps move towards a whole institution approach. Some respondents referred to wider collaborations such as between institutions and across the sector to share good practice, and also collaborations with the health service and the local community.

“A system where academic staff are anticipating adaptations to their programmes whilst they are writing them, where students may or may not disclose a disability but are offered reasonable adjustments which still meet learning outcomes. A system where staff are confident to talk to individual students about any modifications they may need and not defer to the disability services team as ‘the experts’ in an individual’s condition.”

“We are also joining up the need for inclusivity in the curriculum around decolonising the curriculum so that academic staff have more understanding of the proactive things they can do to ensure they are not continuing to put up barriers for anyone covered by the Equality Act. This non-siloed approach is very important to have enough sway with the academic community as we are asking them to work differently, which can be uncomfortable, particularly if they haven’t ever been taught how to design a programme, what assessments can link to learning outcomes, and how to offer accessible learning materials.”

“A collaborative approach to supporting students with disability. This should include all areas/departments of the educational setting and the local community, a close network with the local community to provide support to students with disabilities when they go shopping, go out or need additional support in, for example, the local hospital or charities.”

“A whole HEI approach, all academic and other provision provided with disabled people in mind to minimise the need for individual adjustments. Disabled people (staff, students and visitors) should feel very much at home and included.”

4.1.6 Physical accessibility

A smaller group (16 per cent) of providers specifically mentioned physical accessibility as one of several factors characterising inclusivity. The relatively low number of mentions of the built environment may well reflect that this has been a starting point for change and that a move towards inclusivity has broadened well beyond the physical environment. Indeed, as the quotes below illustrate, inclusive provision involves a web of services and staff with awareness, expertise and commitment to ensure not just access but ‘dignified’ access.

“Ensuring that not only buildings and the physical environment are accessible to disabled learners but that the curriculum and whole school environment are accessible too. Also ensuring that support for and training for staff to enable them to support disabled students through inclusive curricula and assistive technology.”

“An inclusive model of disability is multi-faceted, covering a range of considerations including promoting and valuing diversity, the development of an environment which is fully accessible to all, the design and delivery of curricula and assessment, and the delivery and monitoring of services through co-production.”

4.1.7 Importance of the social model of disability

In addition, 12 per cent of providers explicitly referred to the social model of disability when defining the characteristics of inclusive models. This social model has been the basis of legislation as well as funding and policy initiatives regarding the inclusion of disabled students in HE (DfE, 2017¹⁹).

“Following the social model of disability, which means that when the barriers are removed, students can get equality of opportunity and independence with choice and control over their own lives. It’s a levelling of the playing field so that disabled students are enabled to fulfil their potential just as non-disabled students can.”

“The characteristics of inclusive support is based on the social model of disability where the built environment, curriculum design, assessment methods, procedures and processes that are within HE are the disabling factors and not the student's disability/medical condition. Students need to be at the heart of the learning experience and methods revised in order to mitigate the barriers that currently exist.”

“An inclusive model of disability support is based on a social model of disability, where attitudes and methods are employed to ensure fair access for all learners, irrespective of disability. Support should be seamless and transparent for the individual to facilitate their development and achievements. An inclusive model can benefit all learners, not only disabled learners.”

In addition, the interviews revealed the diversity of nuanced responses and differences in terms of how inclusivity is characterised. Again key aspects emerged covering: an institution-wide approach, legal equality drivers including reasonable adjustment and anticipatory duty, the role of students, importance of training, influence of technology and UDL.

4.2 Senior management commitment to inclusivity

Respondents to the survey were asked to what extent senior management instilled and supported a culture of inclusivity across the institution, with open-text responses. There was a widespread view that inclusivity was well supported by senior management, with key individuals taking an active interest and securing additional resources. This was also evidenced by senior level ‘champions’ for inclusivity, inclusion of senior staff with responsibility in key decision-making committees, key reporting lines directly to senior management, commitment of resources to specific inclusivity projects/working groups or task forces, or inclusivity being a priority in the strategic plan. This is illustrated by the following responses. Note that specific job titles or committee titles have been omitted to protect the anonymity of providers:

¹⁹ Department for Education, 2017 ‘Inclusive Teaching and Learning in Higher Education as a Route to Excellence’

“Inclusivity has the support of senior staff, for example the [senior leader] for education 'owns' and drives our inclusive curriculum.”

“The VC is a consistent advocate of inclusive design and practice; PVC student experience is driving policy and helping with strategy development.”

“Senior management, particularly the vice-chancellor and [senior leader] (education) are fully committed to a culture of inclusivity at the institution. For example, the [senior leader] education identified the importance of having the [student services head] on the Academic Standards and Quality Committee, to ensure that issues of inclusivity are considered during the policy making relating to academic standards. Likewise, for the last two years, the [student services head] is on the Programme Approval Subcommittee. The [senior leader] (education) has also personally supported activities such as ‘Disability History Month’ and is very active at flagging up any inclusivity issues which [they] believes require attention and/or discussion.”

“The PVC (education) is sponsoring work by our centre for teaching and learning on inclusive teaching and assessment. This work includes working closely with academics, and the disability service to understand inclusive practices in the university context. We have had a number of events for teaching staff and support staff focusing on this issue, and are planning for workshops as we move towards developing resources to support academics in developing more inclusive practices. The VC is very openly supportive of development of an inclusive environment for all staff and students.”

“The [senior leader] for teaching and learning is driving this through a mandatory series of workshops for all academic departments to attend in the next year which covers inclusivity, decolonising the curriculum, unconscious bias, and curriculum design.”

“Inclusivity is a core value of the university, and is clearly promoted and celebrated by the board of governors and senior management at every opportunity; for example, it is a central theme of the new strategic plan (as it was in the previous one).”

“The university has set out clearly in its vision and strategy its commitment ‘to equality, diversity and inclusion [and] in creating and fostering more equitable societies.’ Investment in these values underpins changes taking place within the digital infrastructure, staff training and in particular training for new academic staff, a drive to embed equality analysis within the university’s reorganisation, building improvements and procurement policies and processes. In addition, there is considerable senior academic support within faculties to foster inclusivity within available resources.”

Involvement of senior management in the development of the provider’s APP was also highlighted as a demonstration of their commitment to inclusivity:

“Senior management are fully engaged in supporting a culture of inclusivity across the institution. An example of how this is displayed is their full involvement in the creation and implementation of the university’s access and participation Plan.”

“The PVC for student experience authored the access and participation plan and is responsible for driving forward key goals for disabled students and reducing attainment gaps.”

However, a few respondents said that senior management’s commitment was still a ‘work in progress’, that they would value more opportunities from senior management to continue work in this area, or that commitment was limited or variable:

“Historically limited but leadership is growing and becoming more focused around a more inclusive culture. Recent initiatives, including a campaign against harassment and assault, plus the development of an institution-wide mental health strategy for the whole community of staff and students, are indicative of this more focused effort from senior management. Recent development and approval by senate of the new disabled students policy is an important policy step that aims to drive and build a stronger culture and commitment to inclusion from a disability perspective.”

“Senior managers provide limited support of an inclusive culture, providing a reactive, not a proactive style of management.”

4.3 Range of inclusive practices

The survey asked providers about a range of typical inclusive practices for teaching, learning and assessment, including the use of technology to aid inclusion, provision of alternative formats, and alternative methods of assessment.

Some practices are common and appear to have become standard practice. In all providers, course materials were provided online, and alternative assessments and providing lecture notes in advance were offered in almost all the institutions surveyed. Attendance monitoring to help identify any potential wellbeing issues was less widespread, undertaken in approximately three quarters of providers (see Table 4.2). These practices are explored further below.

Table 4.2: Prevalence of key inclusive teaching, learning and assessment (TLA) measures?

| | Current | | Baseline | |
|---|---------|-------|----------|------|
| | Number | % | Number | % |
| Course materials online | 63 | 100.0 | 100 | 99.0 |
| Specialist software | 54 | 85.7 | 95 | 94.1 |
| Alternative assessment methods | 60 | 95.2 | 92 | 92.0 |
| Lecture notes in advance | 57 | 90.5 | 89 | 88.1 |
| Lecture capture | 50 | 79.7 | 79 | 78.2 |
| Attendance monitoring to help identify wellbeing issues | 45 | 71.4 | 75 | 75.0 |

| | | | | |
|-------|----|---|-----|----|
| Total | 63 | - | 101 | -- |
|-------|----|---|-----|----|

Source: IES Surveys 2017 and 2019; base = all respondents

The open questions in the survey and the case study interviews also provided details on the range of practices providers were adopting or considering. Indeed, there were numerous examples of how institutions were trying to adopt a more proactive approach regarding:

- **Course validation quality processes** where course teams as well as academic quality and standards colleagues would think about inclusivity at the beginning of programme development. This included scrutiny of learning outcomes and whether they were or were not competence standards (see the good practice example below).
- **Pedagogy** where academics would think about the implications of aspects of their teaching such as group work, large lectures and presentations.
- **Assessment** including use of alternative and inclusive assessments as well as the timing and regulations regarding anonymised marking and mitigating circumstances.
- **Technology** as an aid to inclusion and solution to some of the changes associated with DSA-funded support, but also ways in which the use of some software may act as a potential barrier.
- The **physical and virtual learning environment** with both 'spaces' raising different issues for groups of staff and students (see the good practice examples below).
- **Sharing good practice and learning.** A concern and disappointment highlighted in the interviews is that great ideas and examples of good practice were not always well known across their own institution. Staff working in specific areas such as learning technology, the library, estates, and those in more general services such as disability or wellbeing commented that there were often benefits derived from their membership of university-wide committees where issues relevant to disability or the broader inclusive agenda were discussed. (See the good practice examples below).

Good practice example: The Open University

Critical reader and curriculum reviewer guide and use of student profiles

The following strategies used by the Open University encourage a proactive approach that focuses course designers on the implication of curriculum design decisions on specific groups of students.

The **reader and reviewer guide** invites comments and feedback from internal and external reviewers of their programme material. It includes an equality, diversity and inclusivity checklist of issues and questions that act as prompts to consider a broad range of students. This guide builds on the idea of a checklist used by staff at course validation. It is of relevance to the OU context where materials are prepared by teams before the course is rolled out. However, the idea is transferable to colleagues offering online learning materials and in contexts where colleagues are involved in peer review of teaching. It can also be used as a prompt for students evaluating the inclusivity of their teaching and learning.

The use of **student profiles** includes descriptions of hypothetical students and acts as a basis for individual consideration and/or group discussion about the implications of curriculum design decisions. These profiles cover a range of student requirements and allow course tutors and teams designing courses or offering services such as information, advice and guidance (IAG) to reflect on the possible barriers and help them to enhance the pre-entry information they provide.

4.4 Using technology to aid inclusion

In the online survey, institutions were asked about the steps they have taken to introduce and mainstream technology-assisted learning.

4.4.1 Lecture capture

Four fifths (80 per cent) of respondents currently use audio/video recording of lectures. Of the small group of providers that did not currently use recording of lectures, most were planning to introduce this technology in the future (nine out of 13). The proportion of providers using recording of lectures is very similar to that from the baseline survey (78%).

Table 4.3: Use of audio/video recording of lectures by type of institution

| | Current | | Baseline | |
|-----------------|---------|-------|----------|------|
| | Number | % | Number | % |
| Size | | | | |
| Under 5,000 | 12 | 63.2 | 19 | 59.4 |
| 5,000 to 11,000 | 20 | 76.9 | 26 | 81.3 |
| Over 11,000 | 19 | 100.0 | 34 | 91.9 |
| Type | | | | |
| Specialist HEI | 9 | 81.8 | 12 | 66.7 |
| High tariff | 18 | 100.0 | 24 | 96.0 |
| Medium tariff | 15 | 88.2 | 20 | 87.0 |
| Low tariff | 7 | 58.3 | 17 | 70.8 |
| FEC | 2 | 33.3 | 6 | 54.5 |
| All | 51 | 79.7 | 79 | 78.2 |
| N= | 64 | - | 101 | |

Source: IES Surveys 2019; base = all respondents

All large providers, and all high tariff providers, who responded to the survey reported that they used audio/video recording of lectures. In comparison, 63 per cent of small providers, 58 per cent of HEIs with low average tariff scores, and 33 per cent of FE colleges (two out of six that responded) used audio/video recording of lectures.

One FEC noted that, although they have been piloting lecture capture, they felt it was perhaps not appropriate for them. They explained that *“it may not fit as well as it would with universities as most of the learning delivery is via small classes rather than large lectures.”*

The 51 providers that did record lectures were asked if this was video recording, or audio recording only. Just over two thirds (69 per cent, n=35) reported that they used video recording, although this is a slightly lower proportion than in the baseline survey (75 per cent). Small providers, and HEIs with low average tariff scores, were most likely to use audio recording only.

Although the prevalence of audio/video recording of lectures was very similar to the baseline survey, there has been a substantial increase in the proportion of lectures that are recorded. In the baseline survey, 23 per cent of providers (n=17) reported that more than half of all lectures were recorded, whereas in the current survey this proportion was nearly double at 39 per cent (n=18).

Table 4.4: Proportion of lectures recorded

| | Current | | Baseline | |
|--------|---------|------|----------|------|
| | Number | % | Number | % |
| 0-10% | 10 | 19.7 | 24 | 31.1 |
| 11-20% | 8 | 15.4 | 17 | 21.7 |
| 21-30% | 8 | 15.4 | 10 | 12.2 |
| 31-40% | 3 | 6.6 | 6 | 8.1 |
| 41-50% | 2 | 4.4 | 3 | 4.1 |
| 51-60% | 2 | 4.4 | 7 | 9.5 |
| 61-70% | 4 | 8.8 | 3 | 4.1 |
| 71-80% | 4 | 8.8 | 2 | 2.7 |
| 81-90% | 4 | 8.8 | 1 | 1.4 |
| 91-99% | 0 | 0 | 1 | 1.4 |
| 100% | 4 | 7.8 | 3 | 3.8 |
| N= | 51 | - | 78 | -- |

Source: IES Surveys 2017 and 2019; base = all respondents using lecture capture. Baseline n = 78 and Current = 51

Providers were asked what factors were taken into consideration when deciding which lectures were audio or video recorded. More than half of providers with lecture recording (53 per cent, n=24) said it was at the lecturer’s discretion to opt in and 20 per cent (n=9) said lecturers could opt out, while 44 per cent (n=20) said it was based on availability of technology in the lecture theatre or room. Factors influencing usage therefore span the individual and institution. Changes in usage are likely to be context specific which was very evident from the more detailed accounts given in the case studies. In the baseline (Phase one) study, an example of good practice from De Montfort University (HEFCE,

2017 p70²⁰) outlined an institutional commitment to UDL. This example covered the multiple steps taken to introduce lecture capture including gaining senior leadership to act as a champion, infrastructure changes, training, and then monitoring and evaluation to help embed the changes.

Interviews with the case study institutions in the current study suggested that where changes were happening, it was this multi-pronged approach (outlined by De Montfort) which was most effective. However, some interviewees admitted resistance remained, and that the process of change was patchy at both the departmental and individual level. A diverse response to adoption of lecture capture and wider technology changes was mentioned by interviewees in large HEIs, those with a devolved approach to change as well as by smaller specialist providers where the resources and infrastructure were a more obvious constraint. One learning technologist suggested that for some colleagues:

“It is the exciting and new that captures imagination, [staff] get easily bored by routine, yet my natural approach is to get the very basics right, rather than too much high-level innovation, that way you reach more students and it’s more sustainable.”

One case study described how they have the infrastructure in place for lecture capture throughout their campuses and an underpinning policy, and they are in the process of rolling out lecture capture and working towards its widespread use. They noted that the roll-out has had practical, logistical and technical challenges but also some more ‘philosophical’ challenges where individuals (largely academics) were resistant to using the technology with concerns over data protection, copyright, privacy, and attendance. They felt that the emerging evidence base around the positive take-up and impact of lecture capture which was proven to support learning, has helped to ‘win over’ some of these resistant colleagues and there was the feeling that soon students will expect it to be ‘part of the university package’.

Providers that recorded lectures were also asked if they used technology to caption or transcribe lectures. The majority at around two thirds (65 per cent, n=32) said they did not currently use this technology. However, 18 per cent (n=9) said that they captioned lectures that had been video recorded and 14 per cent (n=7) said that they both transcribed audio and captioned video. Approximately half of the providers using this captioning or transcribing technology made this available to all students, while the rest made it available to specific groups of students including those who had disclosed a disability.

Good practice example – The University of Huddersfield

Widespread use of lecture capture

The university has automatic video-recording of all lectures. The only reason a lecture would not be recorded would be if the tutor requested to opt out for pedagogical reasons. Recordings are available to all students, not just those with a disability or personal learning support plan, and the university monitors usage. Their latest data shows that at least half of all students had

accessed a lecture recording in the past year. Recordings are felt to enhance the learning experience particularly for widening participation students and international students or others for whom English is not their first language. The lecture capture system allows students to add bookmarks to recordings to highlight important sections, to add notes to recordings to assist their learning, and also to share bookmarks and notes with their peers.

The university is now looking at enhancing the ability to caption videos for hearing-impaired students by starting a project to use linguistic students at the university to do the captioning. This would keep the process in-house and help to reduce the costs (which would be considerably higher if using an external company).

4.4.2 Specialist software

The vast majority of providers (86 per cent, n=54) reported that they provided specialist software as part of their mainstream IT provision to students. This was slightly lower than the proportion in the baseline survey (94 per cent), although the difference was not statistically significant at the standard five per cent level. The most commonly mentioned types of software²¹ provided were:

- Mind mapping software, mentioned by 82 per cent of providers (94 per cent in the baseline survey)
- Document reading software, mentioned by 78 per cent of providers (88 per cent in the baseline survey)
- Magnification software, mentioned by 52 per cent of providers (not included as a response option in the baseline survey).

Table 4.5: What type of software is provided? (multiple response)

| | Current | | Baseline | |
|------------------------------|---------|------|----------|------|
| | Number | % | Number | % |
| Mind mapping software | 44 | 81.5 | 88 | 93.6 |
| Document reading software | 42 | 77.8 | 83 | 88.3 |
| Magnification software | 28 | 51.9 | | - |
| Speech recognition software | 26 | 48.1 | 64 | 68.1 |
| Document conversion software | 24 | 44.4 | 35 | 37.2 |
| Note taking software | 20 | 37.0 | 32 | 34.0 |
| Recording software | 17 | 31.5 | 31 | 33.0 |
| Other | 17 | 31.5 | 32 | 34.0 |
| N= | 54 | | 94 | |

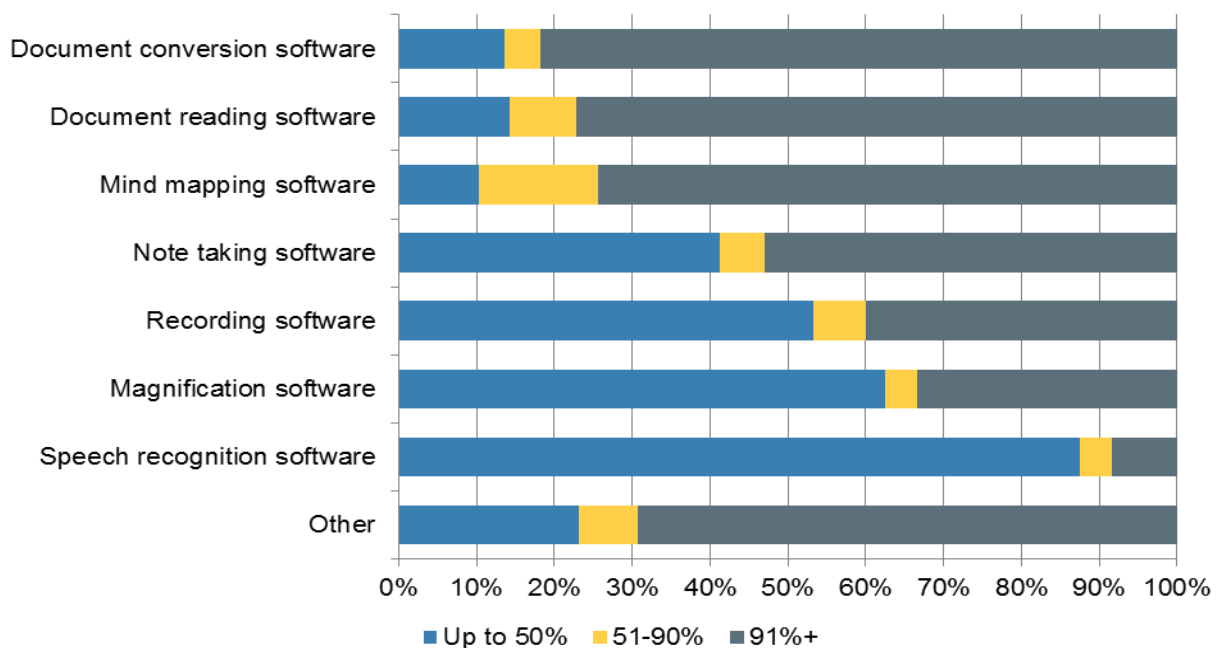
Source: IES Surveys 2017 and 2019; base = all respondents who provide specialist software

²¹ The online survey included the names of common proprietary software for each type to aid respondents in completing the survey.

Document conversion software, document reading software, and mind mapping software were the types of specialist software that were most widely available within providers that provided them, with at least three quarters of providers reporting that they were available on more than 91 per cent of computers across the provider (Figure 4.1). Speech recognition software was the least widely available, with less than 10 per cent of providers saying it was provided on nearly all computers.

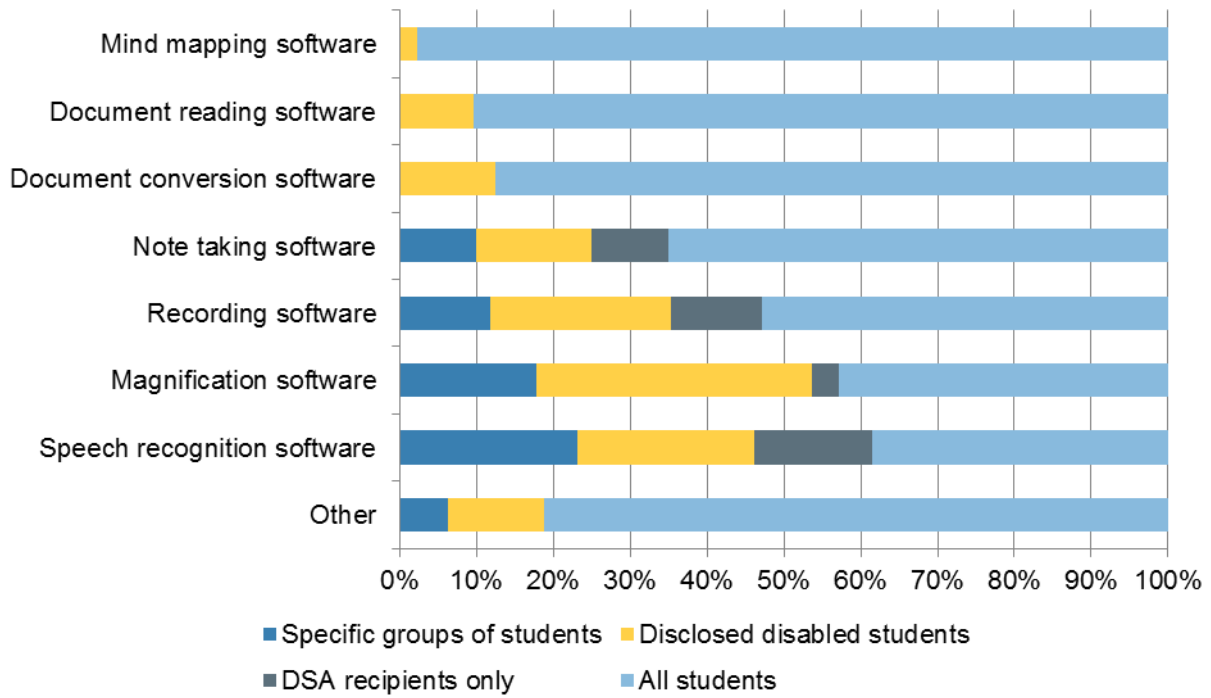
Similarly, in terms of which students can access specialist software, nearly all providers said that all of their students could access mind mapping software (98 per cent, n=43), document reading software (91 per cent, n=38) and document conversion software (88 per cent, n=21). In those providers who did not offer these types of software to all students, they were available to students that had disclosed a disability (Figure 4.2). The proportions of providers saying that specialist software was available to all students without any eligibility or qualifying criteria had increased since the baseline survey, as shown in Figure 4.3.

