

NHS England Statutory and Mandatory Training Programme

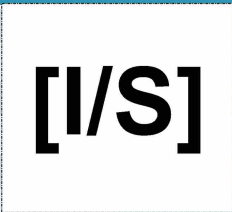
Resuscitation SME Webinar

21st January 2026



Standard title slide

Agenda

No.	Item	Presenter
1	Welcome & Session Aims	
2	Reform Overview	
3	Case for Inclusion	
4	Ask of Stakeholders	
5	Q&A	
6	Next Step	

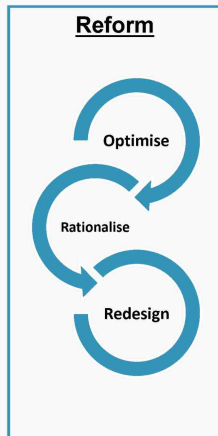
Plain slide with subhead and bullets

Reform of Statutory & Mandatory Training for NHS in England

NHS England is leading a programme to optimise, rationalise and redesign statutory and mandatory training in partnership with DHSC, CQC, HSSIB and NHS Resolution.

Issues:

- “Training is not relevant, too long, repetitive and not portable.”
- Demand is growing, as often recommended post-incident investigations.
- Should be about people working safely, however, limited evidence of efficacy.
- Training is least effective intervention under the *Hierarchy of Effectiveness*.
- Spend estimated 1.5 million days of time on nationally mandated training alone.
- Local subject matter experts often set policy, leading to variation.



Aims:

- Improve outcomes – keep people safe.
- Avoid incidents and less harm.
- Improve evidence that training delivers.
- Build competence, not repeat training.
- Reduce time burden.
- Improve learning experience.
- Make learning:
 - relevant
 - high quality
 - accessible
 - valuable
 - portable

Optimise and Rationalise – the headlines

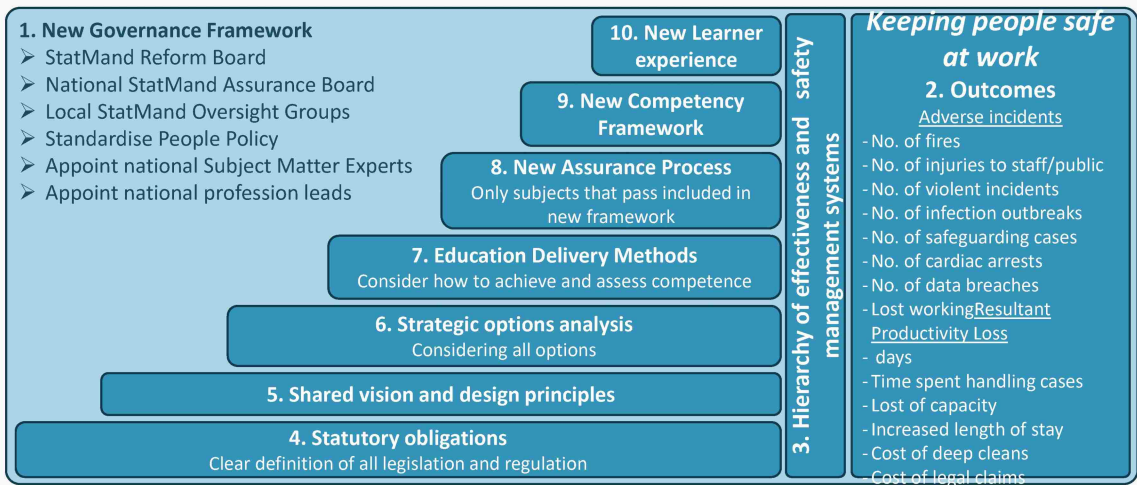
Optimise	<u>Making most of what is currently available</u> • 100% coverage across NHS organisations and FY24/25 Priorities and Operational Guidance directed all to: • align to Core Skills Training Framework (CSTF) - now at 93%. • Utilise elearning for healthcare content – now at 75% usage. elfh content updated. • Reasons for non-alignment and non-utilisation captured. • 264 NHS organisations signed the StatMand Staff Movement MOU to accept prior training from 1st May 2025.
Rationalise	<u>Making most of what is currently available</u> • Letter sent to the service on 14th November 2024 setting out the shift to an outcomes-focus approach: • Establish local Mandatory Learning Oversight Groups (MLOG) • Elongate refresher frequencies, where safe to do so • Reduce the number of people mandated, where safe to do so • People Policy Framework launched in April 2025 to adapt and adopt.