Figure 4.1: Proportion of computers with access to specialist software



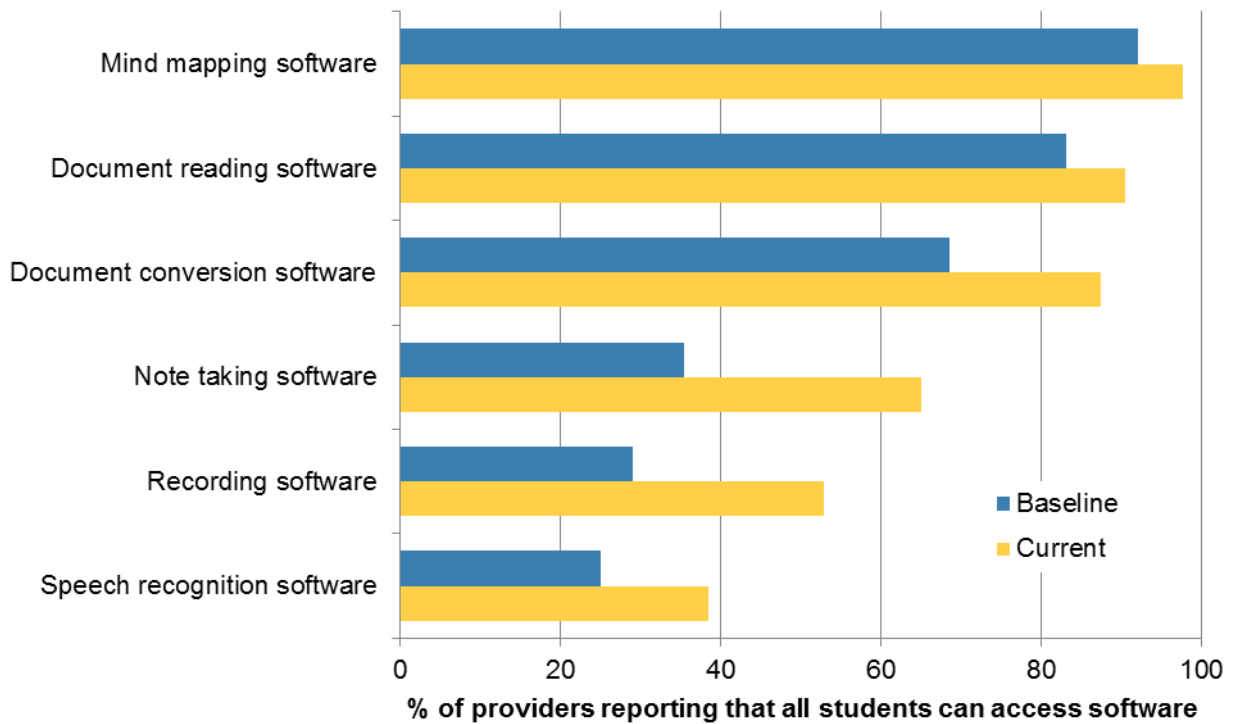
Source: IES Surveys 2019; base = all respondents who provided each type of specialist software

Figure 4.2: To which students do you offer specialist software



Source: IES Surveys 2019; base = all respondents who provided each type of specialist software

Figure 4.3: Providers reporting that specialist software was available to all students



Source: IES Surveys 2017 and 2019; base = all respondents who provided each type of specialist software

Case study interviewees explained that decisions to make technological solutions available to all students were made because it was a more inclusive approach and reduced the need for multiple arrangements needed for individual students. For several there had been an increase in this approach as they responded to changes in the DSA arrangements. At some providers, software such as mind mapping software was available on all institutional computers, while more specialised software such as voice recognition or screen reading was available on multiple computers, with priority given, if necessary, to disabled students.

The case study interviews also highlighted how mainstream software and operating systems are improving their accessibility features which can remove the need to purchase specialist or bespoke software. Similarly, they noted the variety of free software available to students which could supplement the specialist technology supplied by the institutions.

Good practice sample: Bath Spa University

Auditing the range of assistive technology (AT)

Technology is important to the university and they promote a blended approach to learning. The student support team are currently undertaking a small project to look at the ATs they have already and to check they are 'being smart in its use'. This audit will also enable the team to improve the awareness among all students of the range of 'free tech' that is available. Currently the university provides access to AT on their open access computers across campus(es) and have a smaller number of computers that have specific software to support people with specific impairments.

Monitoring use of specialist software

The baseline survey did not explore the use of specialist software so this current survey provided an opportunity to better understand what providers are doing in this respect. The survey indicated that few providers are monitoring use. Only one in four providers (26 per cent) reported that they measured the extent to which the assistive software they provided was being used by students. There was very little variation in monitoring by provider characteristics.

Where providers did undertake monitoring, most commonly this involved automatic tracking of use such as monitoring of how many times programmes were opened. This could then be used to inform changes to provision and purchase of software and licences.

“Our software is deployed using our Software Hub which records each student’s access to any piece.”

“Packages provide reports as well as individual views of learners.”

“We can count every use of the software and, in some cases, obtain details of numbers registered.”

Other methods described were to survey students receiving DSA about how they used the software, and gather qualitative feedback from individual users who were in contact with the assistive technology team. Few providers said that this monitoring fed into

planning by student services. Some case study providers who had rolled out the use of software more recently acknowledged that there were plans to monitor its use to determine if it was cost effective.

Training in the use of specialist software

The baseline study suggested it would be useful to explore the extent to which institutions were providing training in the specialist software offered to enable staff and students to use it effectively. The current survey therefore included questions to address this issue. The survey found that training was generally (but not always) provided.

Three quarters (76 per cent, n=41) of institutions reported that they provided training for students on assistive technology software and/or the accessibility features of mainstream software (not including training that is funded by DSA). Also approximately two thirds (68 per cent, n=37) provided such training to staff. In both cases, a majority of those providing training did so for both assistive technology and accessibility features. There was little variation by provider characteristics.

The importance of training in specialist software to increase its use is illustrated by the following quote from a case study interviewee:

“There are barriers to take-up such as a lack of awareness and understanding about what is out there. [The lecturers] are experts in their field but may not know about what is a suitable technological solution. For example, we’ve used augmented reality and virtual reality ... the staff don’t know those things exist but we try to help with advice and training and say, ‘This could help involve your students more, using technology in different ways’ but they need training.”

Table 4.6: Provision of training in assistive technology or accessibility features to students and staff

| | Students | | Staff | |
|---|----------|------|--------|------|
| | Number | % | Number | % |
| Yes – AT software | 7 | 13.0 | 9 | 16.7 |
| Yes – accessibility features of mainstream software | 4 | 7.4 | 3 | 5.6 |
| Yes – both | 30 | 55.6 | 25 | 46.3 |
| No | 13 | 24.1 | 17 | 31.5 |
| N= | 54 | - | 54 | |

Source: IES Surveys 2019; base = all respondents who provide specialist software

Of the 41 providers that offered training in assistive technology to students, around half (49 per cent) said that this was offered to all students, while a quarter (27 per cent) offered it only to those who had disclosed a disability, and just under a quarter (22 per cent) offered it to specific groups of students aside from those who disclosed a disability.

Good practice example – The University of Huddersfield

Dedicated assistive technology trainer

The university has site licences for a range of assistive software and they have an IT trainer with a specific role to support disabled students with accessing the full benefits of assistive technology. The trainer will work with students who receive specific software as part of their DSA award. They provide one-to-one support after the initial training from the software provider has finished. They feel it is essential that DSA students get additional training on top of that included in the DSA award, otherwise a lot of students don't know how to use the assistive technology to its fullest potential. The trainer also offers bookable training sessions available to any students and staff.

In addition, the university's IT trainer supports accessible formats for learning materials, with a range of activities including a weekly email to lecturers with accessibility tips of the week. These tips include, for example, not using serif fonts, and ensuring minimum font sizes for documents and presentations. The trainer also highlights to lecturers the built-in accessibility checker features of mainstream software. The university also uses a third-party tool, 'Blackboard Ally', to help with ensuring documents are accessible. They estimate that around one in five students across the university needs accessible content. Other work with lecturers includes software demonstrations that simulate dyslexia and colour blindness, to help them understand the issues students might face when materials are not fully accessible.

4.4.3 Digital accessibility

A new section was added to the current survey which focused on digital accessibility. This was added to take account of the new accessibility requirements for public sector bodies, including HEIs, which were introduced in September 2018 (since the baseline study). The regulations require providers to make their websites or mobile apps more accessible by making them 'perceivable, operable, understandable and robust'²². They require providers to meet the international Web Content Accessibility Guidelines (WCAG) accessibility standard (2.1 AA) and to publish an accessibility statement that explains how accessible their website or app is.

Four fifths of providers (80 per cent, n=47) said they offered a range of alternative formats for the same content, such as Word, PDF, HTML, audio and sign-video. There was little variation in the proportion offering alternative formats by provider characteristics. Practice ranged from providing alternative formats on request, on a case-by-case basis, or at the discretion of the tutor or lecturer, through to using branded VLE tools to assist with automatically providing alternative formats. The latter was a new approach for some, with a few providers who currently had a request or case-by-case system reporting that they would be using tools for format conversion in the next academic year. Some providers specifically mentioned providing materials in braille, or as captioned videos (e.g. video assignment briefs), while others mentioned providing guidelines for staff on creating accessible materials.

²² See gov.uk guidance on understanding the new accessibility requirements for public sector bodies. <https://www.gov.uk/guidance/accessibility-requirements-for-public-sector-websites-and-apps> (accessed 15 September 2019).

“All course material is available online for students to print/read in preferred format.”

“[Branded tool] procured to enable students to automatically request alternative formats onto VLE.”

Working towards meeting digital accessibility standards

Providers also reported a range of steps they had taken to ensure that online course materials met digital accessibility standards, including:

- Producing WCAG, including use of heading styles (to provide a standard format that is readable by the majority of assistive technology), use of colour and adding alternative text for images.
- Producing good practice inclusivity guidance for staff, with some providers reporting that this included UDL principles.
- Developing a specific policy or including this within a wider accessibility and inclusive learning policy.
- Convening working groups to specifically address this agenda.
- Gathering advice from internal and external specialists (e.g. learning technologists), having dedicated staff with a remit to support digital accessibility, and providing training for staff.
- Undertaking reviews or audits of their VLE.
- Using integrated accessibility checking tools on VLEs.

The following quotes illustrate the range of providers’ responses:

“We recently won an internationally recognised award from [VLE supplier] for the extent of content that was available in accessible formats online. Our centre for enhancement in learning and teaching plays a lead role in assisting students to get the best out of this feature.”

“At [university] we have guidance on inclusivity for teaching and learning support. This includes UDL principles in planning for diversity. In 2015 guidance on the creation of inclusive learning resources was formally approved via committee. Workshops on the creation of inclusive learning resources ran during 2016/2017 to support the embedding of digital inclusivity skills across the university. Microsoft Office 365 is available across the whole university. The accessibility features of Office 365 and creation of accessible learning content is included within our mandatory [name] programme which has trained 560 staff since it began in 2018. The guidance and training is now supplemented by regular accessibility-focused articles such as ‘Inclusive Sway presentations’ and ‘Inclusive PowerPoint presentations’.”

“Our technology enhance learning team make every effort to ensure materials produced by them are accessible. Teaching staff are encouraged to engage with the team in the creation or refresh of course material. The accessibility regulations have

an additional level to consider and this is currently being worked through and an accessibility action group being formed to address this.”

“The education strategy has a working group which includes a project about universal design, which will need to switch from promoting best practice to being about compliance. We expect to initiate a rolling programme of support, followed by compliance checking for academic staff, in the same way we have approached copyright compliance.”

“The university has developed a digital accessibility toolkit for teaching staff. This toolkit provides clear guidance on how to create accessible content with a focus on: structure, provision of text alternatives, use of accessible colours and use of descriptive text in links and headings. The toolkit is supported by a suite of professional development opportunities which run throughout the year. The university has also promoted the availability of [accessibility checker tools] in the university’s VLE, to enable staff to check for accessibility errors in content they create directly in the VLE. A ‘health check’ of modules in the VLE is undertaken prior to the start of each semester to identify accessibility issues. A report detailing any issues identified is sent to schools along with recommendations on potential actions to resolve. An accessibility audit of the library webpages and content was commissioned in May 2018.”

The importance of specialist staff to support digital inclusion was illustrated in one case study. The university noted how it had a team of learning technologists who have a responsibility for digital inclusion, and they provide guidance within academic areas/departments. This group is about to be renamed and reorganised as part of the re-structuring process but their role remains the same. They reported that the group regularly comes together, and was recently responsible for the revamp/relaunch of the university’s VLE in order to make it more accessible. They have also been involved in supporting the roll-out of lecture capture.

Supporting staff with digital accessibility

The responses to the open text question asking how providers have taken or are taking steps to ensure digital accessibility highlights the importance they place on supporting staff. The methods used to do so include working to raise awareness, training and workshops (face to face or via webinars), development and distribution of guidance or toolkits, and provision of good practice examples.

Nine out of 10 providers (90 per cent, n=54) said that they provided guidance to teaching staff and other content creators to ensure that they were creating accessible digital content. All providers that had a digital accessibility statement said that they provided guidance on accessibility to content creators, compared with 82 per cent of providers without a digital accessibility statement. Similarly, a higher proportion of providers who considered digital accessibility in learning resource procurement or in mainstream IT procurement reported that they provided accessibility guidance (95 per cent, compared with around three quarters of those that did not consider accessibility in learning resource procurement or mainstream IT procurement).

One case study institution highlighted the importance of providing staff training for digital accessibility and how this needs to be broader than covering basic accessibility regulations to think about how to create content in this new context:

“The VLE platforms are being improved and updated in such ways that staff are able to create more accessible resources by default or will be helped by the platform to spot accessibility issues in their content and fix them accordingly.”

“However, we are asking our academics and support staff to use and share digital assets on these digital platforms (VLEs, intranets, websites etc.) but we do not train them in how to write for those platforms. They know how to write a report, minutes of meetings etc. including the type of voice and language to use. But when it comes to creating content that will be shared and consumed on a screen or a mobile device, [staff] do not think of how to write appropriately.”

Digital accessibility statements

Around two fifths of providers (41 per cent, n=24) reported that they had a digital accessibility statement in place, although the open text responses indicate that for some of these this statement is still being formulated. Larger institutions were significantly more likely to have a statement: 65 per cent of HEIs with 11,000 students or more reported that they had a statement compared with 42 per cent of medium-sized providers (5,000-11,000 students) and 18 per cent of small providers (under 5,000 students).

Consideration of digital accessibility in procurement

Nearly three quarters of providers (72 per cent, n=42) reported that they formally considered digital accessibility as part of procurement of learning resources. A similar proportion (69 per cent, n=40) reported that they formally considered digital accessibility as part of mainstream IT procurement. Open text responses indicated that this is often a formal part of the tender process and/or set out in the procurement policy.

There was a strong correlation between the two groups. Around nine out of 10 providers that considered accessibility in learning resource procurement also considered accessibility in mainstream IT procurement. In contrast only one in five providers that did not consider accessibility in learning resource procurement reported that they did consider it in mainstream IT procurement.

There were substantial differences in considering digital accessibility in learning resource procurement by institution size, with only half (50 per cent) of small providers doing so compared with 89 per cent of medium-sized providers and 76 per cent of large providers. Furthermore, providers with a digital accessibility statement were significantly more likely than those without a statement to formally consider digital accessibility as part of learning resource procurement (88 per cent and 61 per cent respectively).

Challenges with digital accessibility

The current survey asked providers about the challenges, if any, they have encountered in implementing the new digital accessibility regulations on accessibility of websites and

mobile applications. The responses indicated that this is posing a substantial challenge to many providers.

A key challenge was a lack of understanding of the requirements across institutions (outside of the specific disability support team) and among suppliers, and a lack of technical capability within institutions. However, even within disability support a proper understanding of the requirements of the regulations, including their scope and timelines, was mentioned as a challenge by some providers. For example, several providers were uncertain whether they would need one overarching statement or one for each system they operate. This group also felt that sector-level guidance had at times seemed contradictory. The scale of the work, due to the size of providers' websites and the vast number of content authors, coupled with limited resources available particularly among small providers, was also mentioned. Other challenges noted included control over ensuring accessibility in third-party systems and understanding who should take responsibility for or lead this work within their institution.

“Challenges have been in understanding and raising awareness of the requirements derived from the web accessibility directive and ensuring sufficient capacity and capability is in place to deliver them.”

“Current dilemmas concern whether separate accessibility statements are required for the library website, the VLE etc. in addition to the university statement. Another significant challenge in meeting the requirements of the regulations relates to distributed authorship of content and ensuring that all staff have access to, and are aware of, guidance and support to ensure content is produced in an accessible format and that existing content is checked and, if necessary, modified to be accessible to users.”

“Getting buy-in from academics. Time to review and update resources. Lack of technical staff awareness, lack of technical staff, lack of preparedness from suppliers.”

“Lack of information, particularly with relevance to HEIs. Understanding the scope of regulations, as well as roles and responsibilities across the institution for leading and implementing change. Additionally, given our STEM focus, there doesn't seem to be a uniform understanding of accessibility (e.g. maths/chemical equations), with no easy solutions and requiring technically demanding skills that take time to establish and develop.”

“Mainly resources. We are a small specialist institution with limited staff and financial resources to implement changes in the ways that we would ideally like. However, we did form a working group to determine how we could ensure we were compliant.”

“Similar to across the sector, lack of clarity around what needs to be covered, especially when determining what is classed as a 'substantial revision' for VLEs. A lack of appreciation by Government Digital Service about some of the technical challenges in ensuring content, especially multimedia content, will be accessible. Also, in relation to accessibility statements – our interpretation is that we will need a

separate digital accessibility statement for each system, i.e. one for VLE, one for library catalogue etc. not a single statement.”

“The challenge is minimal in terms of those services that are completely within the control of the university library. However, we may have limited control over third-party systems and therefore could be constrained in terms of what can be achieved.”

“The main challenge is a clear definition of what we need to include in scope for the respective three deadline dates. Depending on scale, the university (Accessibility Action Group) will need to make a decision on what must be completed by deadlines, what else should be considered as improvements to service and what we might consider to be a ‘disproportionate burden’ for us to fix at the moment.”

4.5 Other teaching and learning inclusive practices

The online survey asked providers to indicate which steps they had taken to help to ensure that learning resources were inclusive. Table 4.7 shows that nearly all providers responding to the survey said they offered: reasonable adjustments (97 per cent), electronic versions of books (95 per cent), guidance and support (94 per cent), hardware solutions (e.g. laptops, induction loop technology, 94 per cent), and software solutions (e.g. for document reading, conversion or magnification, 90 per cent).

Table 4.7: What steps have you taken to ensure that learning resources are inclusive? (multiple response)

| | Number | % |
|---|--------|------|
| Reasonable adjustments | 60 | 96.8 |
| e-versions of books | 59 | 95.2 |
| Hardware (e.g. laptops, induction loop technology) | 58 | 93.5 |
| Guidance and support | 58 | 93.5 |
| Software (e.g. for document reading/conversion/magnification etc) | 56 | 90.3 |
| Documents with adjustable fonts/sizes | 54 | 87.1 |
| Staff with specific expertise | 51 | 82.3 |
| Training in assistive technology | 44 | 71.0 |
| Documents in Braille | 31 | 50.0 |
| Other | 9 | 14.5 |
| N= | 62 | |

Source: IES Surveys 2019; base = all respondents

Although comparisons with the baseline survey are not exact due to the change in the way the question was asked (open text in the baseline survey, response categories in the current survey) there appears to be a noticeable increase in both the proportions and actual numbers of institutions who are considering the accessibility of their learning resources by providing, as a matter of routine, software and e-versions of materials.

Interviewees confirmed this was a ‘quick win’ and an example of where the wider group of students benefitted, such as students for whom English was an additional language (EAL) or groups covered by their APP.

When asked about the extent to which expectations of inclusive learning were embedded within the formal processes around module and programme approval and evaluation, one third of providers (34 per cent, n=21) said it was already embedded within formal processes, and 23 per cent (n=14) said that it was taken into account but was not mandatory. In addition, 37 per cent (n=23) said that it was currently being developed or under review. Thus over 90 per cent of providers had already embedded inclusive learning within formal programme development processes, or were planning to review and improve embedding.

4.5.1 Notes in advance

Nine out of 10 providers (91 per cent, n=57) reported that they provided lecture notes in advance, very similar to the proportion in the baseline survey of 88 per cent. Small providers were much less likely to provide notes in advance (74 per cent, compared with 96 per cent of medium-sized providers and all large providers in the survey), as were FECs (50 per cent, compared to 80 per cent of specialist HEIs and nearly all mainstream HEIs).

The proportion of those who provided notes to all students, rather than being selective about who could receive notes in advance, was also very similar to the baseline survey, at 46 per cent (n=26) compared with 45 per cent in the baseline survey. Where notes were not provided to all students (n=31), nearly all providers (94 per cent, n=29) said that notes would be provided if it was in the student’s support plan, and just over half (55 per cent, n=17) said that it was at the lecturer’s discretion, while a quarter (23 per cent, n=7) said that notes were provided on request.

4.5.2 Course materials online

All responding providers said that they made course materials available online; in the baseline survey, all but one responding provider said they made materials available online.

When asked the nature of online materials in a multiple response question, the most commonly mentioned materials were: course handbook (97 per cent); PowerPoint presentations (97 per cent); reading lists (95 per cent); lecture notes (87 per cent); and audio files (86 per cent).

Table 4.8: Types of course materials made available online (multiple response)

| | Number | % |
|--------------------------|--------|------|
| Course handbook | 61 | 96.8 |
| PowerPoint presentations | 61 | 96.8 |
| Reading lists | 60 | 95.2 |
| Lecture notes | 55 | 87.3 |

| | | |
|---------------------|----|------|
| Audio files | 54 | 85.7 |
| Interactive quizzes | 49 | 77.8 |
| Video files | 49 | 77.8 |
| Other | 4 | 6.3 |
| N= | 63 | |

Source: IES Surveys 2019; base = all respondents

4.5.3 Alternative assessment methods

Nearly all providers, 95 per cent of survey respondents, said they offered alternative assessment methods; in the baseline survey, a very similar proportion, 92 per cent, reported that they offered alternative assessment methods. The most commonly cited examples included:

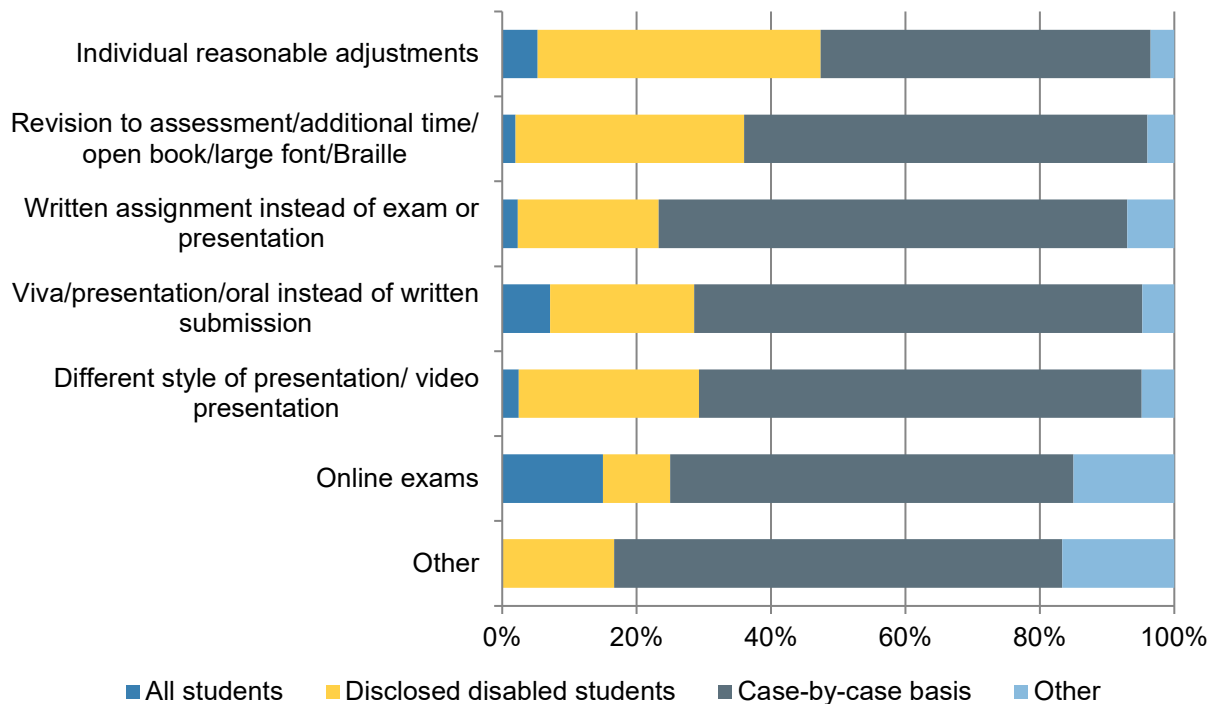
- Individual reasonable adjustments for assessment (95 per cent)
- Revision of assessment or additional time given to students (including open book, large font, Braille) (83 per cent)
- Written assignment instead of exam or presentation (72 per cent)
- Viva or presentation instead of a written submission (70 per cent)
- Online exams (33 per cent).

Table 4.9: Use of alternative assessment methods (multiple response)

| | Number | % |
|---|--------|------|
| Individual reasonable adjustments | 57 | 95.0 |
| Revision of assessment/additional time/open book/large font/Braille | 50 | 83.3 |
| Written assignment instead of exam or presentation | 43 | 71.7 |
| Viva/presentation/oral instead of written submission | 42 | 70.0 |
| Different style of presentation/video presentation | 41 | 68.3 |
| Online exams | 20 | 33.3 |
| Other | 7 | 11.7 |
| N= | 60 | - |

Source: IES Surveys 2019; base = all respondents who offered alternative assessments

Very few providers offered alternative assessment methods to all students, as Figure 4.4 shows. Assessments were commonly considered on a case-by-case basis, although in a sizeable minority of providers, alternative assessments were routinely offered to students with a disclosed disability, particularly as an individual reasonable adjustment.

Figure 4.4: Eligibility for alternative assessment methods

Source: IES Surveys 2019; base = all respondents who offered alternative assessments n=XX

In the 2017, the baseline or Phase one report (p73²³) highlighted the difference between alternative and inclusive assessment, with the former often targeted at individual students based on offering a reasonable adjustment. An inclusive model of assessment would not only offer choice, but potentially involve the re-design of assessment strategy to remove the need for reasonable adjustment. Also it could include students playing a more active role in the development and design of assessments which allows them to demonstrate their achievement of learning outcomes in a variety of ways.

“Inclusive assessment: I think we are at the beginning of a journey, and that includes inviting students [to say what they think] and what inclusive assessment might be, but we are working against [academic colleagues] who have a definite idea about assessment. Optionality [giving students a choice of alternatives] is a first step and then moving to students developing their own [assessment] co-authorship.”

One case study institution described the reluctance to move to fully inclusive assessment. They noted the ways in which, across the institution, flexibility is offered for assessments and adjustments are made around exams e.g. solo room, extra time, frequent rest breaks. Generally adjustments are made on a case-by-case basis and require evidence of a need such as a letter

from a GP/medical professional. They are finding that some course models and individuals have a more open approach to alternative assessments. They note that some academics are starting to think more generically about alternative assessments 'without nudging', and are starting to offer alternative assessments more holistically. However, they have experienced some reluctance to introduce a suite of alternative assessments across the university as standard. For some academics, alternative assessments are regarded as setting a 'dangerous standard or attack on standards'. They felt there perhaps needs to be a debate about what alternative assessment means, particularly in the context of concerns about academic quality.