Releasing 200,000 days of staff time

Plain slide with subhead and bullets

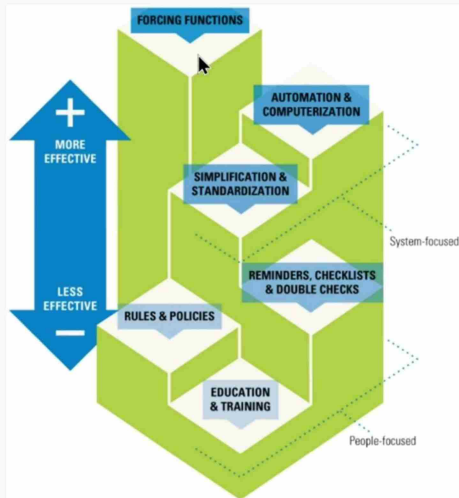
Redesign of StatMand Training for NHS in England – 10 steps

Zero-based review to consider what is needed to improve outcomes.



Plain slide with subhead and bullets

Use more effective interventions - Hierarchy of Effectiveness



Hierarchy of Controls

Used by other safety industries (e.g. airlines, nuclear, rail, construction etc.)

<https://www.cdc.gov/niosh/hierarchy-of-controls/about/index.html>

Hierarchy of Effectiveness - adapted for patient safety.

Human Factors in Patient Safety Article

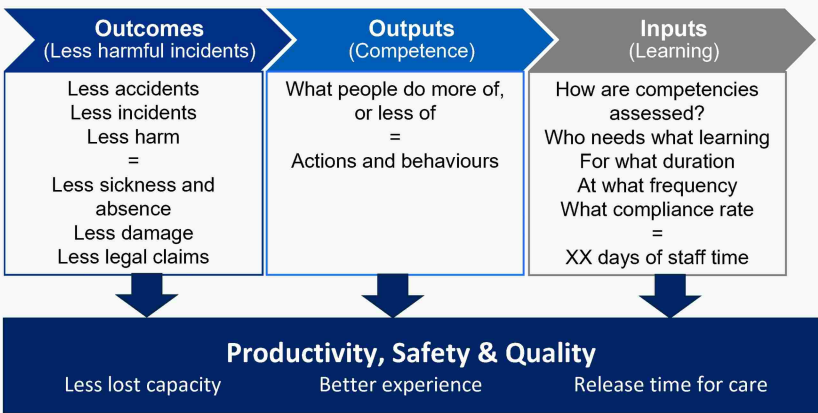
<https://patientsafe.wordpress.com/wp-content/uploads/2015/12/hierarchy-of-intervention-effectiveness-copy.pdf>

Mandating training is least effective intervention

Plain slide with subhead and bullets

Shift from Inputs to Outcomes by defining Competencies

New Competency Framework focuses on what staff in the NHS in England need **to do** to reduce harmful incidents.



Mandatory Learning – a shared vision

Mandatory learning provides a foundation of competence to keep people safe, essential for care quality, patient safety and productivity.

Our people work together, taking every opportunity to keep people safe, avoid incidents and reduce risk of harm. Mandatory learning is effective and efficient, alongside other interventions.

Mandatory learning is relevant, high quality, accessible, valuable, and portable for learners.

- **Our learners** can easily access high quality learning, relevant to their sector, setting and role. They take professional responsibility for gaining and maintaining their competence and take their record of competence with them wherever they work.
- **Our leaders** ensure the right training is delivered, to the right people, at the right time. They maximum outcomes from the investment of time spent, through multi-disciplinary oversight of requirements and delivery.
- **Our subject matter experts (SMEs)** monitor number and cost of incidents and near-misses, work together to evidence root causes, consider all possible interventions and where a lack of competence is a clear contributing factor, they input into learning design and delivery.
- **Our education and organisational development (OD) specialists** work together to co-design and co-deliver optimal education and OD interventions with SMEs to build the knowledge, skills, behaviours and routines of all our employees, workers, students and volunteers.



**Safe working, ever
reducing incidents**

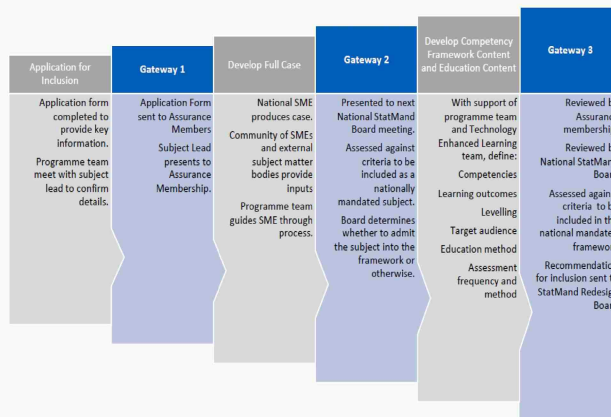


**Effective training,
competent workforce.**



**Easy access to high
quality education.
Portable record of
competency.**

Assurance Process – 3 gateways ensuring a thorough review



Key assurance questions:

1. What is the problem that mandating learning aims to resolve?
2. What interventions have been considered – using Hierarchy of Effectiveness and considering Safety Management Systems approach?
4. Where competency of the workforce is a key factor, what do you want people to do more or less of?
5. What is the current and proposed investment of staff time for mandated learning?
7. Does what is proposed help employing organisations satisfy their statutory obligations?
8. What is the optimal learning delivery method and assessment approach?

Plain slide with subhead and bullets



**Development of the Case
for Inclusion –
Resuscitation**

Standard title slide

Approach Taken

- Appointed by National Medical Director and overseen by National Clinical Director of Heart Disease and National Director of Patient Safety
- A number of local SME expressed an interest in being involved, via local StatMand Leads.
- Task and finish group met several times between April and August 2025
- Engagement with Resuscitation Council UK (UK) and Intensive Care National Audit and Research centre (ICNARC) regarding the National Cardiac Arrest Audit (NCAA)
- Application for Inclusion presented to National StatMand Assurance Board (Gateway 1)
- Case for Inclusion presented to National StatMand Assurance Board (Gateway 2)
- Presentation to NHS England Medical Advisory Group (MAG)

Plain slide with subhead and bullets

Problem Statement

During 22/23 there were 13,426 cardiac arrests in hospitals. Of these, 50.4% were successfully resuscitated and 23% were successfully discharged (Source: National Cardiac Arrest Audit FY22-23).

The current training model is very expensive at c. £500m averaged over 10 years. As well as the financial cost, the investment of staff time takes clinicians away from other patient activity.