Another case study institution reported a recent pilot exploring the use of digital exams which again highlighted concerns about the widespread use of alternative assessments. Before the pilot it was assumed students would support the initiative, however the initial feedback highlighted several student concerns. They were worried about technology failure or the noise and distraction from others during the exam, as well as the unfamiliarity of this format.

Uncertainty of new or novel forms of assessment also appeared to raise concerns amongst students and staff in other institutions.

"Globally with technology moving on, do we have the right models for assessment, should we be including other forms? ... It's quite new and we are fighting an entrenched system. People are reticent about change; it will take a while before new activities can be introduced. We try and encourage [programme] teams to introduce new activities that are not assessed; we have to ensure that learning outcomes are constructively aligned. ... Any change that will have an impact on tutors takes time [because] you have to introduce different criteria."

4.5.4 Attendance monitoring

Just under three quarters of providers (71 per cent, n=45) reported that they used attendance monitoring to help identify any potential wellbeing issues among students. This is slightly lower than the proportion in the baseline survey of 75 per cent but the difference was not statistically significant. A further 18 per cent (n=11) said that they monitored attendance but not for the purpose of identifying potential wellbeing issues, and 11 per cent said that they did not monitor attendance.

Institutions that undertook attendance monitoring did it in various ways. Just over three quarters (78 per cent) of institutions said they monitored attendance for all courses. A substantial group (44 per cent) reported that attendance monitoring was used where a professional body requires it. A much larger proportion (71 per cent) said they monitored attendance for visa compliance purposes. The proportion of providers saying that they monitored attendance for visa compliance has increased substantially since the baseline survey, which may reflect the changing environment regarding immigration. It should be noted that as the questions were asked in different ways in the two surveys comparisons are not truly like-for-like. In the baseline survey respondents were asked to give details of their attendance monitoring, whereas in the current survey respondents were presented with a number of options and asked to tick all that applied.

In addition, the current survey indicated that many institutions had systems in place to report low attendance to student services. Two in five providers (40 per cent) reported

that staff flagged low attendance to student services, and 26 per cent of providers had an automatic system which flags up low attendance to student services.

Table 4.10: Attendance monitoring methods

| | Current | | Baseline | |
|---|---------|------|----------|------|
| | Number | % | Number | % |
| Staff flag low attendance | 22 | 40.0 | 36 | 40.9 |
| Monitoring on all courses | 43 | 78.2 | 28 | 31.8 |
| System flags low attendance automatically | 14 | 25.5 | 24 | 27.3 |
| Monitoring on some courses | 8 | 14.5 | 18 | 20.5 |
| Piloting | 8 | 14.5 | 8 | 9.1 |
| Visa compliance | 39 | 70.9 | 8 | 9.1 |
| Where professional body requires it | 24 | 43.6 | N/A | N/A |
| Other | 5 | 9.1 | 7 | 8.0 |
| N= | 55 | | 88 | |

Source: IES Surveys 2017 and 2019; base = all respondents who undertook attendance monitoring

Note: Caution should be exercised when comparing results between the two surveys due to the change in question approach from open text to closed multiple response.

4.5.5 Learning analytics

A new question was added to the current survey to explore the use of learning analytics to monitor engagement such as logging onto the VLE, and going to the library. Just over half of providers (55 per cent, n=34) said that they used learning analytics in this way. The survey responses provided further detail on how these were used and supported, with several noting the use of swipe cards to monitor access to library, capturing data around VLE use, and student dashboards. The responses also indicated that several institutions felt this was limited and so were working to develop this through projects or small trials.

There was considerable (and statistically significant) variation by type of provider in the use of analytics. It was considerably more common among HEIs with low average tariff score than among those with high tariff score (around nine out of 10 compared with one in three HEIs with high average tariff scores). There was also a strong association between using learning analytics to monitor engagement and their self-rating of inclusiveness. Those who rated themselves highly for providing an inclusive model of support were more likely to use learning analytics to monitor engagement than those who rate themselves lower down the scale. Of those institutions who used learning analytics to monitor engagement, the vast majority placed themselves at '6' or higher on a scale of 1 to 10 where '1' represented not inclusive and '10' represented fully inclusive. This compared to around one third of those who rated themselves at '5' or less.

4.6 Physical accessibility

Just under two thirds of providers (63 per cent, n=38) in the current survey reported that they had an accessibility plan, up from half of providers (52 per cent, n=57) in the baseline survey. There was little variation by provider characteristics such as size and tariff group.

In terms of the accessibility of the physical estate, Table 4.11 shows that:

- Around a quarter of providers (27 per cent) felt that only a very small proportion of their **accommodation** spaces were fully accessible²⁴, that is, less than 10 per cent of buildings/estate were felt to be fully accessible. However, one in five (20 per cent) felt that at least 80 per cent of their accommodation spaces were fully accessible. Views on the accessibility of accommodation were slightly less positive than they were in the baseline survey, where 22 per cent of providers felt that only 10 per cent or less of their accommodation was fully accessible, and 29 per cent felt that at least four fifths were fully accessible.
- Just over half of providers (53 per cent) felt that at least four fifths of their **teaching and learning facilities** were fully accessible, although this is slightly lower than the proportion in the baseline survey of 60 per cent.
- Almost half (46 per cent) of providers reported having over 90 per cent of their **social and recreational space** as fully accessible, and the vast majority (95 per cent) reported that at least half of their social and recreational spaces were fully accessible. These proportions are very similar to those in the baseline survey.
- Seven out of 10 providers (71 per cent) felt that over 90 per cent of their **library** space was fully accessible (providers were not asked about library space in the baseline survey).

Table 4.11: Proportion of different estate elements that are approaching full accessibility

| | Accommodation | Teaching and learning facilities | Social/recreational spaces | Library |
|--------|---------------|----------------------------------|----------------------------|---------|
| 0-10% | 26.5 | 3.5 | 0.0 | 0.0 |
| 11-20% | 8.2 | 1.8 | 0.0 | 0.0 |
| 21-30% | 8.2 | 0.0 | 0.0 | 1.8 |
| 31-40% | 10.2 | 0.0 | 0.0 | 0.0 |
| 41-50% | 2.0 | 5.3 | 5.4 | 0.0 |
| 51-60% | 8.2 | 1.8 | 0.0 | 0.0 |
| 61-70% | 6.1 | 8.8 | 5.4 | 3.6 |
| 71-80% | 10.2 | 26.3 | 16.1 | 7.1 |
| 81-90% | 12.2 | 22.8 | 26.8 | 16.1 |

²⁴ As in the baseline study, we have used the term 'fully accessible' but acknowledge that buildings, facilities and spaces cannot ever be fully accessible for all people.

| | | | | |
|---------|-----|------|------|------|
| 91-100% | 8.2 | 29.8 | 46.4 | 71.4 |
| N= | 49 | 57 | 56 | 56 |

Source: IES Surveys 2019; base = all respondents

The case studies highlighted the work that providers are undertaking to support accessibility of their estate and the types of spaces required for different purposes and disciplines.

Good practice example: University of Warwick

Accessible spaces for studying, learning and teaching

1. Accessible sensory study rooms

Across the library and learning grids there are bookable rooms providing a range of software and additional facilities including different types of seating, lighting and resources. Currently there are seven rooms with details of the facilities described and publicised on the library website. For example, one room contains various lighting options including a bubble tube and LED strip lighting, different seating options include a rocking chair, bean bag, soft seating and wobble cushion; relaxation music and headphones are available at the computer, and various sensory objects and a yoga mat are also available.

2. Teaching grid

To encourage and provide support for staff to experiment and access training, Warwick have a 'teaching grid' which is a large flexible space which can be divided in different ways. It contains a range of equipment and resources and provides opportunities for academics to access a range of services to support inclusive teaching, join colleagues in discussing teaching and learning or access good practice from a database of teaching ideas generated by other academics or postgraduates who teach.

The case studies also indicate how the involvement of staff with responsibility for digital accessibility in a wider accessibility team can highlight both the interconnectedness of many parts of the inclusivity agenda, and also the benefits of staff coming together on cross-cutting issues regarding accessibility.

Good practice example: University of Cambridge

Accessibility committee – an opportunity to make connections, learn from others and share expertise

The university has a sub-committee involving colleagues from across the university to discuss a wide range of accessibility issues: "We discuss access to buildings, new building plans, access to buses and access to learning materials". This can involve discussion about new software to support staff and students, and more recently the new accessibility EU legislation covering websites and virtual learning environments.

This committee meets four times a year and its broad agenda benefits colleagues by raising their awareness of accessibility from the perspective of other specialists within the university. For example, from a learning technology perspective there is an appreciation of the unique challenges in terms of infrastructure, the restrictions associated with a listed building, the space

required for wheelchair access or turning circles, the restrictions on changing electrical points which impact on where equipment can be located, the needs of lecturers when working within a space or the influence of particular pedagogical approaches which raise different accessibility challenges.

Membership of committees as well as institutional networks or institutional working groups can provide a valuable opportunity for colleagues to learn from one another. This provides a more informal source of professional development: "It's like a kind of osmosis, keeping ideas in the forefront and keeping abreast of new ideas, ... because I sit on the accessibility committee, I can draw on contacts and ideas for some of the project boards I sit on ... which is helping me with the current big drive to promote web accessibility".

Committees and networks also serve to build relationships which are an important basis for collaboration. For example, the head of the disability resource centre and a learning technologist both sit on the accessibility and digital learning committees and have a close working relationship which has supported the development of web accessibility guidelines and VLE that has benefitted from their respective areas of expertise

4.6.1 Accessibility checklist

In the current survey, 85 per cent (n= 51) of providers reported having an accessibility checklist for use by estates staff involved in new builds and redesigns. This represents a large increase as in the baseline survey just under half of providers (47 per cent) used an accessibility checklist. Most commonly this included relevant legislative requirements such as Document M; building regulations such as the updated British Standard BS8300; local authority Disability and Discrimination Act (DDA) requirements; Equality Act; Health and Safety Act etc.). Several also had their own internally designed checklist which some noted was aimed at exceeding the legal requirements, and/or noted the involvement of specialist support (such as that provided by DisabledGo). One institution noted they had used Advance HE's process checklist for managing inclusive building design for HE.

Six out of 10 providers (60 per cent) said they had a named individual in estates who was responsible for providing internal advice in the organisation on physical accessibility. This represents an increase from the baseline survey (up from 51 per cent). Larger institutions were more likely to have a named individual in estates providing advice on physical accessibility (83 per cent) compared to medium and small providers (48 per cent and 50 per cent respectively). This is likely to reflect the larger staff resource. The open text responses indicated that this accessibility lead in estates was often at a senior level, and worked with both their institution's disability/support services and third-party organisations, and attended key internal committees.

In addition, many (43 per cent of) providers said they provided specialist accessibility training to estates staff. This was slightly higher than the proportion in the baseline survey of 36 per cent. This could include disability awareness training, Disability Confident training, training in unconscious bias, training on relevant legislation, or general equality and diversity training. These types of training were generally provided to all staff including estates staff. However, training for estates staff could also involve more tailored and

specific training such as training porters on how to correctly use 'Evac chairs' and emergency egress from buildings.

"We provide [training in] patient manual handling in emergency situations to all our front-of-house staff and porters so that in the event of an emergency we are fully equipped to ensure their safe transit out of the premises. No other formal training is provided."

"Training is provided through providing specific advice on projects, presentations at team meetings and departmental talks and update bulletins. In addition the department has trained access consultants to work within the department as technical advisors."

4.7 Overall progress towards inclusive provision

As indicated in Chapter 1, inclusive practice is a key goal for the sector. This survey not only provides details on what this means to providers and what they are doing to achieve this but also provides feedback on how well providers feel they are doing in terms of inclusive practice and provision. In addition, the survey explores how providers have used the additional funds provided by the OfS to support the development of inclusive models of provision.

As in the baseline survey, the wording of the current online survey reminded providers about the additional funding from OfS:

In 2016/17 the funding delivered to HE providers for support and provision for disabled students was set at twice the previous amount (from £20 million to £40 million). The purpose of the increased investment has been to support HE providers to further develop inclusive models of provision and to meet the rapid rise in students reporting disabilities. This level of funding has since been maintained, to include the 2019/20 academic year.

4.7.1 Use of additional OfS funding

The survey asked institutions to provide details about how the additional funding had been used in the last two years. It was most commonly used to:

- **Replace support previously funded by DSA** (78 per cent, n=47)

Respondents described how the additional budget was used to replace the funding for Band 1 and 2 support which had previously been funded via DSA. Most providers said that they now funded this Band 1 and 2 support themselves, such as note takers, practical mobility support/campus assistance/orientation, exam support, readers, audio description, scribes and mentors. This was commonly resourced using staff directly employed by providers but in some cases this support was purchased externally. Some providers reported that they had set up a reasonable adjustments fund, which considered adjustments on a case-by-case basis, and one provider said that this fund had now fully replaced DSA. Respondents also described how the additional budget

was used to help those not eligible for DSA support, to provide some Band 3 and 4 support, to provide discounts for campus accommodation, and hardship funding.

One case study institution explained how the funding is used to provide interim support for those waiting for DSA support, for those needing support on top of the DSA support (excess DSA), and for those not covered by the DSA (e.g. international students). They also noted that they have seen a shift over time in the use of the DSA funding in terms of what students are accessing. Interestingly they have found that students do not always take up all the support they are entitled to. This can be challenging on a number of points, particularly as students are not able to access additional university-funded support until they have used all of their DSA-funded support (if eligible). The university is not sure why this is happening but are looking proactively into this. Anecdotally they feel it is due to “DSA not always being user friendly, and generally clunky ... and inherently problematic”. “Students get lost between all the different communication streams. For example, they get a needs assessment report from one agency, communications from student finance, communications from the university support service, communications from the NMH provider, and then the student has to make arrangements with the provider. They have seven to eight different communication ‘hurdles’ to overcome before any support is received.” This is particularly the case for new undergraduates (although there is a recognition that for continuing students the system is much ‘lighter touch’) and can also be problematic for undergraduates transitioning to postgraduate study who don’t realise they have to re-apply.

■ **Introduce or expand assistive technology** (68 per cent, n=41)

Comments here noted how the funding allowed for: additional staff resource to be secured such as a new post of AT manager, AT trainer or advisor or even the development of an AT centre; projects and pilot studies to be funded (e.g. lecture capture project, lecture captioning project); a significant increase in the amount of loan equipment for students and/or renewal of equipment when required; and development of new or expansion of existing resources for students. The latter commonly involved software licencing – such as renewing specific software licences, expansion of single-use licences or purchase of site-wide licences – and also installing software on more or all computers.

■ **Expansion of staff in disability services** (53 per cent, n=32)

This included being able to employ additional full-time or part-time staff and developing new roles, which providers felt was critical in being able to meet rising student demand. These additional staff and new roles included specialist staff such a dyslexia tutor and autism specialist, but most commonly mental health practitioners and advisors, wellbeing advisors and counsellors. Other roles that were funded through the additional money included: support workers; inclusivity assistants and accessibility advisors; dedicated AT staff (as noted above); and general disability advisors (expanding caseload capacity) or assistants (which one respondent noted would allow advisors more time to work with academic staff). One provider had created a new academic post – a lecturer in musicians’ health and wellbeing.

■ **Improve inclusivity of teaching and learning** (50 per cent, n=30)

Improvements described here included supporting the development or purchase and then roll-out of lecture capture, investing in new technology and associated training, offering more alternative formats, purchase of additional specialist resources such as

Braille transcription and e-books, and funding of a dedicated staff member to focus on inclusive practice. Training, advocacy and guidance in inclusive teaching and learning approaches were also mentioned as something the additional funding was used to support, for example funding attendance at relevant conferences, developing a training package and toolkit for academic staff, and developing an inclusive assessment and feedback policy. One provider described how they had used the funding to deliver a suite of projects aimed at enhancing inclusive approaches to teaching and learning. Another noted that they were undertaking a complete accessibility audit of teaching materials.

■ **Additional training/resources** (37 per cent, n=22)

Comments here included using the funding for CPD and training for disability support staff, development of e-learning resources, bespoke training for security and accommodation staff, mental first aid training, mindfulness workshops, and training of in-house NMHs, and training in the use of inclusive resources. Thus the funding was used to enhance training and related resources for both staff and students.

The vast majority of providers (91 per cent, n=53) reported that they would have made at least some of these changes if the additional funding had not been provided. However, their comments suggested that the additional funding had enabled a more comprehensive and speedier response to meet students' needs, enabled a wider group of students to be supported, and enabled wider collaboration, communication and liaison. Some providers, however, felt they wouldn't have been able to make the changes needed without the additional funding. One such provider noted how they were a small institution and so budgets were difficult to increase without additional external funding. Another noted that they had undergone a series of staff redundancies so without the funding it would have been difficult for them to adequately resource their support.

A small group (15 per cent, n=9) said that they would have made all of the changes without additional funding. These providers tended to comment that it was a legal requirement to do so, and so they had legal obligations to make reasonable adjustments. They also described having an inclusive offer which they needed to deliver. Others mentioned that the changes were essential activities and critical areas of development for students and so funding would have been obtained from other sources if needed.

A further question in the online survey pressed respondents on how they ensured disability issues were fully reflected in their APPs or statements to promote inclusion and remove barriers to participation and success for disabled students (as encouraged by the OfS). The comments here included aspects such as:

- Drawing on senior-level support
- Taking a cross-institutional approach involving close collaboration between staff (for example between disability services and careers and employability teams) and representation on relevant committees and working groups
- Involving disability support/student services and student representatives in the development of the plan/statement

- Devising suitable internal key performance indicators (KPIs) or targets (often around attainment and progression) and monitoring these to identify gaps and target action/initiatives.

These key points are illustrated in the following comments from the survey:

“Staff in the core teams supporting disability input to the access and participation plan, and the development of the plan is overseen by the PVC who has overall strategic responsibility for disability support.”

“Members of student support services are on our widening participation committee and have additional regular meetings with widening participation management team to give expert input to the development and implementation of our APP. Our APP assessment of performance reviews all metrics by different disability groups and identifies gaps against non-disabled students. On this basis we have built our areas of strategic focus in terms of access and participation for disabled students including progression to graduate-level employment or further study.”

“The APP plan produced for 2020-25 has a whole section devoted to the successful outcomes of disabled students across the student lifecycle. We have used the data and additional evidence to identify successes in our outcomes and also strategic measures where there are gaps in performance. This will enable us to direct our resources in more targeted ways.”

“The key staff within the university who have institutional responsibility for disabled students are actively involved in the annual review and development of the access and participation plan. The pro vice-chancellor for student experience, the pro vice-chancellor for education, the director of student support and wellbeing and the head of disability support are all involved in the drafting, editing and approval of the plan and ensuring that it covers the needs of disabled students. These staff are also included in the workshops instigated each year to capture new ideas and innovations for inclusion within the plan. The student registry team provide data on the performance, progress and retention of disabled students which is analysed as part of the development of the plan.”

4.7.2 Further progress towards an inclusive model

“An inclusive approach is about being confident that all possible anticipatory adjustments are embedded into every aspect of university life so that students with disabilities do not need to ask for them. I don't think we are there yet, but we are working very hard to remove some of the access barriers to our service, trying to question why we are working to a medical model of diagnosis in order to put in adjustments, and trying to challenge our ways of working. We should then be able to provide more support individually to students who have more complex needs and be available for more consultation with academic staff.”

Survey respondents were asked to rate how far along they felt they were in providing an inclusive model of support, using a scale from 1 to 10 where ‘1’ was ‘not inclusive’ and

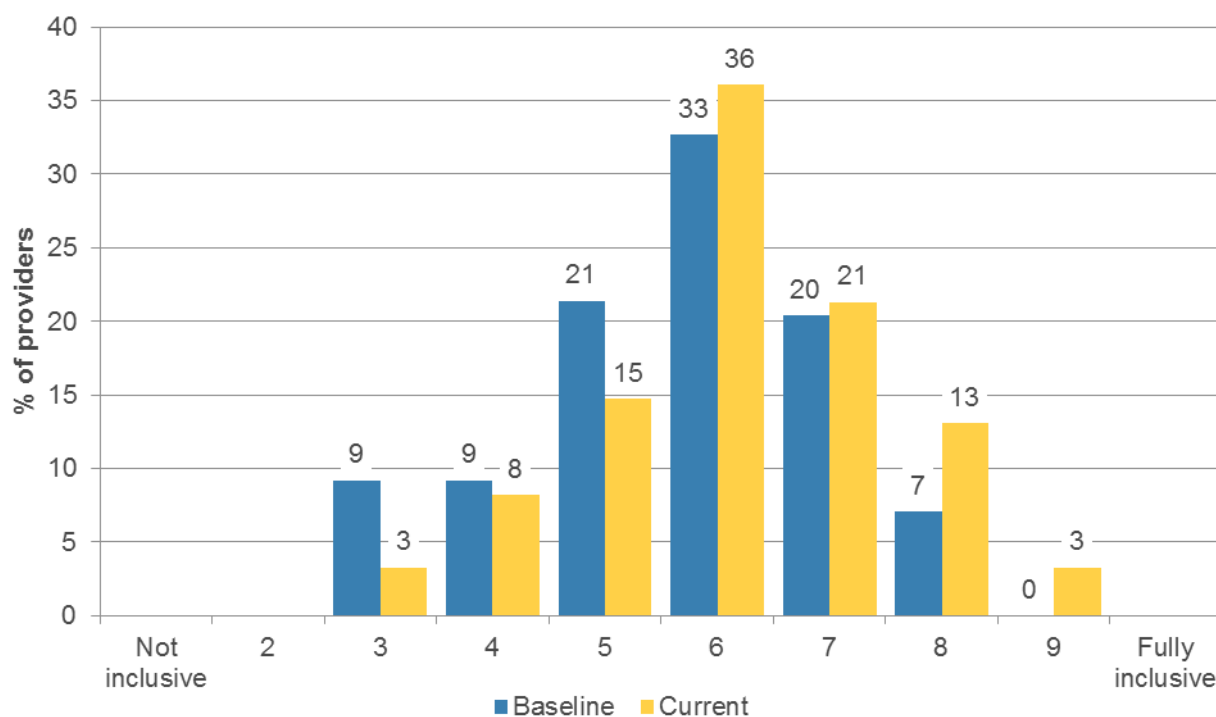
'10' was 'fully inclusive'. The most common response from respondents was to place themselves at '6' on the scale (also the modal response in the baseline survey), with 36 per cent of providers (n=32) placing themselves here. Around two fifths of providers (38 per cent, n=23) placed themselves further up the scale at '7' to '9', while 26 per cent (n=16) felt they were lower down the scale ('3' to '5') (Figure 4.5).

Providers' views on their progress towards an inclusive model were generally more positive than they were at the baseline survey, when only 27 per cent felt that they were at '7' or higher, and 39 per cent felt they were '5' or lower. The mean progress score in the baseline survey was 5.67, and in the current survey this had increased to 6.16.

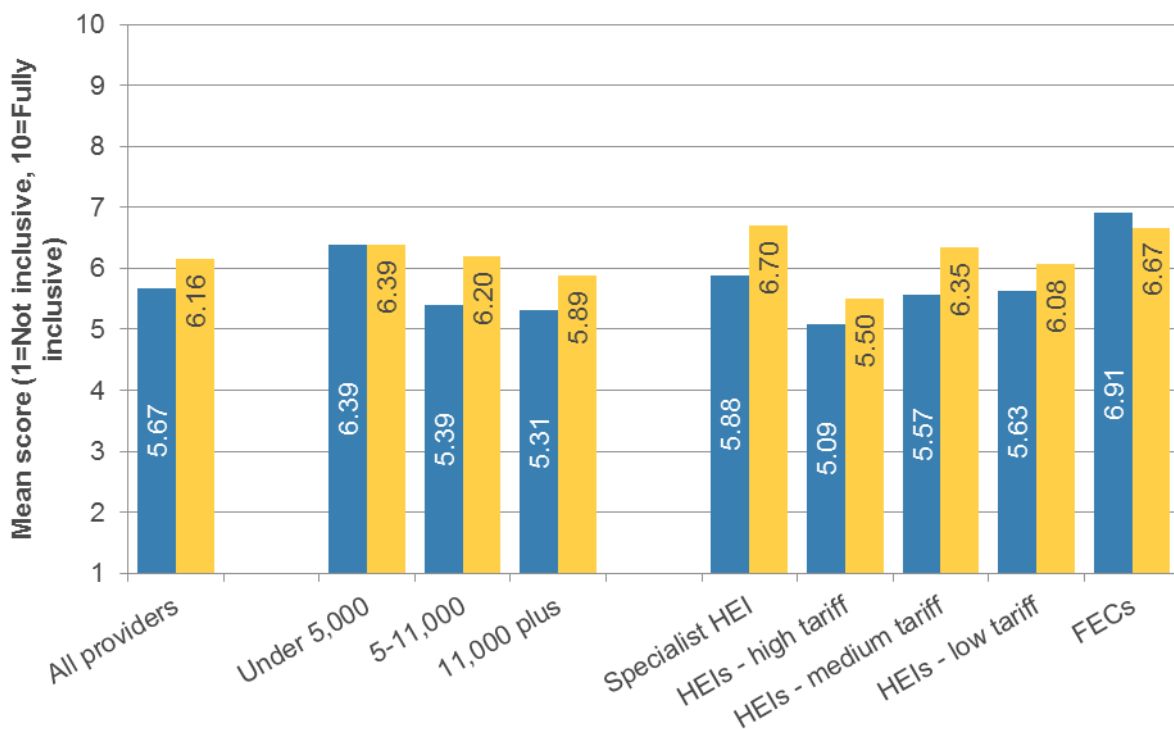
Small providers felt they were further towards fully inclusive provision than larger providers. This mirrors the pattern found in the baseline survey, although their mean score was unchanged since the baseline (6.4). In contrast the mean scores for medium and large providers had increased somewhat – from 5.4 to 6.2 for medium-sized providers, and from 5.3 to 5.9 for large providers.

HEIs with high average tariff scores again gave the lowest average scores among the different types of providers (5.5, compared with 5.1 in the baseline survey), while specialist HEIs and FECs again felt they were furthest towards fully inclusive provision (mean of 6.7 for both types of providers).

Figure 4.5: On a scale of 1-10 where 1 is not inclusive and 10 is fully inclusive, how far along do you feel you are in providing an inclusive model of support?



Source: IES surveys, 2017 and 2019; base = all respondents Baseline n = 98 and Current n = 61

Figure 4.6: Mean scores on inclusiveness scale by type of provider

Source: IES surveys, 2017 and 2019; base = all respondents Baseline n = 98 and Current n = 61

Good practice example: Bath Spa University

Senior level champion

The university feels there has been a culture shift over the last few years in terms of having an understanding of what inclusive practice is and means. This has been supported recently by the appointment of the new VC who is a champion of inclusive practice.

The university's proactive approach to inclusivity is partly driven by the range of creative disciplines offered, and staff feel they work hard and deliberately to be innovative and challenge themselves to think differently. The university has a developing evidence base of good practice across the university community, including core academic disciplines and professional/student service departments.

4.7.3 Challenges to developing a fully inclusive model of support

Providers were asked what, if anything, they felt still needed to be done in moving towards a fully inclusive model of support. Increasing or improving staff engagement in training was the most commonly mentioned area (85 per cent), followed by inclusive teaching and learning delivery (80 per cent), inclusive course and module design and validation (77 per cent) and inclusive assessments (67 per cent). (See Table 4.12.)

Table 4.12: Providers' views on what still needs to be done in moving towards a fully inclusive model of support (multiple response)

| | Number | % |
|---|--------|------|
| Staff engagement with training | 51 | 85.0 |
| Inclusive teaching and learning delivery | 48 | 80.0 |
| Inclusive course/module design/validation | 46 | 76.7 |
| Inclusive assessments | 40 | 66.7 |
| Assistive technology | 32 | 53.3 |
| Funding for training | 31 | 51.7 |
| Adjustments to estates | 28 | 46.7 |
| Use of accessible documents/formats | 26 | 43.3 |
| Executive team buy-in | 14 | 23.3 |
| Other | 5 | 8.3 |
| Total n= | 60 | |

Source: IES Survey 2019; base = all respondents

The open text comments noted that it could be hard to **engage some staff**, particularly academic staff, in inclusive practices and that it can be difficult for them to see inclusivity as good practice rather than additional work.

“[We need] Wider buy-in from teaching staff to see it not as an add-on, but an enhancement.”

This is leading providers to consider their training approach including adopting more proactive approaches and providing follow-up sessions rather than a succession of ‘one-off’ training sessions; considering the format (e.g. workshops, toolkits, online modules, events), content (shifting from general to more specific training) and timing of training (giving consideration to staff schedules and the working patterns of part-time and/or hourly paid staff); and considering whether it should be made compulsory. One respondent noted that their institution is developing a training matrix which identifies the elements that need to be compulsory. Another noted that they are developing a suite of face-to-face and online training courses on inclusive practice. Comments also indicated how making improvements to their training required additional (and ring-fenced) funding either to develop provision in-house or to outsource training and enable staff to attend external events (where appropriate). One noted that having access to low-cost online training specific to the HE context would be particularly helpful. Another noted that the pace of change in the field required more training and development than their current resources would allow.

“HE resources are limited at this time and it is a major constraint... but the will/desire is there!”

Comments around **delivery of inclusive teaching and learning** indicate that challenges are seen here as trying to develop a better understanding of what this means and the concepts involved, gaining clarity of expectations, getting commitment across the

institution and working towards consistency. Work is developing here but respondents noted that this required additional training for staff and that pockets of good practice needed to be disseminated across the institution and the sector.

“A better understanding of concepts such as universal design which move away from a deficit model.”

“Consistency - some academics are excellent but there are patches needing improvement.”

In terms of **inclusive curriculum design and validation**, the comments indicate that for many providers this is something they are currently wrestling with. Some noted that they are working to embed principles of UDL into existing processes for new and existing programmes (e.g. module review and revalidation); that they are looking at best practice across the sector; that they are establishing dedicated working groups to focus on inclusive curriculum design; and/or that this area is under review.

“We have a commitment to inclusive curriculum and assessment, but are still evolving the plan.”

“Work is underway as part of the wider curriculum transformation project.”

Respondents noted the challenges and further work required in **offering inclusive assessments** again included understanding the concepts involved and achieving some degree of consistency across the institution. However, this also involved working to move away from ad hoc adjustments to offering more than one way of demonstrating knowledge from the outset/built into programme design (moving away from a reliance on written examinations). Some respondents noted that they are in the process of reviewing their assessment methods and looking at best practice from across the sector.

“Much achieved but need to consider assessment as a menu of choice rather than a reasonable adjustment.”

Respondents also commented on the challenges around **AT** and their ambitions for it. They noted that they were working to: increase access to AT and broaden the range of AT through increased investment; ‘normalise’ the use of AT (particularly lecture capture) through raising awareness of the full range of AT available, training, the use of research evidence to allay concerns, and making subtle shifts in culture; and monitor its usage.

“We need to be more overt in our communications about what is available.”

5 Engagement with stakeholders

This chapter investigates providers' engagement with internal and external stakeholders to design and deliver support. These stakeholders include students and their representatives, wider staff (beyond the core disability services) across academic and professional services, and external organisations and bodies such as local statutory or voluntary service providers.

5.1 Engaging with students

Institutions demonstrated a strong commitment to engaging with their students around disability issues and support. It was clear that to many providers inclusivity was about being student centred (as discussed in Chapter 4). This would be enhanced by working closely with students, as highlighted by one response to the survey:

"[Inclusive practice is] identifying ways to reduce institutional barriers for students with disabilities and ensuring all students feel valued and able to contribute fully to all aspects of university life. Barriers are often historic systems or processes that it is possible to change when we adopt a proactive approach. It is vital to anticipate learning needs and preferences. [University name] is committed to involving students in the development of its inclusive model/approach, (as we have in our Mental Health Working Group, for example) recognising that students are best placed to identify the barriers and find alternative solutions that improve the experience for all, e.g. providing definitive 'beginnings and endings'; ensuring students have access to lecture notes 24 hours ahead of a lecture; making the recording of lectures 'opt out'; providing alternative assessments. We aim to enable all students to engage meaningfully with all aspects of university and achieve their potential."

Institutions mainly engaged with the student body on issues around disability support through their students' union or guild (93 per cent). They also used survey feedback (88 per cent) and focus groups (70 per cent) to obtain the views of disabled students about the support provided. In the baseline survey, engaging with the students' union/guild was the most common method mentioned in an open text question. Other methods of engagement identified in the current survey included liaising with the disabled students' forum, or similar groups formed by disabled students, and individual one-to-one discussions with disabled students. There was little variation by provider characteristics, although small providers were less likely to use focus groups than medium or large providers.

Table 5.1: How does your institution engage with the student body on issues around disability services?

| | Current | | Baseline | |
|-----------------------|---------|------|----------|------|
| | Number | % | Number | % |
| Students' union/guild | 56 | 93.3 | 65 | 67.0 |
| Survey feedback | 53 | 88.3 | 28 | 28.9 |
| Focus groups | 42 | 70.0 | 14 | 14.4 |
| Other | 10 | 16.7 | 16 | 16.5 |
| N= | 60 | | 97 | |

Note: Caution should be exercised when making comparisons between the two surveys due to the different methods adopted. In the baseline survey, the question was asked open-ended and multiple responses were coded, whereas in the current survey all response options were presented and respondents were asked to tick all that applied.

Source: IES surveys, 2017 and 2019; base = all respondents

Just under three quarters of providers (70 per cent) reported that they had a nominated disability representative on their students' union, council or guild, slightly below the proportion in the baseline survey of 75 per cent. Larger institutions were more likely to have a nominated student representative compared with smaller institutions (82 per cent compared to 47 per cent of small providers). There was also significant variation by tariff group. HEIs with high or medium average tariff scores were most likely to have a nominated disability representative (88 per cent) although this pattern may be driven by size of provider as HEIs with high or medium tariff scores are generally large providers.

In providers that did have a nominated disability representative on their students' union, council or guild, the disability support manager (or equivalent) was the individual who most commonly liaised with the nominated disability representative about day-to-day disability issues. However, some providers said this liaison was at a more senior level with the head of student services or support, or the head of wellbeing. Others reported that liaison was with a range of individuals within and outside of the disability support team.

Nearly all providers (95 per cent) that did have a nominated student disability representative said that the representative fed into broader disability policy issues. This was commonly because there was students' union/guild representation on a wide range of (or indeed all) key working groups and committees. Some providers also mentioned that students' union/guild representatives and/or sabbatical officers were involved in reviews of policies, and others mentioned there were regular meetings with the heads of student support and members of the students' union executive.

“SU rep has traditionally had a good working relationship with disability team, who have an open-door policy with regards to questions, concerns and feedback.”

“Policies sent to student union regularly for comment and representatives invited to disability forum meetings. Good dialogue and working relationship with our student

union on matters and they will also come to us when they want to discuss things and have ideas for policy introduction and change.”

“There is student representation on all university governance groups at which disability issues are discussed, including: council, senate, the Wider Student Experience Committee, the Student Support and Wellbeing Sub-Committee. The SU (including the president of the Students with Disabilities Association) are active members of the university's Accessibility Review Group which meets regularly to discuss physical accessibility issues within the university and to determine the use of bespoke funds set aside for enhancements in this space. The PVC for student experience and the director of student support and wellbeing have regular, diarised meetings with the SU sabbatical officers.”

5.2 Engaging with staff

Survey respondents were asked to indicate the ways in which their main disability service worked with academic departments, using a number of response options. All providers said that their disability service worked with academic departments in providing consultancy about disability issues. Similarly, most reported that the disability service discussed reasonable adjustments (97 per cent), discussed exam arrangements (97 per cent), provided training and staff development (95 per cent, see below); and encouraged and supported referrals between faculties/departments and the disability service (92 per cent). However, a considerably lower proportion of providers (52 per cent) said the disability service collaborated with faculties/departments on curriculum design.

There was an even split between providers who had faculty and department staff with explicit roles and responsibilities to support disabled students, and those who did not, while in the baseline survey, 61 per cent of providers had staff in faculties/departments with explicit disability support roles. Larger institutions were more likely to have staff supporting disabled students in faculties and departments than smaller HEIs (82 per cent compared to 54 per cent of medium-sized providers and 15 per cent of small providers). Providers with high average tariff scores were also more likely to have disability staff in faculties and departments (82 per cent, compared with 53 per cent of medium tariff HEIs, 50 per cent of low tariff HEIs, 17 per cent of FECs (one of the six that responded), and nine per cent of specialist HEIs). However, providers with high proportions of students in receipt of DSA, or students who disclosed a disability (8 per cent plus), were less likely than other providers to have disability support staff in faculties and departments.

In just under half (45 per cent) of providers who had faculty and department staff with explicit roles and responsibilities to support disabled students, these staff were academic staff with responsibility for disability issues in their faculty/department. Far fewer providers (10 per cent) had disability advisers located in faculties/departments. The remaining 45 per cent of providers with faculty representation for supporting disabled students, reported these staff were in some other role or combination of roles. Examples of the latter include disability coordinators or disability liaison officers based in academic departments who could be either in an academic or support role.

Working with staff on the inclusivity agenda

The case study discussions highlighted the fact that the increased profile of the inclusivity agenda was identified by some as providing a helpful mechanism for encouraging greater communication and interaction between academic departments and professional services. Interactions extended beyond discussion of individual students' reasonable adjustments, and included disability service and learning technology colleagues adopting a more holistic approach where they would receive invitations from individuals or academic departments to talk about:

- Changes to processes regarding individual support plans
- How departments would respond collectively to students with specific requirements
- What practices could become 'business as usual'
- New developments with a VLE that responded to disabled students' requirements but also supported departmental staff to adopt a consistent approach, for example in the layout of VLE pages or the nomenclature of plugins or features
- Disability service support for academic colleagues introducing a new assessment, or pedagogical approach
- Disability service support for academic colleagues working with a new student or group of students with whom they had not had much experience.

Several case studies also outlined how they established working groups with the remit of taking forward different aspects of their inclusive agenda. These typically involved professional services as well as academics, and representatives for other protected characteristics. The status of these colleagues varied, but were typically individuals who within the institution had a reputation for their commitment to a specific agenda. As one colleague explained:

"We have pulled together a reference group who tended to be professional services and equality, diversity and inclusion, library or disability, Athena SWAN, race, LGBT champions as well as academic staff. Also sometimes senior academics who have become the public face and want to see how things develop."

Good practice example: The University of Huddersfield

Internal disability champions, co-ordinators and consultants

The university has a senior disability adviser and projects officer within the disability support team who has a remit of promoting inclusive practice across the institution. Disability service activities include promoting inclusion by design in course development, linking up with the careers service to help prepare disabled students for work placements and career moves after graduation by getting employers in and talking to students, and working on ways to increase retention among incoming disabled students transitioning to higher education for the first time.

In addition the university has a committee of disability co-ordinators, made up of two or three co-ordinators in each of the schools. These co-ordinators act as a key link between disability support and academics – some co-ordinators are academics themselves – and they act as a

point of contact at school level and are involved in the agreement of personal learning support plans. The committee meets formally three times a year, but has on-going liaison within the committee and with disability support.

Academic departments are also supported by the senior disability adviser and projects officer who can offer consultancy around course development, subject validation and evaluation. As academics develop a course, the project officer will advise on any changes that need to be made to make the course more inclusive. These can often be small measures such as how to address students, not making students read out loud, helping students to feel comfortable with seating arrangements in tutorials and seminars. These small changes can make a significant difference to the student experience. Advice is also provided on building in alternative assessments from the outset. As part of the longer-term vision, the university is looking into developing a branding, accreditation or recognition of a course being fully accessible.

Good practice example: New College Durham

Annual improvement projects: a cross institutional approach

The college has several institution-wide initiatives to promote collaboration and tackle aspects of inclusive teaching and learning. For example, there are annual professional development days designed to raise awareness of topics that relate to inclusive teaching and learning. They have also initiated the introduction of annual improvement projects which bring colleagues from across the institution to work together to research and share good practice to respond to topics identified in their monitoring processes. For example, they have been exploring how students are responding to and making use of feedback, considering if there are particular barriers to this aspect of learning faced by particular groups of students. They've also undertaken an induction project which has involved collaboration to develop activities not so much relating to their subject but developing broader skills such as report writing and research skills.

Challenges in engaging staff

Comments and case study feedback highlights the fact that there could be challenges to engaging with staff in professional services and academic departments. These related to working in silos and also to institution size and lack of awareness. For larger organisations there was a challenge of communication and consistency:

“It is difficult to embed a cultural change; there are loads of people and bringing people in has been and will continue to be a significant culture change, so it's small steps and taking every opportunity to explore how we centralise and adopt a more joined-up approach to mitigating circumstances and reasonable adjustments.”

Several interviewees had worked in different types of institution within the sector, and their reflections on the differences highlighted the contrasting approaches of different organisations. For example:

“When I worked in FE it tended to be quite joined up, the lecturers buy in because it's the nature of the students, so I've brought these practices from FE and they tend to be more inclusive.”

Although many spoke about the importance of working relationships, interviewees from the smaller institutions identified this as a positive feature of their context because it allowed them to have more direct and personal working relationships with academic departments. Adopting a proactive response was also identified as important and there was a general sense that professional service colleagues felt there was a greater openness than there had been in the past.

“Over the years we’ve been proactive, we’d go to Heads of Department and [ask them if we could attend a meeting] to have a Q and A, but it was us asking, now we get invited as a team to talk to them about things they find a challenge, so there is a huge willingness. ... In the past we felt like a separate department ... but now they regard us as having a role in education and the teaching and learning of students’ whole journey.”

5.3 Staff training

A key aspect to core disability services engagement with wider staff is the provision of training. Providers were therefore asked about the training they provide to staff with specific roles to support disabled students, and whether this is part of general continuing professional development (CPD). A wide range of training was described and the comments tended to broaden beyond key/core disability services staff to talk about what was available to a wider group (or all) staff.

Where comments specifically referred to disability service staff/student support staff (including those undertaking work funded by DSA) they often referred to training being linked to development reviews/appraisals. Training for these staff tended to focus on meeting certain requirements or undertaking statutory CPD (in line with the regulations/requirements of their professional bodies), and gaining and maintaining accreditation (e.g. National Association of Disability Practitioners (NADP)). The importance of networking across the sector for these staff was also noted through attending events and conferences and keeping in contact with fellow professionals. This was felt to be a vital part of keeping skills and knowledge up to date. Comments here included:

“All the members of the disability advisory service are full members of the National Association of Disability Practitioners and/or Patoss. They undertake regular relevant CPD, attend conferences and engage with colleagues in the sector through email discussion forums. Specific members of the team have also undertaken academic study (masters level) in the fields of autism and SpLD.”

“Many staff have specific qualifications e.g. PGCert in dyslexia/SpLD and many are members of professional bodies requiring CPD. Staff have recently undergone training in a solution-focused approach and unconscious bias. Non-Medical Help staff have completed training required by DSA-QAG. All staff undergo a yearly personal and development review and identify development opportunities as part of this process, including conference attendance, shadowing, peer supervision, skills sharing.”

“Annual CPD programme for all specialist staff e.g. diagnostic assessors, specialist mentors, specialist one-to-one study skills tutors and support workers as well as the wider disability team. An annual programme of meetings is provided for disability link tutors from academic and other departments.”

“Attendance at internal and external conference events. Professional body membership and networks appropriate to the role, in-house updates and information as part of CPD refresher training re specific disabilities, legislation, inclusive practice.”

“Specialist disability support staff are recruited with specialist knowledge, experience and expertise in supporting disabled students with the whole range of impairments. They receive 'on the job' training about [the university's] in-house policies, processes and protocols by shadowing and being shadowed by more experienced staff. They are all members of professional bodies such as National Association of Disability Practitioners, Dyslexia Guild, British Dyslexia Association or Professional Association of Teachers of Students with Specific Learning Difficulties and are encouraged and supported to attend relevant training/conferences offered by these bodies and other suppliers as part of their professional CPD.”

“Staff regularly cross-train in order to share best practice and up-to-date practice with each other. Fortnightly supervision is provided to allow reflection on their practice and ways of working. Membership of NADP allows practitioners to access a range of training throughout the year that will be based on need, changes in cohort or a particular increase in students presenting with specific disabilities. Currently developing a CPD framework that focuses more on supporting staff with knowledge around Universal Design for Learning so that they can in turn support colleagues in curriculum review.”

Where broader training was mentioned, for staff beyond the core and specialist team, comments indicated that this training can be delivered in-house by advisers from the disability support services (or equivalent) teams or can be purchased from external suppliers. The types of training described included:

- Broader general equality and diversity training which will include disability.
- General awareness raising of disability (and safeguarding) issues and support available to students. This could include suicide awareness and prevention, and unconscious bias.
- Specific disability-related topics including dyslexia, dyspraxia, learning difficulties, autism, eating disorders, deaf awareness and mental health (including mental health first aid and supporting students in distress). These were often provided by specialist third-sector organisations such as the National Autism Society or MIND.
- Training on key topics such as inclusive practice, providing reasonable adjustments, AT, and creating accessible content and formats.
- Bespoke training for different staff groups such as disability awareness training for accommodation and library staff, and personal and senior tutor training.

Comments here included:

“Key representatives from the academic, professional, technical and wellbeing staff have met together regularly over the course of the last academic year. Initially the aim was to increase the awareness of all staff as to support available for students and pathways to pass on concern. This proved effective, with staff citing a tangible difference both in how equipped they felt as well as the amount of students who were aware of and accessing appropriate support. The representative team have then moved on to look at positive impact they can have. Wellbeing workshops have emerged from this, with our on-campus art gallery and the provision of pianos across campus for anyone to use. Plus online resources and information for students and staff such as workbooks for strategies to manage anxiety and self-esteem, and a dedicated academic skills kit website with resources to develop strategies for academic writing, time management, transition to university; quizzes and online learning.”

“Training is provided on a number of disability-related topics by advisers in student support and wellbeing but attendance is voluntary. Sometimes this is bought in from external providers on an ad hoc basis. An online training model relating to supporting students with mental health difficulties was introduced last year and we are aiming for a high take-up of this.”

The online survey included a new question asking providers whether teaching staff received training on inclusive teaching, and just under three quarters of providers (73 per cent, n=40) reported that they did. There was no significant variation in this proportion by provider characteristics such as size, tariff group, or proportion of disabled students. Here providers commonly described how this was included as part of their postgraduate certificate in HE or equivalent (e.g. PG CAP) and/or induction process for new staff. Other providers noted that training on inclusive teaching was provided on request as a bespoke training programme, was part of a broader approach to equality, diversity and inclusion (EDI) or was provided through guidance materials and online resources. These programmes included aspects such as curriculum development, VLE, and creating accessible resources/content.

5.3.1 Which staff groups receive training?

Respondents to the online survey were asked to name the staff groups across their institutions that received training to support disabled students. Nearly all providers (97 per cent) offered training to their academic staff, while around nine out of 10 offered training to library staff (90 per cent) and to student support staff excluding disability advisers (89 per cent). Far fewer provided training to research staff (52 per cent), research support staff (44 per cent) or science/engineering and health staff (34 per cent) to help them in supporting their disabled students. (See Figure 5.1.)

For most staff groups, the proportion of providers reporting that they provided training on disability issues was higher in the current survey than in the baseline survey, the exceptions being managerial, finance and administrative staff, and science, engineering

and health staff. These differences may reflect the type of training these categories of staff typically access.

There were some statistically significant differences by provider characteristics. Small providers were less likely than larger institutions to provide training to a range of staff groups including:

- Research staff (26 per cent, compared to 62 per cent of medium-sized providers and 69 per cent of large providers)
- Research support staff (16 per cent, compared to 54 per cent of medium-sized providers and 63 per cent of large providers)
- Science, engineering and health staff (5 per cent, compared to 46 per cent of medium-sized providers and 50 per cent of large providers)
- Security staff (53 per cent, compared to 65 per cent of medium-sized providers and all large providers)
- Residency staff (32 per cent, compared to 77 per cent of medium-sized providers and 88 per cent of large providers)

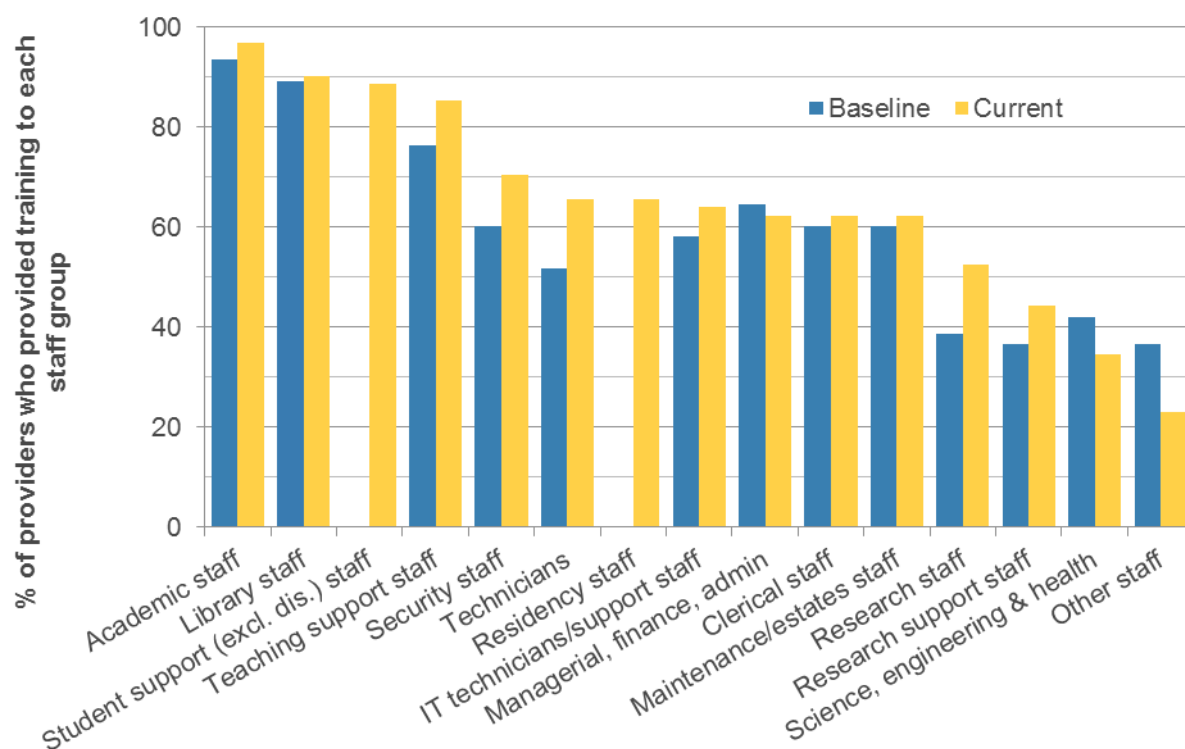
FECs were generally less likely than HEIs to provide training to these staff groups.

It is worth noting the importance given during case study interviews to increased awareness or access to learning opportunities which shaped their and their colleagues' future working practices.

One interviewee described how membership of the accessibility committee increased their awareness of barriers associated with the built environment and allowed them to inform colleagues about the implications of technological decisions.

"I've gained insights into the unique challenges in terms of its infrastructure, for example, a new building or one going to be refurbished, what is the wheelchair access going to be like and the teaching space? ... what are the implications if you can't change electrical point? And then you begin to understand the lecturers' perspective and what they need to happen. There is a knock-on effect on the education [students] can access, if there is noise or a lack of equipment. ... It allows me early notice for [academic departments'] requirements, for instance wanting to use Moodle in a particular way 'We want to do audience response' I can share with them about alternative formats."

Figure 5.1: Which staff groups across the institution receive training to support disabled students?



Source: IES Surveys 2017 and 2019; base = all respondents. Baseline n = 108 and Current n = 67

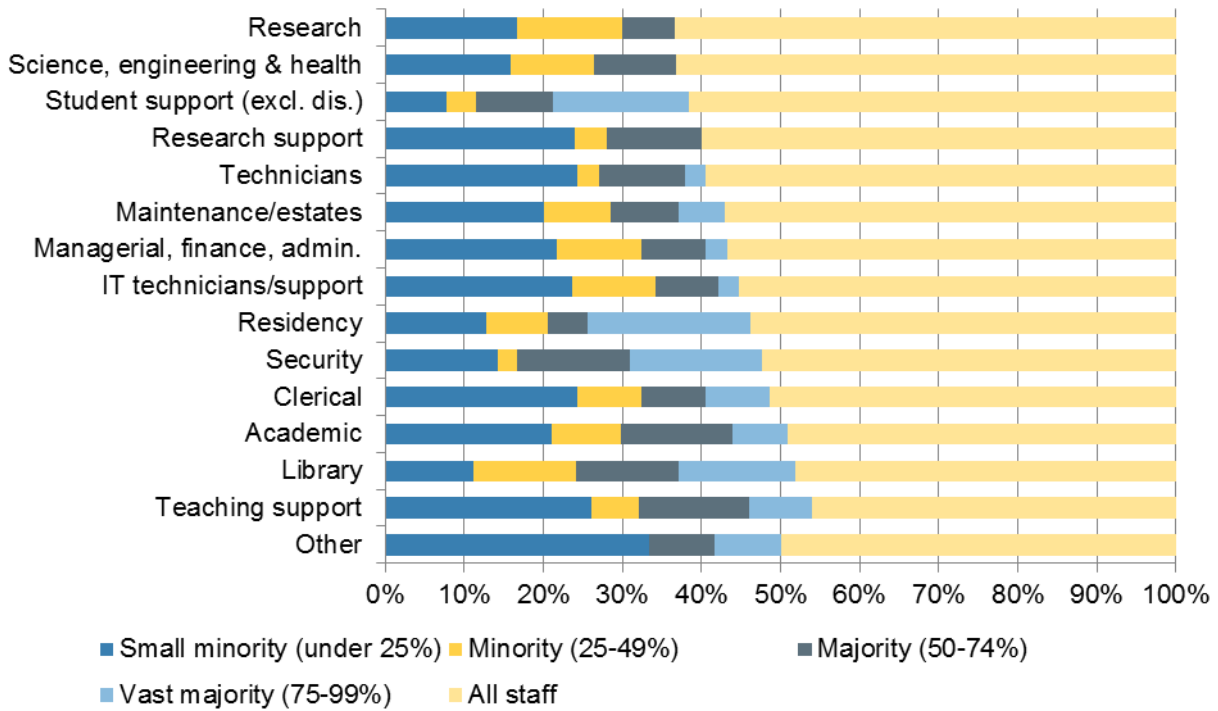
5.3.2 Nature of the training

Those providers who indicated their staff received training to support disabled students were asked to provide further details for each staff group in terms of:

- Coverage - Is this for all staff in this group, or just some staff?
- Requirement - Is this voluntary or compulsory, or a mixture?
- Mode - Is this face-to-face training or virtual training, or a mixture?
- Content - Is this general disability awareness training or training about specific issues, or a mixture?
- Frequency - Is this one-off training, or is it updated periodically?

Less than half of providers reported that all academic, library and teaching support staff received training on disability issues, and these groups were among those most likely to receive training. Conversely, high proportions of providers reported that all research and research support staff, and science, engineering and health staff, received training, and these groups were least likely to receive training. This pattern is similar to that found in the baseline survey. Student support staff were both highly likely to receive training on disability issues, and for all staff to be trained.

Figure 5.2: What proportion of the staff group is trained?

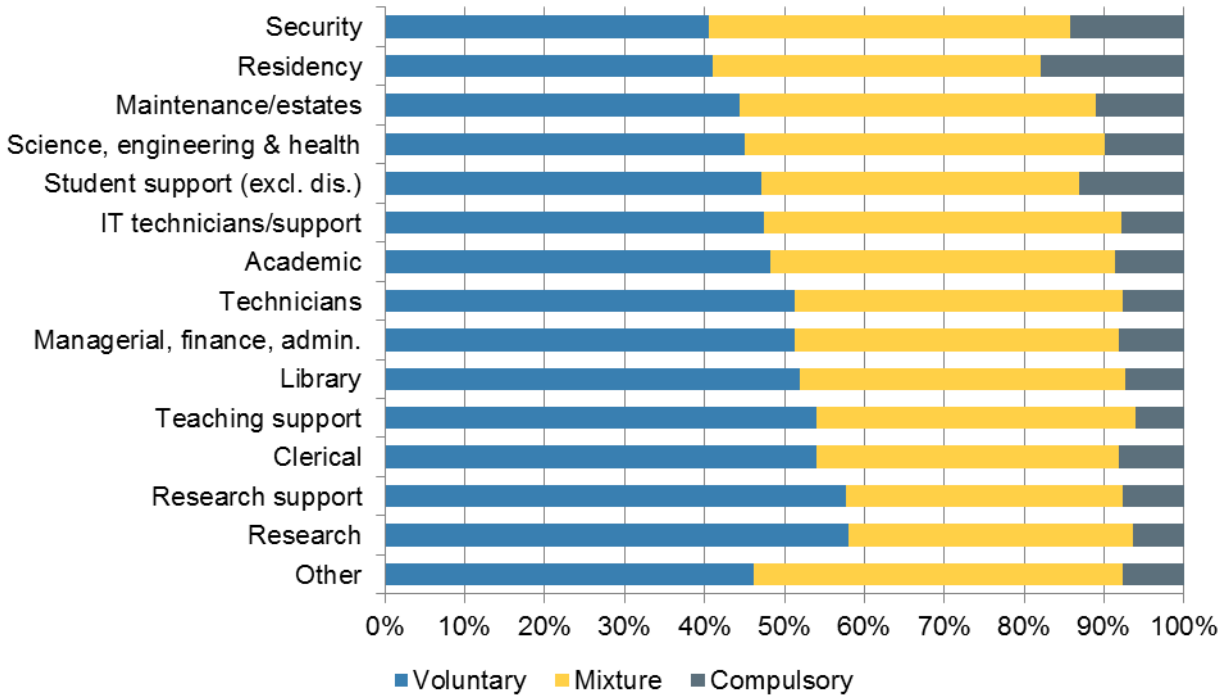


Source: IES Survey 2019; base = all respondents that provided training to each staff group

In the main, training to support disabled students was voluntary. Around half of those who provided training reported that the training was entirely voluntary across all of the staff groups (Figure 5.3), and this was very similar to the picture from the baseline survey. Security and residency staff were most likely to have some form of non-voluntary training, either compulsory or a mixture of compulsory and voluntary.

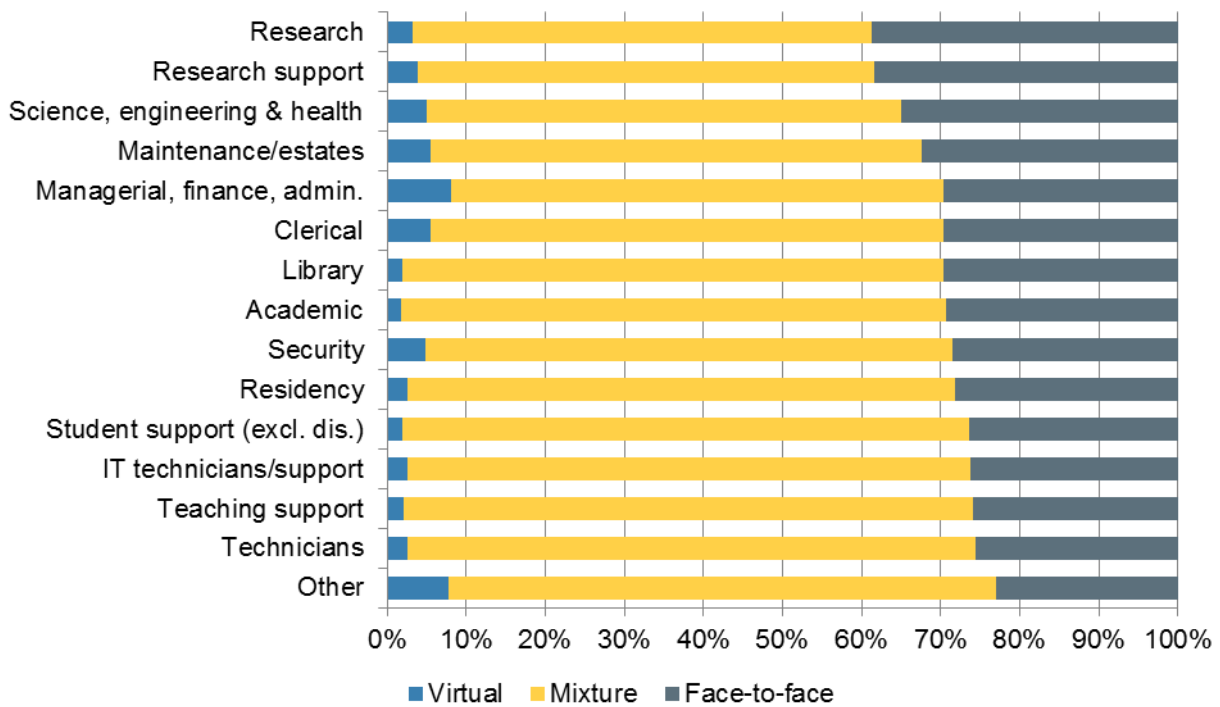
Only a small minority of providers reported that training on disability issues was delivered entirely virtually, and a majority of providers delivered training using a mixture of virtual and face-to-face training (Figure 5.4). Virtual-only training was most commonly delivered to managerial, finance and administrative staff, while face-to-face-only training was most commonly delivered to research and research support staff.

Figure 5.3: Whether training is voluntary or compulsory?

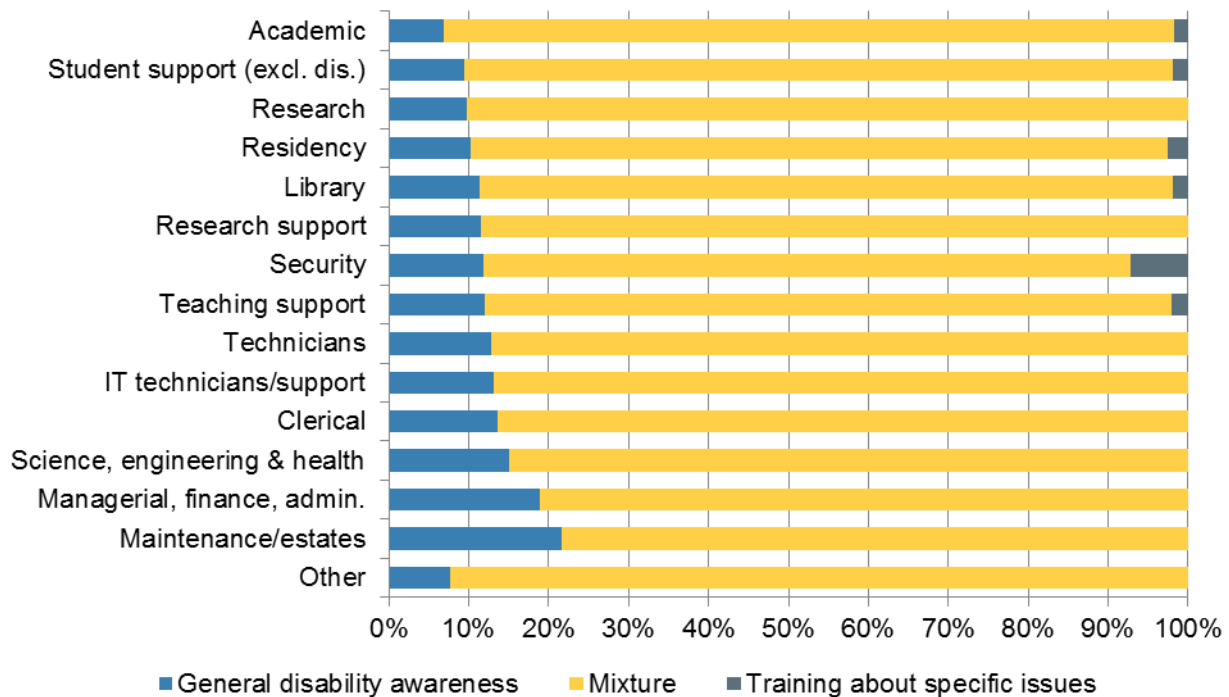


Source: IES Survey 2019; base = all respondents that provided training to each staff group

Figure 5.4: Method of providing training



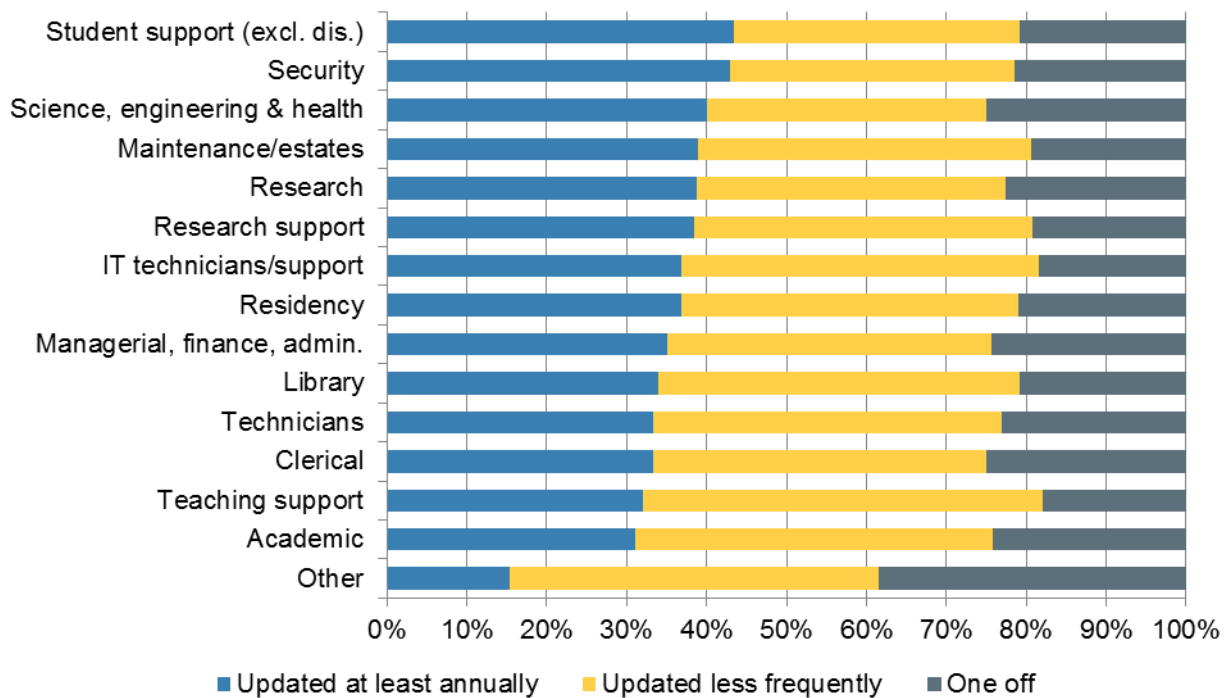
Source: IES Survey 2019; base = all respondents that provided training to each staff group

Figure 5.5: Content of training

Source: IES Survey 2019; base = all respondents that provided training to each staff group

Training was predominantly a mixture of general disability awareness and training about specific disability-related issues for all staff groups (Figure 5.5). This was similar to the findings from the baseline survey. Security staff were the staff group that were most likely to receive training about specific issues only, while maintenance/estates staff and managerial, finance and administrative staff were mostly likely to receive general disability awareness training only.

The final question related to training asked about the frequency of training. As was the case in the baseline survey, one third of providers updated training for all staff at least annually, although around one in five said that training was organised on a one-off basis (Figure 5.6). Student support (excluding disability) and security staff were most likely to have disability training updated annually, while academic staff were least likely to have training updated annually.

Figure 5.6: Frequency of training

Source: IES Survey 2019; base = all respondents that provided training to each staff group

The findings from the case studies showed that institutional approaches to training were varied, and provided some examples of the more successful approaches and the range of foci covered for training.

Good practice example: University of Warwick

Maintenance toolbox training and wheelchair challenge

These two examples highlight the benefits of experiential learning and how this enables different groups of colleagues to gain insights into the reasons why the physical environment can provide a challenge for some people. Two important features for both courses were firstly, the sensitivity required when delivering the training and secondly the benefits of explaining where the word disability comes from and its connection to the social model. It was acknowledged that the approach was dependent on context and on trainer.

Maintenance toolbox training is offered to estates staff and those involved in installing equipment or refurbishments. The examples given included: viewing an accessible toilet and demonstrating why the location of the pull cord was important, or demonstrating the importance of a dropped curb being flat.

The 'wheelchair challenge' included an opportunity for groups of staff often working in a particular service to experience the perspective of a person using a range of mobility equipment or considering in close detail the challenges people with a specific disability might experience. This included people who use a walker, an electric or manual wheelchair and people who have a hearing or visual impairment.

Good practice example: Bath Spa University

Range of training offered

A range of training is offered to new and existing staff; including two e-learning modules:

1. Implementing reasonable adjustments for disabled students
2. Supporting students' mental health and wellbeing) co-developed by student support and an external provider).

New academic staff undertake a PG Cert in HE and student support co-delivers a module around disability and mental health, which covers boundaries, roles and responsibilities.

Student support also delivers an open CPD session for university staff called 'Our students' on a rolling programme throughout the academic year. 'Our students' provides an overview of the student cohort, case studies, student voice and lived experience.

Student support also provides bespoke 'consultation/development' sessions for groups of staff, both academic and professional services. A recent example is for domestic services (including porters and cleaners) as these staff are often well placed to notice out-of-the-ordinary behaviour or indicators that a student may be struggling.

Student support is also in the process of developing a training session for SU club and society committees.

5.4 Engaging with external providers

Respondents were asked to describe how their institutions interacted with their local NHS and they tended to describe a multitude of interactions. These included regular liaison, provision of medical advice and support, and involvement in delivering workshops and awareness projects. It also involved more formal interaction such as involving NHS specialist staff on provider committees (such as health and wellbeing committees), forming partnerships with NHS services, having a GP practice on site and/or offering drop-in sessions for students with nurses. Respondents made it clear that it was not only for general health conditions that they work together, but they made use or liaised with their local NHS services on specific issues. This was most notably mental health but also issues such as eating disorders, and sexual health.

Reflecting findings discussed in Chapter 3 on the use of external services, providers reported that a range of external providers delivered support to students within the institution. Most commonly, the external providers institutions engaged with were charities (69 per cent) and mental health support/Improving Access to Psychological Therapy (IAPT)²⁵ support (66 per cent). In addition, just under half of providers (47 per cent) had a GP practice on campus.

²⁵ IAPT is run by the NHS in England and offers approved talking therapies delivered locally by fully trained and accredited practitioners for treating adults with depression and anxiety and to help them better manage

Table 5.2: External providers delivering support in the institution

| | Number | % |
|----------------------------|--------|------|
| GP practice on campus | 26 | 47.3 |
| Mental health support/IAPT | 36 | 65.5 |
| Social Services | 16 | 29.1 |
| Charities | 38 | 69.1 |
| Other | 10 | 18.2 |
| N= | 55 | |

Source: IES survey 2019; base = all respondents

Open text responses provided additional detail about how institutions interacted with these different external providers.

- Working with **charities** to support students was common and a wide range of charities were cited. These organisations tend to provide support for specific issues or conditions or groups of students such as support for mental health, eating disorders, substance misuse, LGBT support, autism spectrum disorders, and sexual assault and domestic violence. The working relationships with these external providers could take many forms including drop-in sessions, presenting at events, working jointly on campaigns or awareness raising, or could involve more formal partnerships to provide bespoke support.
- Many providers reported working with **local IAPT services**. This could involve IAPT workers working alongside the disability services core team to support students with mental health conditions and 'provide an enhanced service'. It could also involve less intensive interaction such as working to undertake joint projects and co-deliver initiatives or, most commonly for IAPT services, to have access to space on campus to meet with specific students: *"We provide rooms on campus for local IAPT providers to meet with students"*. Providers also described how IAPT services worked with students off campus.
- Those providers reporting they had a **GP practice** or healthcare centre on campus tended to host a satellite branch of a local GP practice which provided dedicated services and access to their students and staff. Those with multiple sites tended to have a GP presence at only one of their campuses. Also some institutions reported that the surgery may have limited opening hours (e.g. three days a week, Monday to Friday, or term-time only etc.). Others noted that they did not have a GP practice on-site but they did work together with a practice that is close by (and may contract with them to deliver services to their students). A few reported that local GPs can come onto campus to promote local services, notably during the induction or welcome week at the start of the academic year.

“We have a relationship with a local GP partnership and they have a practice on our largest campus.”

Nearly two thirds of providers (63 per cent) reported that they fed into local working groups on disability issues that involved NHS, Social Services and local authority partners. This was an increase on the proportion in the baseline survey of 50 per cent, and perhaps reflects the conclusions respondents had in the baseline survey that interactions with local external services would increase. There was no significant variation in this aspect of external engagement by provider characteristics.

Providers commonly reported that they had representation on local mental health partnership boards, Prevent partnerships, safeguarding groups, local disability advisory groups and GP networking groups. They could often take the lead in multi-agency working groups, and could work in collaboration with other local providers to develop student-focused services. Several providers talked about playing a key role in local mental health groups, which could involve developing effective pathways between universities and mental health services, and on suicide prevention groups (e.g. regional suicide prevention network, regional suicide and self-harm strategy group).

“Working in collaboration with NHS partners, universities and public health – our group is named Mental Health Integrated Pathways. This group is focused on developing pathways between the universities and mental health services. It is an area of work within the mental health work stream as part of the zero suicide ambition agenda and in the context of university mental health being raised as an area for action in the NHS 10-year plan (as well as our own university strategy).”

One provider was particularly proud of their working relationship with their local NHS trusts, and suppliers of mental health support:

“We would also like to emphasise the strength of our relationship with local NHS providers and the way in which these are embedded within our support structures. Specifically, we would highlight our newly formed University Community Mental Health Team (UCMHT), delivered in partnership with the [county] Partnership NHS Trust.”

However, as noted in the case study feedback, collaboration and interaction with primary care services can be challenging for providers.

One interviewee noted how government policy and lack of consistency in the working arrangements with primary and secondary care can create challenges.

“I sit on strategic bodies and attend regular meetings but still find it difficult to progress a strategic dialogue especially with the Clinical Commissioning Group which is incredibly frustrating ... We have good relations but we haven't been able to achieve partnership working/co-investment.”

They also noted how difficulties in the NHS has had spill-over effects for HE:

“The benchmark for entry [for support/treatment] has increased, it is harder for the university to facilitate entry to support and there is a lack of consistency ... We are working to prevent a crisis point for the individual but we have lost our capacity to help.”

The university has been working with another local university to try to join forces to achieve change. For example, they worked together to bid for the OfS challenge competition on supporting students' mental health.

5.4.1 Changing nature of interaction with external providers

Around three-quarters of respondents (76 per cent, up from 64 per cent in the baseline survey) felt that their interactions with local NHS or other external services had increased over the last two years. Again this corresponds with expectations reported in the baseline survey that, looking forward, interactions with local external services would increase. Respondents to the current survey felt the increase was most commonly due to significant increases in demand for support from the student body, particularly for mental health support. Other reasons reported included closer working relationships with external partners leading to more inter-agency referrals, and increased attendance at local strategic bodies.

Looking to the future, an even greater proportion of providers, 87 per cent, expected that their interaction with local NHS or other external services would increase over the next two years. Again this was largely due to continued increases in demand, and also students experiencing more complex difficulties. Other reasons included closer collaboration between providers and statutory agencies, particularly around mental health, driven in part by national policy developments such as the NHS 'Big Plan' and the green paper on children and young people's mental health.

6 Review, monitoring and evaluation

This chapter focuses on the monitoring and evaluation plans and practices of providers.

6.1 Reviews of current disability services

The survey indicated that a majority of providers (65 per cent, n=40) had taken steps to review their support for disabled students in the last two years, with 34 per cent of providers (n=21) reporting that they had conducted a review, and a further 31 per cent of providers (n=19) in the process of conducting a review at the time of the survey. This is below the proportion of providers in the baseline survey that had conducted (50 per cent) or were conducting (35 per cent) a review. It is likely that this reflects the regularity of service reviews, and that many institutions noted in the baseline survey that it was DSA changes that had stimulated a review. The review cycle, as the open responses suggest, varies considerably from institution to institution. Another potential explanation for the difference between the current survey and the baseline may reflect the extent to which targeted reviews, sometimes taken by other sections within providers (for example learning technologists reviewing VLE accessibility) may not be reported as part of a disability service review.

Among providers who had not conducted a review nor were in the process of conducting one (n=22), the majority (64 per cent, 14 out of 22) said they were planning to conduct one over the next two years.

Further analysis of the current survey responses found no significant variation in reviewing practice by provider characteristics. However the open text responses where providers described what was covered in the review revealed a wide range of responses to the review process. These can be categorised into five themes which explore the extent to which the provider:

- Adopts a holistic approach regarding coverage of who and what is reviewed, and the frequency of the review process (See 6.1.1)
- Reviews specific student services or targeted activities for groups of students and involves students in the review process (See 6.1.2)
- Engages with and uses external quality tools to support the review process
- Covers curriculum and assessment issues
- Considers physical and digital accessibility. (See 6.1.3)

In addition, providers were also asked to describe typical outputs of the review process. (See 6.1.4)

These themes differ quite considerably from those identified in the baseline survey where cuts to DSA featured strongly, followed by inclusive teaching and learning, training and development, policy, and technology.

6.1.1 Committees or groups involved in reviewing and monitoring disability support

Comments from respondents highlight how the majority of providers undertook a review of their services internally and involved a number of existing committees or convened specific working groups to support the process. A smaller group drew on the support of external consultancies.

Table 6.1 shows the responses from providers regarding the institutional committees and groups that were involved in reviewing and monitoring their disability support. Three quarters of providers reported that senior management (77 per cent) and the equality and diversity committee (75 per cent) were involved in reviewing support. Similarly the student experience committee or sub-committee, the education/teaching and learning committee, and the committee responsible for APPs were also commonly involved (with 72 per cent of providers reporting each of these committees being involved). In around half of providers, the review of disability support involved the executive team or the board of governors.

Table 6.1: Committees or groups involved in reviewing and monitoring disability support

| | Number | % |
|--|--------|------|
| Senior management | 46 | 76.7 |
| Equality and diversity committee | 45 | 75.0 |
| Student experience committee/sub-committee | 43 | 71.7 |
| Education/teaching and learning committee | 43 | 71.7 |
| Committee responsible for Widening Access | 43 | 71.7 |
| Students' union/guild | 37 | 61.7 |
| Executive team | 30 | 50.0 |
| Board of governors | 29 | 48.3 |
| Other | 7 | 11.7 |
| N= | 60 | |

Source: IES survey 2019; base = all respondents

The involvement of committees and specific strategic or operational teams in the review process is encouraging, although there is room for providers to consider if and how their boards of governance might be engaged in the review process.

When describing the review process, institutions also provided examples of how they adopted a more holistic approach whereby evaluation of support services was integrated into a broader strategic agenda. For example, several mentioned connections with university strategy and outlined a comprehensive approach, for instance:

“[Following an] institutional level internal audit in 2016 all aspects of university policies, roles and responsibilities, as well as operational procedures around accessibility/disability related issues were reviewed. A Disability Change Working Group (DCWG) was established to review and implement actions resulting from audit recommendations, chaired by [senior lead with responsibility for] (learning and teaching).”

And another explained how they have been:

“Following [a] student journey mapping exercise as part of university strategic transformational change programme .”

The survey comments also helped to reveal the frequency of the review process. Several providers mentioned having undertaken thorough reviews in readiness for the DSA changes:

“A ‘Disability Deep Dive’ previously mentioned, albeit this was longer than two years ago to anticipate future changes in DSAs. We commenced this project round about 2015.”

Motivation for reviewing services and models of support was not only due to DSA changes (“to ensure we were compliant”) but in response to wider pressures or external influences including the need to develop an APP. APPs were also mentioned in the case study interviews. These were generally regarded as an aid, mechanism or framework whereby providers could engage a wider audience with issues associated with disability service provision. The survey feedback and case study discussions also pointed to other tools and strategies that were used to provide some external quality assurance to work they were undertaking internally. These included external quality marks such as Matrix, Disability Confident, and the 'Office of the Independent Adjudicator²⁶ (OIA) Good Practice Framework: Supporting Disabled Students', and Disabled Students Allowances Quality Assurance Group (DSA-QAG) ²⁷.

“Disability support provided by student support and wellbeing is reviewed by termly quality assurance meetings, and annually by completion of a self-evaluation document with external audit undertaken annually by DSA-QAG, including NMH provision of support. An inclusivity framework in association with quality and standards is about to be launched and subsequently reviewed. Plus student (and staff) wellbeing frameworks which will also be reviewed.”

“We are going through the self-assessment process to gain the Disability Standard.”

²⁶ Office of the Independent Adjudicator (OIA) are the independent body established to review student complaints about HE providers in England and Wales.

²⁷ Disabled Students Allowances Quality Assurance Group (DSA-QAG) was set up by DfES in 2004 and became a charity in 2008. It works to ensure minimum standards for service providers by undertaking audits and maintaining a register of approved members. It has a quality assurance framework that is used to audit and accredit assessment centres, AT service providers and NMH providers.

Many providers saw the review process as continual and wide ranging covering the whole range of the disability support service activities and also a variety of related services:

“We regularly review the activities and service provision for disability support, and we consider this is a continual process. We have reviewed systems, procedures, feedback mechanisms, staff development training, engagement with external providers and DSA processes.”

“ [Review covers] roles and responsibilities (vis-à-vis the whole of the university), team composition, team location, systems and processes in academic departments, Taking ownership? links with careers/employability, links with national and local networks, why [the university] needs to have Disability Confidence to be an inclusive organisation, all stages of student journey.”

6.1.2 Reviewing targeted services and student involvement

Feedback on the review process suggested that some providers complemented their broader reviews with exploring specific services provided for students or specific aspects of the student experience. Decisions about what to focus on were informed by: initial widespread reviews; a need to evaluate the introduction of new services arising from DSA changes; or in response to feedback from students.

“Review of support plans and how these are communicated and disseminated to staff, and review of support for particular groups (mental health; autism).”

“[It is] not a single review, but reviews of various aspects have been conducted or are underway: funding requirements in particular in relation to support for students with mental health conditions; accessibility of physical space; accessibility of web materials (including the VLE); accessibility of digital teaching materials.”

“Student mental ill-health, triggered by rapid increase in student disclosure. A wellbeing working group was convened, culminating in a 54-page report to the executive committee in March 2018.”

Only five providers mentioned the involvement of students in review processes. However, comments in response to other questions and the question which specifically asks about the involvement of students’ unions/guilds suggests that providers are engaged in gathering student views as well as involving them in the wider review process (See Chapter 5). One provider referred to their use of ‘LEAN Principles²⁸ and use of student voice’ to guide their review processes. Others reported that “an annual student survey is conducted by the disability service” or “in-depth canvassing of students supported via student advice service to obtain qualitative feedback”.

²⁸ LEAN is a continuous improvement methodology originally developed in Japan for use in the manufacturing sector. The principles are now used in a variety of sectors and settings.

6.1.3 Reviewing digital accessibility

In addition to describing the content of the review, the survey asked providers specifically about whether their online VLE was included in the review. Only one in three providers (33 per cent, n=13) that had conducted, or were conducting, a review reported that the review included their online VLE. No small providers reported including their online VLE in their review of support for disabled students, compared with 37 per cent of medium providers, and 50 per cent of large providers.

Three of the 13 who did review their VLE referred to digital accessibility and clearly saw this as a priority. These institutions provided further detail about their recent and future plans for evaluating and enhancing their VLE provision. Their motivation and drive for reviewing accessibility was related to the forthcoming changes and EU legislation regarding website accessibility. This involved:

“... procurement of the VLE with mandatory consideration of accessibility and user testing to include students and staff with disabilities. [There is also] a scheduled review of VLE when the existing contract ends in 2020. This has provided a timely opportunity to ensure the VLE is designed to be accessible to all users.”

“A review of the styling, look, feel and navigation has been undertaken. This included usability studies and user acceptance testing with blind users, and/or those users who use screen readers.”

6.1.4 Outcome of the review of disability services

Respondents described how they used the findings of their reviews to effect change. This often involved institutions changing or enhancing their current disability support to improve aspects that were shown to be not working or not well developed or to introduce services that were felt to be lacking. Here some institutions described developing new structures such as establishing collaborative working groups, recruiting new staff and/or clarifying staff roles and responsibilities. Outcomes of the review could also involve development of policy, and some institutions described how they developed or enhanced their guidance or policy framework for the institution.

“The establishment of a student wellbeing and mental health working group which includes membership from across the institution including students, external stakeholders and professional and academic departments.”

“The key recommendation from this review was the introduction of a ‘mixed model’ of support – drawing from government funds (where available) for the most complex support, and ‘topping up’ with university funding in those situations where disabled students were no longer eligible for DSA-funded support.”

One provider noted how they drew heavily on their findings to take action across the institution to develop new policy, improve collaboration, help staff, and change culture:

New ‘Disabled Students’ policy for the institution, outlining legal duty, roles and responsibilities, reasonable adjustments etc. Improved joined-up thinking and working between disability service

and other areas of student services, plus better support for staff across the university (academic and professional services) in support of disabled students. Change of culture within disability service around continuous improvement of support interventions and complementary models of service delivery (e.g. one-to-one specialist support, group and peer activities, more inclusive 'mainstream' skills programme etc.).

Institutions clearly saw their services and provision as something that would continue to evolve. Here providers talked about how they intended to continue to review their services and particularly to undertake evaluations to find out if the services or schemes they established following their review of provision were effective.

Good practice example: The University of Huddersfield

Using review findings to speed up students' access to advisers

The university undertakes an annual survey of disabled students registered with the disability service in June every year, which achieves around a 10 per cent response rate. The survey covers a number of performance measures including the proportion of students who got access to support quickly, the proportion who had their support plans implemented, and the proportion who were happy with their academic tutors. The survey also gathers general comments which they find are very helpful with service planning, identifying areas of service improvement and recognition of a positive student experience. The survey findings are used on an annual disability service away day to identify any issues and develop solutions.

For example, two years ago they introduced same-day appointments with a disability adviser, for a half hour session, and in 2018 added a 'five-day rule' where a student can see any adviser within five days to discuss any issues, although this may not be their regular adviser. This new system was introduced to speed up students' access to advisers and to stop caseloads of particular advisers building up while others had space in their diaries.

6.2 Evaluation of current practices

Providers were asked about how they evaluated the effectiveness and impact of their support and how they monitored student success, and specifically how they evaluated the impact of disability support services. The vast majority referred to a range of quantitative and qualitative sources of evidence including existing management information data such as attendance, retention, progression and service use – which could be supported by harnessing learning analytics (See Section 4.5.5); as well as specifically commissioned surveys, focus groups and consultations.

Good practice example: Bath Spa University

Providing structures and resources to support evaluation

The university recognises the importance of evidence-based practice and particularly to understand what works (or indeed doesn't work). It is therefore working to become more sophisticated in its use of existing internal data for monitoring and analysis, and to focus on (comparative) attainment and retention of specific student groups and courses etc. They appreciate that this can be quite resource intensive so to support this work the university has appointed a new data analyst who will sit within the student experience strand of work.

The student support team are also working collaboratively with the university's IT department to get 'more agile reporting capacity (e.g. access reports, dashboards etc.)' and to get better at harnessing learning analytics. They are using this data analysis to support the business case for additional requests. For example, their analysis indicated a particular spike in the number of students in one subject who were on the autism spectrum and so it meant that the student support team could undertake proactive work with the academics on the relevant courses prior to the start of the academic year (giving briefings etc.).

6.2.1 Approaches to evaluating the impact of support

Student feedback surveys were the most commonly used evaluation method (95 per cent) and this was also the case in the baseline survey. Other frequently used methods in the current survey included analysis of service usage data (93 per cent); and analysis of key metrics such as retention (85 per cent) and attainment (82 per cent). Analysis of retention and attainment data involved assessing whether results for disabled students were commensurate with other (non-disabled) students or the student population as a whole. Other methods of evaluation reported included: running focus groups with students (60 per cent), undertaking specific projects focusing on evaluation (53 per cent) and analysis of attendance data (44 per cent) (Table 6.2).

HEIs with high or medium average tariff scores were much more likely than other providers to undertake specific evaluation projects (71 per cent and 69 per cent respectively), while providers with at least six per cent of students claiming DSA were significantly more likely than others to analyse attainment data (94 per cent, compared to 68 per cent of those with less than six per cent of students claiming DSA).

Table 6.2: How do you evaluate the effectiveness and impact of your support and monitor student success? (Multiple response)

| | Current | | Baseline | |
|------------------------------|---------|------|----------|------|
| | Number | % | Number | % |
| Student feedback survey | 59 | 95.2 | 47 | 50.0 |
| Attainment | 51 | 82.3 | 34 | 36.2 |
| Retention | 53 | 85.5 | 29 | 30.9 |
| Focus groups | 37 | 59.7 | 4 | 4.3 |
| Service usage data | 58 | 93.5 | - | N/A |
| Attendance | 28 | 45.2 | - | N/A |
| Specific evaluation projects | 33 | 53.2 | - | N/A |
| Other | 1 | 1.6 | 19 | 20.2 |
| N= | 62 | | 94 | |

Source: IES surveys, 2017 and 2019; base = all respondents

Providers were also asked about some specific aspects of their evaluation of disability support, in a new series of questions for the current survey. All providers were presented with the questions but a relatively high non-response rate (28 per cent) may indicate that providers with less sophisticated evaluation processes did not respond to the questions at all. The results show that:

- Four fifths of responding providers (81 per cent, n=39, representing 58 per cent of all providers in the survey) reported that their evaluation of disability support included opportunities for core staff involved in disability support to have conversations about evaluation on a regular basis
- Two fifths of responding providers (38 per cent, n=18, representing 27 per cent of all providers in the survey) reported that they used a consistent approach to evaluation planning across all activities, rather than evaluation being piecemeal and ad hoc. The same number and proportion reported use of common protocols for building in evaluation
- One in five responding providers (21 per cent, n=10, representing 15 per cent of all providers in the survey) reported that they worked with specialist academic staff to undertake or commission evaluation. This was most common among HEIs with high average tariff scores (38 per cent).

Providers were asked whether or not they undertook a number of typical methods for evaluating the effectiveness of support. These questions were also included in the baseline survey. Table 6.3 shows that the prevalence of surveying disabled students to obtain their views about support provision has decreased between the two surveys, from 91 per cent of providers in the baseline survey to 64 per cent currently, whereas the prevalence of other typical methods is broadly in line with that found in the baseline survey. The current survey included a question about whether or not providers compared continuation rates between disabled and non-disabled students, and more than nine out of 10 (92 per cent) did, although small providers (79 per cent) and specialist HEIs (73 per cent) were less likely than other providers to do this.

Table 6.3: Providers' use of typical methods for evaluating the effectiveness of support for disabled students (multiple response)

| | Current | | Baseline |
|--|---------|------|----------|
| | N= | % | % |
| Survey disabled students to obtain their views about support provision | 40 | 66.7 | 90.8 |
| Compare academic results of disabled and non-disabled students | 54 | 90.0 | 83.5 |
| Compare NSS results between disabled and non-disabled students | 32 | 53.3 | 59.4 |
| Undertake focus groups/qualitative research with disabled students | 36 | 60.0 | 53.6 |
| Compare continuation rates between disabled and non-disabled students | 56 | 91.8 | N/A |

Source: IES surveys, 2017 and 2019; base = all respondents

Responses to the open text questions provided further detail about the evaluation approaches and measures and indicators used, and the comments illustrated the diversity of approaches utilised to gather evidence to inform future practice. Some providers described how they undertook annual student surveys to explore the use of and satisfaction with services. These could be general student surveys (such as 'student barometer') that were administered by other parts of the institution for example the students' union. However, they could also include surveys to explore experiences of disability support and wellbeing services. Sometimes these surveys were combined with

group feedback. Others complemented this with specific surveys either to gather views of particular groups of students or feedback on particular services offered. Some also talked about using data on service use/take-up. (See also Section 4.5.5 on learning analytics.)

“We primarily use surveys (including anonymous surveys) where we ask for both positive and developmental feedback. There is also a disability equality interest group that provides regular feedback on key issues of support.”

“The disability service runs a general annual survey for all disabled students. There are also specific surveys for students with SpLD, autism and for those students receiving NMH support and also Assistive Technology. Specific evaluation has also been conducted for those disabled students who have access to lecture capture technology.”

“Online student feedback surveys conducted after first meeting with students. Study skills survey conducted annually. Disabled Students’ Network focus group - these are termly – students get the opportunity to discuss issues, concerns and celebrations with staff. Yearly service user survey.”

“... 54 questions using a combination of the 'Likert' scale, 4-13 rate agreement (where relevant) plus open-ended questions and multiple choice. For example: ‘If you used a computer and Assistive Technology such as Claro Read in your exams, how satisfied were you? Very Satisfied, Satisfied, Dissatisfied, Very Dissatisfied, I did not use Assistive Technology in my exam.’”

Some also talked about other more informal feedback mechanisms that they use for evaluation, which highlights the importance of networking and consultation. These include student feedback provided informally at appointments or after events, staff/student committee discussions, feedback from staff (on the impact on students), and feedback from procedures such as complaints, mitigating circumstances or appeals.

“Department Disability Network members are important in providing feedback and evaluation of the services provided. Regular meetings and planning within core staff team. Regular and consistent student engagement directly with students and via the SU (e.g. disability rep).”

“Evaluation is mainly ad hoc. We review NSS measures by priority groups and consider differences in the responses of disabled and non-disabled students. We provide fora for disabled students to meet with senior university staff to provide feedback.”

One provider also talked about external validation of the effectiveness of their provision gained through winning a sector-wide award for their dyslexia service (from the Association of Dyslexia Specialists in Higher Education).

Providers also commented on how they used key measures or metrics such as: student satisfaction (via the National Student Survey (NSS)), attendance, continuation rates (retention and progression from year to year), attainment/academic results (e.g. ‘good degree’ First or Upper Second) and employment outcomes. Some also used waiting times as an evaluation measure, and also disclosure rates. Generally these measures were

identified as KPIs for the institution, and it was noted that they correspond with Teaching Excellence and Student Outcomes Framework (TEF) metrics. Here providers tended to describe how they ran regular reports (e.g. annually or even monthly) which tend to be linked to APP evaluation activity. Some noted that they drew on OfS data/resources and other national data such as Graduate Outcomes, as well as their own internal management information data. Generally providers compared rates for disabled and non-disabled students but did so within different populations such as undergraduate students, and postgraduate students. This allowed them to identify trends and any gaps in the performance against key measures. One provider talked about the importance of seeing these measures as 'distance travelled'. Some providers described more sophisticated and disaggregated analysis: by disability type, intervention or support (funding) received, and/or by faculty or department:

“At an institutional level we compare the performances of non-disabled students to disabled students and also, at an 'activity or intervention' level, we compare those who receive the intervention against those who don't (whether they are disabled or non-disabled). We also break this down to disability grouping and those not in receipt of DSA.”

“Continuation data is analysed according to all characteristics and impairment types, allowing us to identify needs for intervention. Moreover, analysis of this type has been important in the development of our new education strategy and ongoing wellbeing and welfare review, which will allow us to set a long-term vision across the institution for ensuring maximum levels of continuation.”

One provider illustrated the diversity of approaches and range of measures used in evaluation. They commented that their disability service takes a continuous improvement approach to evaluate the effectiveness of the support they provide to students.

“We carry out this evaluation in a variety of methods including survey results, soft/informal feedback, formal feedback through complaints, data usage sets and data sets around retention, attainment, access and outcomes. We also set and measure key performance indicators including tracking the engagement levels in: workshops, training sessions, one-to-one appointments and drop-ins.”

They noted that they use a range of indicators to evidence effectiveness of the support they provide:

- The disability service offers a range of group workshops, one-to-one sessions, and surgery activities. The institution works to evaluate engagement with these through gathering pre-session and post-session feedback. This enables them to track students' progress. The analysis has shown a rise in certain areas such as confidence, success, or ability.
- They analyse data on retention, outcomes, access and attainment as key indicators of effectiveness.
- They use management systems data to monitor take-up of appointments and use of networked AT, and regard increase in the use of these resources as an indicator of effectiveness.

- They track data on the take-up of DSA at the institution and also compare this with sector averages. They regard a rise in the take-up of DSA as indication of the effectiveness of onsite promotion of DSA. They note how this then links into national research which shows that students accessing DSA have improved retention and outcomes.

6.2.2 Consulting with students

Nearly all providers (97 per cent, n=60) consulted disabled students to obtain their views about support provision. This corresponds with the strong commitment from institutions to engage with their students around disability issues and support (outlined in Chapter 5). The most method to gather student views was to seek feedback about disability services (83 per cent). Other common consultation methods included undertaking surveys of disabled students (67 per cent), working the students' union/guild (65 per cent), gathering student services feedback (65 per cent), and facilitating focus groups with disabled students (60 per cent). Evaluation projects related to specific initiatives, reviews of assistive technology, and selected questions for disabled students in all-student surveys, were all less commonly used (43, 30 and 27 per cent respectively).

Formal consultations (these were generally surveys) were commonly conducted on an annual basis. However, some providers reported more frequent consultation e.g. termly, or noted that consultation was on-going involving continual feedback systems, or would depend on need and often linked to projects (where new support is developed or trialled). Others reported that feedback was gathered in a more ad hoc fashion particularly when referring to more informal feedback mechanisms. All the comments indicated that consultation with students happened regularly. Here one provider talked about the importance of closing the feedback loop to show students how feedback has been used:

"We often make changes based on suggestions with the approach 'you said, we did' which shows continued response and value of student opinion."

Just over four fifths of providers that consulted disabled students (42 per cent, n=25) said that they undertook consultation exercises targeted at students with specific types of disabilities. HEIs with high average tariff scores were most likely to undertake targeted consultation exercises (71 per cent). Comments indicated that such consultation exercises were targeted towards a range of disabilities including: students with an autism spectrum condition, dyslexia/SpLD, mental health needs, with complex disabilities, with mobility issues, with sensory impairments. Consultations could also be targeted towards particular support interventions or pilot projects: study skills tutorials, mentoring, building access, exam arrangements, use of lecture capture etc. Consultations were often targeted at specific groups who were involved with specific projects or activities.

"... for changes to, for example, VLE, students/staff with sensory impairments, physical disabilities will be invited specifically as part of the user testing group; for students with autism spectrum disorder, on support with transition to university."

"Where issues have impacted on a specific type of disability, a targeted consultation has been undertaken. Most recently, this was in relation to the provision of accessible toilets, and the views of students with mobility difficulties were sought."

“We have conducted research on both exam access arrangements for students with SpLD and also on the use of lecture capture for students with SpLD, autism, mental health difficulties and sensory impairments. Students with SpLD are also surveyed specifically regarding the screening and diagnostic process.”

“Students with mental health diagnosis this year were brought into a focus group to review our pilot of non-DSA funded mentoring.”

“Mental health: we have student members on our mental health working group so they are involved at all stages and produce resources for staff training.”

Again the comments from providers highlight the importance of consulting with students to help to improve services:

“Our transitions team obtain feedback from the [pre-sessional induction] course for students with autism and communication difficulties. The transitions team obtain feedback from individual events and mentoring activities and submit annual reports relating to access and participation plan processes.”

One case study noted how student feedback has been particularly valuable. They have a student round-table to discuss student support and to share thoughts around development. This involves key student influencers and leaders and aims to promote open dialogue and involve students in development of support. They described how, in the past, they have made changes to service delivery but had not anticipated ‘how it would land’ with students. The round-table therefore acts as a sounding board to test ideas. They also consult with wider student representatives such as the student mental health rep, disabled students rep and representatives from the mental health society.

Several providers (n=12) also mentioned collecting staff feedback as part of their evidence base, raising the potential for consulting with staff to support service improvement. However, there was typically little detail about the methods used and the focus of the consultation. A move to inclusion inevitably involves changes in who and how support for disabled students is provided. Typically this is a shift from the disability service or other professional services (such as study support, careers, AT) toward academic departments. Given this shift it would be useful to learn more about provider plans and how they will gather evidence from different staff groups to complement student feedback and include feedback from staff on the training and development they receive.

6.2.3 Evaluation of inclusive practice

Providers were also asked whether they had undertaken reviews regarding specific topics related to inclusive practice. Table 6.4 shows that this was much less common than consulting students or surveying students around provision of support. Just half of providers (51 per cent) had undertaken reviews of inclusive teaching, learning and assessment, and a similar proportion had undertaken reviews of the use of and views regarding lecture capture. A slightly smaller group (42 per cent) had undertaken reviews of staff training and development needs regarding inclusive practice, and into accessible

spaces. There was little variation by provider characteristics in use of reviews of inclusive practice areas.

Table 6.4: Providers' use of reviews of specific areas related to inclusive practice

| | Number | % |
|--|--------|------|
| Inclusive teaching, learning and assessment | 27 | 50.9 |
| Staff training and development needs regarding inclusive practice | 22 | 41.5 |
| Staff training and development needs regarding digital accessibility | 15 | 28.3 |
| Views on and use of lecture capture | 27 | 50.9 |
| Specific technology projects designed to support inclusion | 17 | 32.1 |
| Accessible spaces | 22 | 41.5 |
| Disclosure | 9 | 17.0 |

Source: IES Survey; base = all respondents n = 53

Comments from providers indicated that reviews of disability support can often run alongside wider ranging reviews which cover aspects of teaching, learning and assessment (TLA):

“Alongside [our disability service review] the university ran an inclusive learning and teaching project looking at the level to which our provision was inclusive. This has resulted in a longer-term project to establish and embed baseline standards.”

“[In our review process we] focus on the student journey and engagement and support at all stages, including underlying processes. In parallel with a major curriculum review and renewed approach to equality, diversity and inclusion work.”

6.2.4 Sharing and using findings

Providers also described how they used and shared their evaluation findings. Findings are fed back to the core disability service team for them to make improvements to services (through continuous improvement), to understand staff CPD requirements and make changes to responsibilities (via the staff development process), and take into account during their annual planning cycle and budgeting process.

“The evidence is collected annually for the primary purpose of enhancing delivery and ensuring we are meeting the current (and changing) needs of our students in our support provision. Service monitoring is annually reported on to senior management and council in order to ensure appropriate resourcing is met and sector best practice is addressed e.g. Fitness to Study implementation and current development of a university health and wellbeing strategy.”

“The [disability service] makes sure that evidence from evaluation, research, monitoring and reviews feeds into continuous service design and improvement through the embedding of the matrix principle of ‘plan, do, review’ within its strategic and operational plans. This cycle of continuous improvement ensures that staff and students feed into the design and co-creation of the service, which are at the heart

of the service delivered. Their feedback helps to shape the service and also ensures that any new policy or procedural changes take place with staff and student consultation and input. Both staff and students of the service have a plethora of opportunities and mechanisms from which they are consulted and can feed into the shape the service.”

Some described how they used trend data to see whether they have closed and are closing any gaps between disabled and non-disabled students on key measures, and how well they compared to the national picture (against national benchmarks). This can then influence institution-wide strategy and help with target setting (and thus areas for development).

“Through these evaluation methods our key performance indicators include the following: tracking the engagement levels of workshops, training sessions, one-to-one appointments and drop ins. By identifying trends and/or gaps in the engagement with such activities by students helps to evaluate the effectiveness of such activities. ... We look to identify increases in usage of such resources as an indication of the benefit and effectiveness of the support that we offer. We also track data around the take up of DSA ... and compare and contrast this around sector averages. A rise in the take-up of DSA has been a key indicator that the promotion of the DSA on site has been effective. This then links into national research which shows that students accessing DSA have improved retention and outcomes.”

“Datasets are available and these are reviewed to monitor the academic results of disabled students against their non-disabled peers to identify potential gaps or trends within our disabled student population. The data set is also compared against national benchmarks to assist in measuring the effectiveness of the support provided. From such data, we are aware that at [university] we have closed and superseded the gap in relation to pass and third class degrees. Where we still have a gap in ‘good degree’ outcomes helps to shape and channel our support provision.”

“Any areas below benchmark are thoroughly investigated and action planned.”

The comments indicated how providers often shared and discussed findings from feedback and KPI analysis in key committees, working groups and boards which feed into the executive/senior management team. Here respondents talked about using existing structures and also creating/convening new groups. Findings were also commonly disseminated more widely across the institution: to all departments, schools and faculties—professional services and academic departments (or even to all staff). The findings can then feed into departmental action plans, service design and staff training plans. Respondents also talked about feeding back to students (‘to close the loop’ as noted above). Providers used a variety of methods to communicate feedback, findings and lessons learned across the university: annual reports, reports to committees, staff newsletters, briefings, intranet, staff conferences and internal seminars, staff training, and data ‘dashboards’.

“Continuation rates are considered annually, including by academic board, and each academic department has an associated action plan where continuation rates

require improvement. The annual planning process includes consideration of continuation rates.”

“The Learn to Transform element of our strategy makes clear that this is key and we have a robust evaluation framework - NERUPI²⁹. Key stakeholders leading evaluation and monitoring sit on relevant forums to ensure all is fed into service design and improvements from residences to graduate support.”

“Continuation rates for disabled and non-disabled students are monitored annually by the Access, Participation and Financial Support working group. This year, for the first time, this data will be made available to departments as part of a dashboard reporting on access and participation gaps across a range of demographics. The college is currently finalising its access and participation plan, and this will include a target for closing the attainment gap for disabled students.”

“Our internal data is reviewed at course and institutional level each year leading to annual course action plans.”

“Statistical reports provided by the strategic governance and planning department and circulated to all departments and senior staff so trends can be identified and action taken where necessary.”

“We empower individual services to lead in their own areas and encourage a culture of continuous improvement.”

“These [findings] are considered at the level of faculty action plans and specific quality enhancement plans for modules and qualifications.”

“As service delivery adapts and expands offering to meet student (and staff e.g. training) support needs, university communication channels are used to highlight changing service provision. The health and wellbeing strategy and Fitness to Study policy are two recent examples that highlight the impact of the learning support and mental health agenda.”

There was no evidence of the reach or effectiveness of these methods in the survey comments. However, in the case study interviews the challenge of communication was expanded upon and identified as an important element of raising awareness necessary for cultural change. The following extract highlights the range of staff who need to engage if an institutional commitment is to be realised:

“Now we’ve got the institutional commitment we are taking things seriously rather than just to tick a box. To change an institutional culture is NOT and CANNOT be about ticking the boxes. We’ve got grand plans that need to be shared across the university getting senior buy-in which is really important. ... sometimes it’s quite difficult. Head of department academic leaders receive lots of messages and have a lot of things pushed onto them. We are coming from an institutional perspective; this

²⁹ NERUPI framework is an evaluation framework aimed to help HE providers to evaluate the impact of widening participation and equity interventions. It was developed by academics in Bath and Bath Spa Universities. <http://www.nerupi.co.uk/>

is not another thing. This needs to be embedded into our practice, getting colleagues to see the bigger picture. If you are taking an evidence-based practice ... whatever we do we need to focus on the student and empowering colleagues to understand the challenges and the successes (and that there are more successes) and focus on the positives.”

The survey comments also indicated that providers were sharing (or planned to share) findings and particularly areas of good practice beyond their own institution. Mechanisms and channels noted for external communication included: professional networks and forums (e.g. NADP, the Association of Managers of Student Support Services in Higher Education (AMOSSHE), and Jiscmail groups) to ‘contribute to sector-wider discussions’; sector conferences; reports and statistics published on webpages; participation in collaborative projects (such as the OfS Challenge Fund projects); and authoring academic articles.

“The dyslexia co-ordinator is a senior member of the executive body of the Association of Dyslexia Specialists in Higher Education, and is able to share good practice there at the highest level including DSA-QAG (Disabled Students Allowance Quality Assurance Group) and DSSG (Disabled Students Stakeholders Group).”

“[We] share best practice at internal and external conferences, sector meetings and feed into any national surveys, sector meetings at local and national level where appropriate to effect change.”

“We hope to share some of our experiences of enhanced approaches to transition, for example at some of the main sector conferences next year demonstrating good practice in proactive pre-entry engagement with our students.”

One case study noted how it has used its monitoring and evaluation findings to highlight the need to engage with students prior to entry. The university noted that through monitoring they identified challenges in terms of progression for some of their students, and are concerned about attainment gaps among some sub-groups of students with disabilities notably those with cognitive and learning disabilities. As a consequence they have increased their active engagement at pre-entry stage. A key component of this is that they send out a standard ‘pre-arrival questionnaire’ looking at support needs. They have also introduced bespoke online screening so they have an early indication of likelihood of positive diagnosis and can access input from a professional educational psychologist much sooner. This means students can be diagnosed much earlier in the process which helps with access to funding and putting in place support.

6.3 Future monitoring and evaluation plans

When asked about plans for future evaluation of the effectiveness and impact of support over the next two years, 42 per cent (n=25) said they would continue using the same methods as they currently used. A slightly larger group, 58 per cent (n=35), said they would do something different. In the baseline survey, 70 per cent of providers said they would try something different, which suggests that evaluation methods have become

somewhat more embedded over the last two years. Large providers were more likely to stick with the methods they currently used (56 per cent, compared to 35 per cent of medium providers and 39 per cent of small providers).

Among providers who reported they would try something new or different, a majority (77 per cent, n=27) reported that they were currently reviewing the evaluation methods. One in four (26 per cent, n=9) said they would try online feedback or feedback via an app. A slightly smaller proportion (23 per cent, n=8) said they would undertake further research or seek to get responses from a larger sample, and one in five (20 per cent, n=7) reported that they would undertake evaluations by specific disability groups.

7 Results from other providers

This chapter presents results from the survey of providers in the OfS 'approved' category, and other alternative/private providers who were receiving OfS funding for the first time. A total of 14 responses were received. This is too few for any detailed analysis, although the findings will provide some insight into this relatively under-researched section of the HE sector.

7.1 Background characteristics

A section on background asked these providers for details about their HE provision and student body. Key findings are:

- All but one provider offered qualifications at first-degree level, with the other provider offering undergraduate provision below degree level. Just over half (eight of the 14, 57 per cent) offered postgraduate taught degrees, and just over a quarter (four of the 14, 29 per cent) offered postgraduate research degrees.
- The number of students ranged from around 50 to 8,000. Half of responding providers were small, with between 100 and 1,000 students, and thus smaller than the institutions in the wider (publicly funded) sector.
- Providers covered a wide range of subjects, including business, theology, health and social care, law, counselling and acting.
- The majority (12 of the 14, 86 per cent) had qualifications that were validated by another provider or their provision was franchised from another provider. Only two of the 14 awarded their own qualifications.

7.2 Governance and funding

Responsibility for supporting disabled students typically rested with the senior management team (64 per cent, n=9), with two respondents reporting that responsibility sat with the head of the provider, and three reporting it sat with the director of student services or academic head. This high-level responsibility is likely to reflect the smaller size of these providers and their flatter management structures.

Written policies were common and reflected the wider sector. All but one provider (93 per cent) said they had written policies describing the support for disabled students. Most providers said that their policies covered student support, teaching and learning, and assessment. Fewer (four of the 13, 31 per cent) said that policies covered inclusive curriculum design/universal design. Similarly relatively few (three of the 13, 23 per cent) said that they had specific policies for students with particular types of disabilities. This

reflects patterns found in the wider sector (among publicly funded HEIs and FECs). Most of the private and alternative providers surveyed (69 per cent, n=9) updated their policies annually.

In half of providers (n=7) the executive team had responsibility for deciding the budget for disability support, and in a further four providers (29 per cent) a member of senior management had responsibility for deciding the budget. Budget decisions were based mainly on the disabled student population size and needs, internal funding available, and providers' legal obligations. Legal obligations also featured strongly in the decisions around budgets for publicly funded institutions. However, for this group of private/alternative providers historic spending might not be available to guide budget setting.

7.3 Disability support

There was considerable variation in the job title of the individual with day-to-day responsibility for disability support, ranging from titles such as disabilities officer, learning support co-ordinator/tutor and student welfare officer, up to academic head, head of student experience and director of student services. However, most (86 per cent, n=12) combined this role with other responsibilities within the provider. Again this is likely to reflect the smaller size of these providers and potentially more limited staff resource.

Responsibilities as disability support manager were more similar across the group. These responsibilities focused on: assessing students' support needs; co-ordinating learning support; and arranging reasonable adjustments.

In around two thirds of providers (64 per cent, n=9) there was a larger disability support team, but generally consisting of one or two other individuals. However, in the remaining one third of providers, disability support was provided by a single individual within the provider.

In just over a quarter of providers (29 per cent, n=4), disability support staff specialised in supporting students with particular types of disabilities – SpLD, mental health problems, and/or social communication/autism spectrum disorders. Having staff with a particular specialism was less common among this group of private/alternative providers than found across the sector as a whole.

Four providers (29 per cent) reported that they bought in services to support disabled students, with the majority (10 of 14, 71 per cent) providing all support in-house. Bought-in support was mostly NMH support, but also included counselling and assessments/diagnosis for SpLD. Use of external support therefore appeared less common than found across the wider sector.

Most providers encouraged disclosure at the application stage (92 per cent, n=11). This was encouraged via application forms and during interviews, as well as via literature provided. Fewer reported encouraging disclosure at other points in the education journey: either pre-application (42 per cent, n=5) or pre-entry (17 per cent, n=2), at entry/induction (58 per cent, n=7), or while on course (75 per cent, n=9). This differs from patterns found across the wider sector where institutions reported efforts to encourage disclosure

throughout decision making, transition and the whole student life-cycle. Comments from the group of private/alternative providers however highlighted the important role of the disability service in encouraging disclosure while on course through publicising the support available, and also the importance of academic staff (and pastoral/welfare teams) in signposting support or making referrals to the disability service. Just over half of providers (58 per cent, n=7) reported that disclosure on digital forms/platforms would automatically trigger signposting to support.

7.4 Inclusive provision

Providers were asked to state what they felt characterises an inclusive model of support. Responses tended to focus on providing reasonable adjustments for students identified as having a disability. This may suggest that this group of providers are slightly behind the wider sector in thinking about and prioritising inclusive approaches to supporting students. However, there were some mentions of broader equality and diversity considerations, and inclusivity by design to reduce the need for individual adjustments. The following responses illustrate the different views:

“Where students can have materials in any format, e.g. braille, audio etc. easily and without having to wait too long; where classrooms and campus facilities are accessible to all; where teaching includes all students.”

“An inclusive model of disability support ensures that those who identify as disabled do not miss out on opportunities available to their peers. We are committed to the principle of equality of opportunity for all staff and students. In line with the Special Educational Needs and Disability Act 2001 (SENDA), we are particularly concerned to make all reasonable provision for students with disabilities so that they may participate in all our programmes without disadvantage.”

“An inclusive model focuses upon the students not the disability. It should focus upon enabling the students to realise their potential by providing appropriate support and accommodation to their individual requirements. An inclusive model should also encourage the wider student body and academic community to embrace diversity and equality and support fellow students and staff irrespective of disability.”

“An inclusive model of disability support would be characterised by student needs being considered from the outset in all realms of the organisation, i.e. including course design and delivery, technology, facilities. This would be reflective of the student profile for the institution and would lead to a reduction in the need for individual adjustments as these would have been encompassed from the outset.”

7.4.1 Inclusive practices

- All providers reported that they made **course materials available online**. Many had a VLE through which materials were made available, but other providers said that they provided class notes, lecture materials, presentations, reading lists, blogs and videos online.

- Most providers had taken steps to ensure that **learning resources were accessible**, most commonly making reasonable adjustments, providing guidance and support, providing e-versions of books, and providing documents with adjustable fonts/sizes.
- Many providers (67 per cent, n=8) provided **lecture/tutorial/seminar notes in advance**, and these were generally available to all students.
- Lecture capture was also common. A majority of providers (62 per cent, n=8) reported that they used **audio or video recording of lectures**, and three of the five providers not currently recording lectures planned to introduce recording in the next year or two. Most (n=7) of those currently using lecture capture used video recording rather than just audio recording. However, it was generally a minority of lectures that were recorded. Decisions about which lectures to record were based on student need, lecturer opt-in, or those with the most attendees.
- Half of providers (50 per cent, n=6) offered **alternative assessment methods**. These included vivas/oral exams, open-book exams, essays instead of presentations, and extensions to submission deadlines.
- **Specialist software** was less common. It was provided as part of the mainstream IT offer in around one in three providers (31 per cent, n=4).
- Just a quarter of providers (25 per cent, n=3) reported that they had an **accessibility plan**.

Digital accessibility

In terms of digital accessibility, the vast majority of providers (83 per cent, n=12) offered materials in a range of alternative formats. Yet only one in three (33 per cent, n=4) said that they had a digital accessibility statement. A greater number (n=6) said that digital accessibility was formally considered as part of procurement of learning resources, and (n=5) said that digital accessibility was formally considered as part of procurement of mainstream IT.

Two thirds of providers (67 per cent, n=8) reported that they provided guidance to content creators (teaching staff) to ensure they are creating accessible digital content.

Staff training

All providers answering the question (n=12) reported that they provided training in supporting disabled students to academic staff. Fewer provided training to student support staff (excluding disability support staff) (n=9), or provided training to teaching support staff (n=8)

7.4.2 Progress towards fully inclusive support

Respondents were asked to indicate how far along they felt they were in providing an inclusive model of support, on a scale of 1 to 10 where '1' represented 'not inclusive' and 10 represented 'fully inclusive'. All respondents answering this question (n=11) felt that they were more than half way towards fully inclusive, with scores of '6' or higher – four

providers gave a rating of '6', five providers gave a rating of '7', and two rated themselves at '8' or '9'. This suggests a greater confidence in their progress than noted across the sector as a whole.

Areas where providers felt they were doing particularly well include:

- Encouraging disclosure and identifying students with potential needs.

"We are strong at identifying students with potential needs and proactively offering them the opportunity to request reasonable adjustments to be considered."

- Providing individual and tailored support throughout the student life-cycle.

"As a small, close-knit college community we have been identified by QAA [the Quality Assurance Agency for Higher Education] as having good practice in this area, it is possible for us to ensure that disabled students are being included in college life. It is possible for all disabled students to receive one-to-one support from the disabilities officer."

"Our small size means we give a personal service to students... many tutors go 'above and beyond' in their support of students."

- Being flexible and transparent.

"Empathetic and fair in the assessment and approval of adjustments, and open to reviewing them as requested by students; open-minded and flexible in our thinking as to type of adjustments and alternative methods of assessment that can be offered."

- Provision of mentoring support.

"We have piloted a disability mentoring scheme, matching students with mentors in the legal sector who have a similar disability/SpLD so that they can learn from them and develop their confidence."

- Focusing on supporting mental health needs.

"We have increased our level of staff training regarding mental health – partly in response to having noticed increased need in this area – and are well equipped to offer students with mental health issues appropriate support."

However, this group of providers still felt there was room for improvement and areas of challenge. In terms of what providers felt still needed to be done in moving towards a fully inclusive model of support, funding for training was the most commonly mentioned factor (n=6). This appeared to be more of a worry to this group of providers than found across publicly funded providers. Other challenges reported were: AT (n=5), staff engagement with training (n=4), inclusive teaching and learning delivery (n=4) and inclusive assessment (n=4).

7.5 Review and monitoring

The majority of providers undertook some monitoring and/or review of the services provided to disabled students.

Half of providers reported that they had conducted a review of their disability support in the last two years or were currently conducting a review (three providers reporting each response). The reviews covered a range of topics, including staffing capacity, incidence of student need, importance of AT, use of different teaching and learning techniques and assessment methods, and student retention and achievement.

Most of those providers who had not conducted a review planned to conduct one over the next two years (five of the six providers who had not conducted or were not conducting a review). Again reviews were planned to cover a wide range of topics, including current student needs, staff training, use of VLE to provide accessible resources, exam arrangements, accessibility of services, and areas of good practice or further improvement.

Three quarters of providers (75 per cent, n=9) reported that they compared rates of continuation between disabled and non-disabled students, and a similar number (n=8) reported that they compared academic results for disabled and non-disabled students. Few reported that they compared NSS results (n=2).

Consulting disabled students to obtain their views about support provision was fairly widespread, with three quarters of providers (75 per cent, n=9) reporting that they did consult students. This was most commonly via student services feedback or via the students' union/guild.

Looking to the future, slightly more providers (n=7) planned to use the same methods to evaluate the effectiveness and impact of support as they were currently using, than planned to try something new or different (n=5).

8 Reflections and conclusions

This final chapter provides reflections from HE providers who responded to the survey and/or participated in the case studies on their provision for disabled students and their progress towards inclusive practice. It also includes feedback on what these institutions felt were the key challenges they faced in supporting disabled students. It finishes with some overall reflections on what are the key learning points from the research and what could be explored or measured moving forwards.

8.1 Overview of provision

The final section of the questionnaire invited HE providers to give open-ended views/free text responses on:

- What they thought they did well in terms of providing support for disabled students
- What they felt they needed more help or support with in providing support for disabled students
- What their immediate priorities for the future were in terms of making changes to support disabled students.

Their frank responses provide a useful insight.

In terms of what they do well, most responded to this question and gave multiple examples. These examples indicated the spread of good practice and the areas institutions feel are working well. The comments also highlighted that HE providers generally described themselves as having a student-centred approach and a willingness to change and improve. The feedback also underlined the dedication and passion institutions and their specialist teams have to ensuring their students have the best experience:

“... compassionate support that really goes the extra mile in trying to get all students to complete their degree even if it takes longer for them, with no judgement about this.”

Several areas of good practice emerged and these reflected aspects discussed throughout the report. Arguably, these suggest key success factors. They include:

- **Strong leadership.**

HE providers commented on the importance of having strong leadership and senior level endorsement around strategy and institutional approach, and having a clear strategy. This was particularly mentioned in relation to embedding a culture of inclusion/inclusive curriculum:

“Support for the inclusive teaching and learning agenda from the executive, driven by the institutional lead (PVC education). This is helping to set the tone and changing the culture.”

■ Holistic approach

Having a holistic approach encompasses considering the needs of all students, working across the student journey, and all members of the institution having responsibility for supporting students.

Here providers described how they provided ‘wrap-around’ support throughout the student journey – from entry, support during the course (including time outside of the university such as time on placements) and transitioning to the labour market. The transition to HE was also key area where support was focused. Providers stressed the importance of engaging early with prospective students to identify issues, give reassurance, and where possible set up appropriate responses ready for their arrival. Early engagement work included: pre-arrival support to help in decision making; providing support during the admissions process/pre-registration (once an offer has been made); and prompt access to support at registration. Examples of early engagement included summer schools for students with autistic spectrum disorder (ASD), campus-based orientation events or early-start programmes where students can access the campus (including accommodation) before the start of term. Several institutions also described how they used online screening for SpLD at enrolment which can speed up the process of identification, diagnosis and access to support. One institution explained the work they do pre-entry:

“A significant proportion of our learning and disability support work consists of consultation, advice and planning with students from the point of offer. There is much that we can do to help students with learning support needs to prepare practically and emotionally to start their studies. Students with more complex needs often benefit from visiting us and their school before enrolment and this can include three-way meetings with course leaders to aid understanding and agree how best to support the student’s learning experience.”

Another noted how they created three schemes to provide holistic support for students with ASDs which cover all aspects of the student’s university experience and have a proven positive impact on retention:

“These schemes help students to address their fear of the unknown and potential feelings of isolation by providing opportunities to develop social communication skills and peer friendships. The autism and Asperger’s support network, social mentoring scheme, and a pre-registration transition event for new students also enable students to become collaborative partners in the development of support provision during their studies at the university. The schemes have been shown to contribute positively to student retention with an increase from 75 per cent in 2014 to 84 per cent in 2018; and with non-continuation correlated to non-engagement with the schemes.”

Providers also talked about joining up support to provide ‘holistic support’ and continuity of support regardless of need or aspect of the university experience where

support is required. This could involve joining up specialists and services into one team working across disability services (e.g. mental health services, counselling, wellbeing, and learner support) to provide a single point of contact for a range of issues. One provider described how collaboration between their support services led to the development of an online service and set of interactive resources (the 'Academic Skills Kit') which provides advice and support with issues such as making the transition to university, time management and academic writing. Joining up support can also involve collaboration with academic departments and professional services (see below).

Holistic support also meant ensuring equity of support across student groups. One institution talked about how they work hard to provide support for disabled students accessing degree apprenticeships, ensuring equity of experience for apprentices with other students.

■ Working closely with staff across the institution

Providers talked about the importance of working closely with staff across the institution to provide a holistic and inclusive model of support where responsibility for supporting students is shared and embedded. This, however, requires staff to be adequately supported with guidance and/or training to better understand: disability issues (including the social model); the need for and benefits of making reasonable adjustments; the importance of inclusive approaches and what inclusive practice means and looks like; and the services available to students such as AT. One HE provider talked about how they provided specific training to all new staff:

“Our Postgraduate Certificate in Academic Practice, delivered by our Academic Development Unit (ADU), has also been a key tool in the development and delivery of inclusive teaching and learning practice.”

The need for the core disability service to develop and maintain good working relationships with academic departments was particularly highlighted. One provider noted the importance of being responsive to academic staff:

“The disability and dyslexia team has an open-door policy with regards to concerns and questions from staff. The team attend course team meetings to discuss disability related issues, including both policy and individual student concerns. The dyslexia co-ordinator also works closely with academic staff to continuously develop the curriculum and assessment to improve accommodation of students with learning differences. The disability and dyslexia team also provide bespoke training to staff groups on request.”

However, a wide range of staff and specialist areas of an institution were mentioned as playing a critical support role within an inclusive approach. These included (but were not limited to) curriculum developers, library staff, learning technologies and IT departments, estates and accommodation teams, and careers and employability teams. One institution described how they undertook a successful pilot programme run jointly by their disability and careers teams around disclosure of disability to employers. They felt this was particularly important as they aimed to provide all students with the opportunity to undertake work placements during their degree programmes. Another

talked about the importance of providing support for the transition to employment and how they deliver employability workshops for disabled students.

Several providers had set up cross-disciplinary working groups and teams to bring different levels and staff specialisms together to consider support issues and solutions. One institution talked about including staff at a variety of levels in work groups such as the Pedagogical Innovation Forum to include their views in reviews, discussions and development. Another institution talked about how they have introduced 'cross-institutional case management' to improve the effectiveness of specific support:

"We have recently established an improved university-wide student support meeting. This has enabled a regular weekly space for all departments (chaplains, security, accommodation, community liaison manager, academic staff, student support teams) to meet to openly discuss the best ways to support students with complex presentations. The regular meeting has improved clarity over support and clear steps to enable student progress."

■ Encouraging disclosure and providing specific support and adjustments

Providers clearly felt encouraging disclosure (and reacting sensitively to disclosure) was still important even in the context of inclusive models of support. This could involve work to create an open and pro-active environment for disclosure across the student journey (not just focused on application and enrolment), and an environment which reduces the stigma in disclosing a disability. Providers noted how success was measured in the increasing numbers of students who disclose:

"We have seen significant numbers of students with access needs over the last five years. The majority of disclosures occur before enrolment, but we also stage opportunities at and after enrolment, with clear procedures for academic teams on how to respond sensitively to information disclosed directly to them."

One provider commented that the support they provide has enabled them to successfully reduce the stigma in disclosing mental health conditions which has resulted in higher disclosure rates (higher than found across the sector) and attracting applications from students with mental health conditions.

The comments highlighted how students disclosing a disability and engaging in a dialogue around their needs helped providers to plan effective support. This was particularly important in the light of the changes to DSA and the greater requirement placed on providers to meet needs. Disclosure and dialogue help institutions to understand the totality of a student's needs, the impact of their impairment or condition on their studies, the barriers and obstacles to learning they face, and how best to address these with specific adjustments, equipment or support (and thus the resources and funding required). Providers can then implement individual tailored support (agreeing and sharing a set of reasonable adjustments) and also feed needs into wider inclusive models of support and considerations for supporting the whole student body.

HE providers stressed the need to continue to provide specific support and adjustments for students on an individual basis even when adopting an inclusive model of support.

This continues to be important as providers described how they are seeing increasing numbers of students with increasingly complex needs and comorbidity.

Additionally, for small institutions it was important that this specific and individual support was provided on a one-to-one basis as this mirrored their general approach to teaching and learning: “We are a small university; we get to know our students well and they tell us they like and benefit from the personalised approach”.

Interestingly, in providing tailored and individual support institutions can build up core knowledge and techniques in supporting particular groups of students. For example, one institution talked about how they have been able to build expertise in supporting students with autism spectrum conditions which encompasses a pre-arrival transition event on campus and then regular support group meetings some of which are run by autistic students. Another talked about how run an ‘autism lunch club’ which provides a safe space for students to meet and socialise.

■ Improving accessibility of services

Providers felt they were working to improve accessibility of support and improving responsiveness of provision to meeting student needs. They noted how successes in this endeavour were evidenced by an increased take-up of services. A wide range of good practices were described including: consultation with students (using a variety of methods); clear communication about/promotion of support available to existing students, new students and prospective students; providing support or adjustments without the need for a full (formal) diagnosis; working to reduce or remove ‘waiting lists’ (including having specialist IAPT support on site and having in-house NMH); making the disability team available to students for informal and formal support; providing a range of different types of appointment to cater to the diverse needs of a diverse student population; offering out-of-hours provision/support; and undertaking research to understand accessibility of services. One institution talked about their out-of-hours service:

“We have recently piloted an out-of-hours support team to work closely alongside our security and accommodation teams. This has effectively supported our security teams to increase their confidence in supporting and signposting students presenting with risk out-of-hours, and has increased and improved our student support provision across departments during evenings and weekends.”

For some institutions improving access to support involved bringing support in-house. This helped them to remove barriers to students initiating support, be more flexible, and react faster to declared needs. These providers talked about how in-house provision and funding removed them from the constraints of DSA protocol.

Some providers stressed that they also think carefully about the accessibility of their estates. One institution noted that they have award-winning facilities for disability sport, including the university arena which is fully accessible for disabled athletes, and how they have good accessibility across their sites in general:

“The university’s estates are widely accessible by design, and every capital project is undertaken with accessibility as a key requirement.”

■ Co-creation of services

Providers described their work to involve students in service design and the importance of giving students a voice in this process.

“Students are genuinely involved in decision making and influencing change, e.g. through the mental health working group, APP preparation and senate, not just the students’ union. We value their input and the insight this gives us and we recognise that what benefits disabled students tends to benefit all students such as Panopto; having lecture notes ahead of a lecture; and increased formative assessment. The university also has an app-based, session-by-session feedback mechanism to ensure all students can provide comments anonymously after every session; the aim is to ensure individual voices are heard as soon as possible.”

“... the disability service now also operate a student panel which acts like a board of governors for the service and contributes towards the development and improvement of service provision.”

■ Focus on mental health and wellbeing

Providers described having a focus on mental health and a strong commitment to support students with mental health conditions or difficulties. This reflects the rising profile of mental health in the HE sector and the public sector more broadly in terms of policy. It also reflects the rapidly rising numbers of students with mental health conditions accessing HE or developing mental health difficulties while in HE. Work here included: focused staff training and recruiting or developing in-house specialists to understand the needs and issues specific to institutions; having mental health first-aiders across the institution; and setting up projects and initiatives around suicide prevention. Some also noted the importance of supporting staff wellbeing.

One institution noted that their mental health tutors and mentors have built up a good knowledge of courses and demands of the specialist subjects (and thus where support is likely to be needed) and that they have been rolling out a programme of mental health first aiders (with 31 staff members trained to date). Another noted that they have trained over 500 staff as mental health first aiders. Another noted that they had been shortlisted for the Times Higher Education Award for Student Support on the basis of their ‘Suicide Safer’ project.

Providers noted how they were also focusing on wellbeing. One institution talked about how they have moved towards a wider wellbeing agenda and thus to focus on *“keeping students well, rather than hitting crisis”*. Another noted that they have introduced an effective and robust set of wellbeing procedures, which are enacted when any staff member has concerns about a student’s wellbeing, behaviour or engagement. This ensures relevant staff (including disability and dyslexia team staff) are ‘pulled in’ to ensure all support that could be available is being accessed. Another described their wellbeing project which offers personalised support for study life and wellbeing:

“[Project name] is an online student engagement platform that provides students with a range of content and tools to enhance wellbeing and engagement, and an opportunity to feedback and support ideas on improvement to the university. Students access the platform through a mobile application and do so anonymously. The university has access to a back-end system which provides interactive dashboards showing measures of wellbeing and engagement by segmented groups, and provides functionality for ideas management.”

■ Increased resources

Here institutions talked about increasing the number of dedicated and specialist staff resource to respond to the increasing numbers of students with declared disabilities and to respond to increased student expectations. One institution talked about developing two new roles to improve support for mental health ‘primary care mental health practitioners’. Another talked about recruiting an autism specialist. HE providers also described building the volume of inclusive resources and technology (developing a ‘bank’ or pool of these resources), and having a budget to enable external referrals (so individuals could access private services such as physiotherapy or psychotherapy which were not available at the university).

■ Harnessing technology

HE providers talked about the work they were doing to harness technology – to make the best use of the technology they have, and to increase the availability of AT. One institution noted that they provided AT for all students in terms of open-access PCs and loan laptops. One institution referred to a specific initiative they have developed where they have successfully engaged with the sector to develop and share knowledge around inclusive practice and particularly the benefits of technology for the whole student population. Through the project they have been able to trial and embed emerging technologies and share this learning with the sector. Another institution noted how their disability team had worked with the university’s IT department on a project where they used virtual assistants to give audio responses to queries. Another HE provider noted:

“The team has increased its commitment to embedding AT in the disabled student support journey through the provision of networked software, loan equipment and a plethora of one-to-one and group training sessions. This has helped to ensure that students benefit from the range of IT and AT that can support their disability, improve their confidence with such support mechanisms and also reduce the need for human support which is a more dependant model of support. This initiative which we have called ‘Get Tech, Go!’ has been rolled out across our disabled student cohort and the data shows and increase in the use of technology and of student confidence and satisfaction.”

8.2 Areas requiring further support

Feedback from surveys and the case studies highlights how providers are facing a number of, often shared, challenges that set the context in which they are working to

develop their services and move towards more inclusive practices. These include: legislative changes such as the GDPR and the new digital accessibility requirements; sector requirements such as TEF and APP; changes to DSA funding; increasing numbers of students with disabilities, particularly mental health conditions/difficulties and those with complex needs; shrinking NHS resources and support; siloed working practices; institutional restructuring and changes to senior management; and patchy commitment to supporting disabled students across institutions. One provider summarised:

“The support provision for disabled students is understandably being affected by external factors. How to manage that impact is a focus for the disability and dyslexia team, this includes: 1: The number of students with ADHD/ADD has grown dramatically in recent years. This group of students are very challenging to support for both the service and for academic staff. The disability and dyslexia service need training and development to enable them to both support these students and the academic staff working with them. 2: Complex mental health needs. The number of students with complex mental health needs is growing, whilst the support available to them outside higher education is less prevalent. Learning how to support these students within the resources we have is priority. 3: The growing pressure to be more inclusive as an institution (thereby reducing the need for individual student adjustments) requires both training for disability and dyslexia team staff, but also the opportunity for them to be involved in teaching, learning and assessment development from the start of the process.”

These challenges can have unintended consequences and act as a barrier to change. HE providers therefore suggested areas where they feel they need more help or support in providing support for students with disabilities: support either from within their institution or from the sector and key bodies which would benefit the sector as a whole.

8.2.1 Sector-level support

Five themes emerged as areas where sector-level support and guidance would be welcomed. They relate to: funding, DSA regulations, creating sector-level levers for change, the need for clearer guidance, and more opportunities to share the increasing good practice that is being developed across the sector:

- HE providers highlighted the importance of **funding** and called for greater funding in recognition of the continuing increase in the numbers of students disclosing a disability (particularly a mental health condition). They felt additional funding would allow for provision of more specialist resource and staff training, allow for greater use of AT, allow for provision of preventative interventions, help to develop universities' estates to improve accessibility, and extend support and allow institutions to offer equivalent support to non-DSA eligible students. One provider also suggested that dedicated premium funding is needed to help institutions support students with complex and severe disabilities. Several case study HE providers described how the numbers of students with complex needs has been increasing: *“Sometimes we have individuals with five or six different diagnoses which can be difficult to pick apart”*.

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- HE providers discussed their frustrations with the **DSA process and regulations** (and how DSA support is based on the medical model of disability) and called for improvements to reduce the administrative burden and inflexibility. One noted how they wanted: *“A less administratively focused DSA process – this does take a lot of staff time up and can be very frustrating for students themselves.”* Another noted: *“Students are experiencing delays in NMH provision as a result of a provider being selected by SFE [Student Finance England] where the provider does not deliver in that area.”* Several pointed to the poor user experience involved with trying to access DSA support.

Suggestions here included the removal of DSA-QAG restrictions which was reported to make recruiting specialist support very challenging (although another provider wanted better quality control of external suppliers); and greater flexibility in the delivery mode and in determining eligibility for support in exceptional circumstances.

- Creating additional **levers for change** was another aspect where sector-level support would be appreciated. Here HE providers noted that funding could be used to create incentives to inclusive practice (such as ring-fenced funding). Whereas one provider suggested that clear expectations could be set through the TEF for institutions to demonstrate inclusive practices which would help to galvanise action within providers.
- HE providers called for better **guidance** for the sector from central bodies on a number of issues, for example:
 - What kinds of support universities should be expected to provide and what support NHS should provide for student populations and thus where the boundary between NHS support and university support should be. One institution noted how they wanted a clear articulation about what is a reasonable expectation of support for a university to offer in the current context of a shrinking NHS resource and increased student (and their parents’) expectation. Another noted: *“We need clarity over where support starts and ends with respect to NHS services and university in-house support”*. One respondent noted how they welcomed the development of the mental health charter to guide expectations around university support for the mental health of its students.
 - Where to focus monitoring activity. HE providers suggested that a checklist could help institutions to audit their current practice and this could help them to identify gaps and thus areas for further development. It was evident in the case study discussions that there is considerable diversity across the sector and multiple data sources and data systems within institutions.
 - How to deal with information sharing with next-of-kin in emergency situations.
 - The Public Sector Bodies Accessibility Regulations 2018 on accessibility of websites/mobile apps.
- Providers felt the sector would benefit from **sharing learning** from practice including specific projects and case studies that focused on what works well in different types of institutions. This would have cross-sector impact, and help institutions to innovate.

8.2.2 Institutional level support

From an institutional perspective the importance of senior management support was identified as pivotal to ensuring the cultural shift necessary to embed inclusivity across the institution. Other themes identified were: 1) collaboration between specialist staff and academic staff to support the move to greater inclusion; 2) ensuring the institution has skilled staff with in-house provision of specialists as well as broader staff training and development; 3) increased awareness, use and availability of AT; 4) the development of inclusive curriculum design, teaching and assessment; and 5) increased access to and use of evaluation and research evidence to inform future provision. Interestingly, these largely echo the areas of good practice highlighted above which suggests that while some providers are doing these well, others recognise they need help to get these right.

- Providers wanted **senior management support**, backed up with clear strategies and policies. These would create effective internal levers for change. One respondent noted: *“More steer from senior management to ensure that supporting disabled students is seen as the responsibility of everyone, not just specialist support staff.”* Another called for: *“Resource to support curriculum review across the institution and design of inclusive curriculum and alternative parallel assessment.”* It was recognised that inclusion initiatives require dedicated time, staff training and funding to be effective, so providers also wanted increased resource.
- Another recognised need was for **better collaboration** particularly between specialist staff and academic departments. Respondents recognised the importance of engaging with and securing buy-in from academic staff which would help move the institution away from making reasonable adjustments and towards more inclusive approaches. *“For the support to be effective for disabled students there needs to be increased collaboration with the academic schools. This will ensure that many aspects of the support can be embedded within the teaching and assessment allowing the [disability service] to concentrate on supporting the more complex students and developing the overall disabled support service.”* Several respondents wanted to have dedicated disability-specific posts within academic departments (variously referred to as ‘academic SEND champions’ or ‘link workers’): *“More staff with disability skills and experience attached to each subject area in each college to be able to embed disabilities in academic matters/content/coursework etc. for that particular department and for academic staff to understand what is meant by inclusive teaching.”*

Some providers also felt they needed to work on creating better linkages beyond the institution, particularly better collaboration with NHS partners around mental health issues. One provider noted that this was priority for them moving forward:

“Developing and enhancing the relationships with our external partners is a key priority in the next two years. With increasing numbers of students with mental health difficulties, in crises and requiring specialist support provision, such relationships are vital if we are to continue to effectively support our students. It is vital that these relationships are developed so that our services on site have clear pathways for referring and ‘buying in’ additional support for our students and, again, can operate in a proactive not reactive fashion.”

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- Having **skilled staff** was important. Some providers felt they needed more in-house and permanent specialist staff to meet the growing student demand. These included mental health mentors, autism mentors, specialist study skills tutors. One respondent noted: *“We need more staff; at a time when staff are being cut, student demand and crises remain high”*. Providers also recognised the importance of staff training and so wanted to be able to offer better and consistent training for staff, particularly training for academic staff on specific disabilities, the specific needs of students, the services provided, and inclusive practice. Here respondents talked about developing online training resources for all staff, how staff training needed to be mandatory not voluntary (and integrated into mainstream staff training), and how training needed to be more standardised.
 - There was a call for better resource for and use of **assistive technology**. This included being able to maximise the use of digital accessibility features in existing software/platforms, as well as further expansion of lecture capture and offering more assistive software. One respondent wanted to be able to offer text conversion software for visually impaired students and those with specific learning difficulties. Another noted: *“We need more support from our IT department who see assistive technology as being used only by individuals with disclosed disabilities and, therefore, not their domain.”*
 - Providers felt they needed a more widespread and consistent approach to inclusive practice which would involve working to embed an **inclusive curriculum**, and working towards inclusive curriculum planning. Several respondents talked about using UDL to help with this endeavour. One noted: *“Some academics are incredibly responsive and innovative in their approach to inclusivity whilst others are less so. Our university values very much embrace inclusivity but we recognise that there are some disparities in attitudes and willingness to grasp the concepts”*. One suggested: *“Establishing some minimum learning and teaching standards re inclusive practice to enable us to move away from a culture of reasonable adjustments and mainstream support even further”*. Other areas where respondents wanted to make improvements to work towards inclusive practice included offering a wider range of assessment methods, and a wider set of anticipatory adjustments.

HE providers recognised there was a balance between providing individualised support while also working to improve wider inclusivity: *“We would not want to lose the benefits of our personal approach but recognise that we need to ensure wider inclusivity and that we don't allow the institutional constructs to stand in the way of inclusivity”*.

- Providers also felt they needed to be better at **monitoring** to assess/review needs and services, to ensure effective support and to make improvements. This was an area where they felt they needed support. Providers wanted support in or with: using evaluation analytics, better data capture, focusing on outcome measures (to understand where there are gaps in attainment), and monitoring of student use of AT. This could be assisted by undertaking specific research projects and developing integrated information systems. For example, one respondent felt their institution

needed a better way to manage and share information about disabled students across the institution.

8.3 Conclusions

Reflecting across the entirety of the feedback provided by HE providers and alternative and private providers, a number of messages emerge:

- Supporting disabled students and moving to an inclusive approach is not a short-term fix but a long journey. Across the sector, providers are at various stages on this journey. However, HE providers feel they are moving closer to being fully inclusive and offering an inclusive model of support covering all students. None feel they are there yet.
- HE providers are frequently using projects to innovate and trial approaches, to test approaches in one area of the institution (often (co)owned and led by a professional service or academic department) or with one specific student group, and to encourage collaboration within and across institutions. These are effective mechanisms to test for implementation issues, potential unintended consequences and impact, using a limited resource and within a set time-period, before rolling out more widely.
- Training and staff development needs to be flexible and ongoing to enable colleagues to acquire role-specific and issue-specific knowledge. This will incrementally add to their awareness and support them in embedding inclusive practices from the start.
- There is a growing recognition of the issues and challenges of intersectionality and the multiple factors that influence students including different equality characteristics, issues relating to social class or other widening-access considerations as well as the needs of international students. Each of these can, and does, combine with issues of disability.
- Approaches and experiences of HE providers appear to be influenced by size of institution, structure and commitment of senior staff. Senior leadership is pivotal for signalling commitment particularly where there are multiple agendas and competing demands. In institutions where senior leaders prioritised a commitment to inclusivity or where it was either a feature of or currently being integrated into revised strategy this was helpful for bringing about the cultural shift required.
- There is no one perfect model, and what works in one institution may not directly translate into another. However, there are some key elements that appear to align with positive change. These include: strong leadership; holistic approach (covering all students and shared responsibility across the institution); collaboration within institutions between core disability services and across all staff groups; balancing inclusive approaches with providing individual tailored support; encouraging disclosure across the student life-cycle; improving accessibility to services, digital resources and estates; giving students a voice and involving them in the creation of services; focusing on mental health and wellbeing; ensuring adequate resources; and harnessing technology.

- Sharing good practice is useful and something that institutions of whatever size are open to. There is a strong desire to use evidence to understand and share what works, but context is key.
- The activities of alternative and private providers mirror those of publicly funded HE providers with few exceptions. This group tended to have smaller core disability support teams (reflecting their smaller student population), had less engagement with external services, and were less likely to have an accessibility plan or digital accessibility statement. They were, however, fairly confident of their progress towards a fully inclusive model of support.

In addition, key changes noticed between the baseline and current study include:

- The use and coverage of AT is increasing, particularly lecture capture which is used in the vast majority of HE providers (with two in five HE providers using it to capture more than half of all lectures).
- Accessibility plans are on the increase but HE providers are still facing challenges in making their teaching and learning spaces and particularly their accommodation fully accessible.
- Engagement with students in relation to disability issues has increased substantially helping to facilitate co-design of services.
- Interaction with external agencies is increasing and a greater proportion of HE providers buy in services from external providers particularly NMH support. Only one in 10 providers now provides all services in-house. This can cause some institutions and students frustrations, particularly around the administration of DSA.
- HE providers continue to evaluate the effectiveness of the support they provide in order to enhance provision. There appears to be a shift towards using hard-outcome measures of effectiveness in line with developments in the TEF and APP. The influence of other demands on universities, such as the APP, the TEF and digital accessibility, can act as drivers for positive change and also help to create useful data to review and evaluate services.

New indicators

Finally, this current research suggests a few areas where additional indicators could be developed which reflect how providers think about inclusive practice. These cover emerging practice (practice that is not yet widespread) and where practice is variable, and thus represent aspirational areas for improvement. These could focus on:

- Senior level commitment to the inclusion agenda.
- Wider staff involvement in encouraging disclosure.
- Written policies describing inclusive support and taking a whole-institution approach.
- Building in considerations of inclusivity/accessibility into curriculum design and programme review.

- Building considerations of inclusivity/accessibility into purchasing of services and equipment (reflected in the tendering process).
- Extent of sharing good practice within institutions and across the sector.
- Provision of advice, guidance and good practice examples to staff on meeting digital accessibility standards.
- Offering alternative formats as standard practice.

Glossary and abbreviations

Abbreviations

ADD – Attention deficit disorder

ADHD – Attention deficit hyperactivity disorder

AMOSSHE – Association of Managers of Student Support Services in Higher Education

AP – Alternative provider

APP – Access and participation plan

ASD – Autistic spectrum disorder

AT – Assistive technology

CBHE – College-based higher education

CPD – Continuing professional development

DDA – Disability Discrimination Act 2010

DSA – Disabled Students' Allowance

DSA-QAG – Disabled Students Allowances Quality Assurance Group

EAL – English as an additional language

EHA – Education, health and care

GDPR – General Data Protection Regulation

FE – Further education

FEC – Further education college

FTE – Full-time equivalent

HE – Higher education

HEFCE – Higher Education Funding Council for England

HEI – Higher education institution (refers to publicly funded HE providers)

HEP – Higher education provider (wider term covering all providers of HE)

HESA – Higher Education Statistics Agency

IAG – Information advice and guidance

IAPT – Improving access to psychological therapy

ICD – Inclusive curriculum design

IT – Information technology

Jisc – Joint Information Systems Committee

KPI – Key performance indicator

NADP – National Association of Disability Practitioners

NHS – National Health Service

NMH – Non-medical helper

NSS – National Student Survey

OFFA – Office for Fair Access

OfS – Office for Students

OIA – Office of the Independent Adjudicator

QAA – Quality Assurance Agency for Higher Education

SEND – Special educational needs and disability

SU – Students' union

SpLD – Specific learning difficulty

TEF – Teaching Excellence and Student Outcomes Framework

TLA – Teaching, learning and assessment

UDL – Universal Design for Learning

VC – Vice-chancellor

VLE – Virtual learning environment

WCAG – Web content accessibility guidelines

Terminology

Academic developers – this includes academic, educational and learning developers with a focus on working with academic staff to enhance teaching, learning and assessment.

Baseline survey or Phase one survey – refers to the first stage of the research undertaken in 2016/17

Current survey or Phase two survey – refers to the follow-up study undertaken in 2018/19

Estates – this includes Buildings Departments as well as Buildings and Estates Departments.

IAG advisors – this includes staff with multiple professional contexts, some of whom have multiple roles as administrators, academics, admission officers but whose comments relate to the activity of information advice and guidance.

Large provider – has a student population of more than 11,000 individuals

Learning technologists – this includes IT specialists, IT technicians, technology designers, learning designers.

Medium provider – has a student population of between 5,000 and 11,000 individuals

Professional services – this is used as a collective term for all services apart from academic faculties, schools or departments. In some instances these services or committees will be named.

Senior leaders – this includes vice-chancellors, deputy and pro vice-chancellors, principals and deputy principals.

Small provider – has a student population of less than 5,000 individuals

Statistical significance – using chi-squared tests to indicate where the probability of the relationship occurring by chance is less than 0.05

Student services or disability services – this includes student and wellbeing, student support, student experience, disability support, disability services.

Technical annex

This technical annex provides full details of the study methodology.

Online survey – Phase two

Drawing the sample:

All publicly funded providers who received at least £20,000 in funding from the Disabled Students Premium in 2018/19 were sampled. The details of this sample were provided by the OfS, and consisted of 127 HE institutions and 30 FECs. A second sample of private/alternative providers was drawn with the support of the OfS from their register of providers. These were drawn from their 'approved' category, plus providers that were new to the 'approved (fee cap)' category in the register.

Developing the survey:

The design of the online survey was informed by the research team's experience of undertaking the baseline study (Phase one) and this was supplemented with stakeholder consultation involving the OfS and a small number of HE providers. This initial work helped to identify the changes in the wider context and changes in provision or technology since the Phase one baseline survey and thus the changes required to the baseline survey questions and to develop new questions for the follow-up (Phase two) current survey. However, the current survey was designed to replicate – as far as possible – the baseline survey. This was to allow for like-for-like comparison over time at aggregate and individual institution levels, particularly in terms of the key indicator measures that emerged from the baseline survey.

In addition, representatives from private and alternative providers provided feedback. This group were not in the baseline study. A modified version of the Phase two main survey was produced for this wider group, and this was facilitated through the membership group Independent HE. The modified survey included additional questions to capture details of the size and characteristics of the disabled population at each provider (as this is not available through the HESA student record dataset), and to capture details on the nature of learning and teaching delivery (for context).

Both surveys (Phase two current and modified) included factual questions about the nature of provision and also open questions to describe key aspects and characteristics of provision and to capture views on progress. More specifically the survey(s) covered:

- Governance and organisational structures
- Budget and expenditure

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- Organisation of support
 - Inclusive support covering technology, other inclusive practices, physical accessibility, digital accessibility, and staff training
 - Disclosure
 - Engaging with students around disability support
 - Engaging with external providers
 - Monitoring and review
 - Reflections on provision, progress and priorities

New questions were added to the follow-up (Phase two) current survey to capture further information on:

- Digital accessibility
- Senior support for a culture of inclusivity
- Assistive technology including captioning or transcribing lectures and training on AT software
- Monitoring, review and evaluation of services e.g. use of learner analytics, dissemination and use of evaluation findings.

Approaching HE providers

The sampled institutions – all publicly funded providers who received at least £20,000 in disability funding from the Disabled Students Premium and those selected from the approved category of the OfS register – were notified of the study by the OfS in May 2019 (in a letter sent to all vice-chancellors and principals). The letter informed providers of the research, and asked them to identify a senior institutional contact to support the study essentially to represent the institution and coordinate input of key staff. The named key contact was then sent an invitation to participate in an online survey (with a secure individual link to the survey) and asked whether the institution would be prepared to provide further feedback and insights by nominating themselves as a case study.

The survey was hosted on IES' online survey provider, SNAP surveys, and was set up so that only one response could be submitted per institution. However, respondents were able to complete the survey over several sessions and thus could consult with colleagues and gather factual data if required (and were provided with a Word/PDF version of the survey to support this endeavour). The survey was launched in June 2019, with reminders sent in June and July and the survey was closed at the end of July. Responses were gathered from 67 of the institutions contacted (this represented 61 completed responses and six partial responses). Provider-level data was added to the survey dataset to allow for an examination of responses by provider characteristics such as size, type of institution and proportion of disabled students (see table below).

Analysis

The survey responses were analysed in SPSS, and the follow-up (Phase two) responses were added to the baseline (Phase one) responses to allow for comparison (including significance testing to understand the strength of any changes over time).

It is perhaps important to note that the number and final composition of the Phase two responding sample differs in some ways from the responding sample achieved in the baseline survey (Phase one) – as indicated in the table above. The number of responding providers is lower than achieved in the baseline survey but this is likely to have been affected by the timing of the survey fieldwork (taking place in summer). The proportion of responses for tariff group, size and percentage of students in receipt of DSA were broadly the same. However, there was a difference in the response rate based on institutions with a small proportion of their student body (less than six per cent) with a self-declared disability. In the current survey this group are under-represented when compared to the baseline survey. Similarly, institutions with a larger proportion of their student body (more than eight per cent) with a self-declared disability are over-represented in the current survey when compared to the baseline survey.

Provider case studies – Phase two

A small number of case studies took place in July and August 2019 to allow for more detailed insights into the issues around developing inclusive provision and the progress made in the past two years. In total, nine HE providers participated including four who had acted as case studies in the baseline study. These nine institutions were identified from a shortlist selected with support from the OfS. The sampling approach mirrored that used in the baseline research. These were selected to be representative of the range of providers and their experiences across the sector. These included universities, colleges offering mixed FE and HE provision, specialist institutions, and those offering a wider portfolio of disciplines and modes of study. It included institutions with different average entry tariffs, located in different geographic regions within England, institutions of different sizes and belonging to different mission groups, and with differing relative proportions of disabled students.

The case studies involved telephone and Skype/ZOOM (virtual) discussions by the research team. Each case study involved discussions with three or four key staff (although one case study involved discussions with over 10 individuals) representing senior management, disability services/student support management and support practitioners. Where possible, student representatives were also consulted, but this proved challenging given the timing of the case study fieldwork. Discussions took place individually and in groups (depending on participants' preferences and availability) and followed a semi-structured topic guide.

The topic guide included similar areas to the online survey, but allowed the researchers to probe for more depth of insight especially on the diversity of perspectives around inclusivity, the details of examples of good practice and the challenges and lessons learned regarding what many referred to as requiring a cultural institutional change.