- RCUK guidelines exist, but they are interpreted by trusts in many different ways.
- There is no standardisation of resus training or the methods of delivery, notwithstanding the differences in needs between differing institutions, e.g. acute trust versus community establishment.
- No data exists relating to arrests outside of NCAA trusts, and submission to the audit is **not** mandatory. In addition, there is no data on choking and anaphylaxis.
- 95% hospital arrests are secondary to deteriorating patient, yet there is no clear data on failure to identify deterioration.
- The National SME is also National Specialty Advisor for Heart Disease (part-time) and working Consultant in a trust. There are no dedicated resources to lead community of local Resus SMEs and complete re-design work.
- Subjectively, many staff are trained in resus to a level they will never use.
- The relationship with the Resus Council needs to be strengthened



Benefits & expected Outcomes from this work

- Greater **focus on improving outcomes**, including:
 - Better outcome data, including anaphylaxis and choking as well as cardiac arrest.
 - Increased focus on the deteriorating patient.
 - Standardisation of equipment e.g. AEDs, algorithms.
 - Work together to agree best practices and roll out.
- Redesigned and **better learner experience**, spending the optimal amount of time:
 - Build competence and confidence – through simplification of messages, focus on actions must they take and opportunity to practice.
 - Simplified training for non-clinical staff.
- **Better use of your expertise**:
 - Clearer definition of Resus expert's role, as coaches not just trainers.
 - More proactive community of practice, spreading insights and best practice.

Opportunities and Interventions Explored

1. Remove from national framework because no statutory obligations and instead, move to local mandatory learning.
2. Early identification of deterioration of patient to avoid cardiac arrest. Improve confidence for staff to raise concerns re deteriorating patient - raise to higher authority.
3. Build public confidence in AEDs and IM adrenaline injections (epi-pens) for general public.
4. Resus Handbook - Standardise processes, team composition and language, attach algorithms to each defibrillator. What are the variations?
5. Devise guidance for community areas re crash trolleys and drugs requirements to prevent wastage in fully stocked trollies that are never used. No need to train when they are not used. Rely on ambulance equipment.
6. Embed competency assessment in practice.
7. Greater understanding of DNAR/Respect form to enable earlier discussed with all patients/relatives to prevent inappropriate resuscitation attempts and improve end of life experience and give more dignity to patients.
8. Bespoke training package for causes of cardiac arrest in mental health/learning patients (re: ligatures).
9. Restrict training in ALS to staff who will be part of cardiac arrest teams or leading high-risk areas e.g. A&E.
10. Redefine success of training from attendance to competency acquisition.
11. Ensure all non-clinical staff are confident to commence BLS and use public access AED.
12. Need to identify high risk settings, locations, staff groups so that training is focused there. Risk assessment and TNA to ensure that training is right/fit for purpose.
13. Understand what is the difference between advanced resus courses currently available and suggest standardisation across NHS to support mobile workforce.

Resuscitation Recommendations

1. Mandate data collection to include cardiac arrests in the community, choking and anaphylaxis data and data around escalating NEWS(PEWS etc) leading to cardiac arrest i.e. the deteriorating patient. This data to be collected in addition to other NCAA data.
2. The efficacy and financial feasibility for automated mannequins be assessed to give correct feedback on quality of CPR as they could be available 24/7 to improve staff competence and confidence.
3. Explore the evidence between first level AEDs (shock box only) versus the AED with manual over-ride and the advantages to each. Then advocate placement of devices and assess the cost implications for wider role out of first level AEDs.
4. Further research to be undertaken to define best practice in high performing NCAA outcomes institutions.
5. Re-definition of roles and minimum numbers of resuscitation practitioners to ensure:
 - Training requirements can be fulfilled.
 - Resus coaches within all cardiac arrest teams.
 - Support for staff, survivors and co-survivors who experience cardiac arrest.
6. The development of a clear National Leadership structure to improve outcomes of resuscitation, ensure clear governance and to strengthen the relationship between NHS and RCUK with the intention to improve outcomes of cardiac arrest.
7. Define competencies and redesigned nationally mandated learning intervention for Resuscitation.
8. Develop competencies for target audiences matched to risk training needs. i.e. Reduce the advanced/ILS training and increase high quality BLS to ensure both confidence and competence.
9. A new 'Recognising and managing the deteriorating patient' module, which may be used alone in areas identifying as requiring need (e.g. through the Datix system) or as an additional module to other resus learning where needed.
10. Creation of a new mental health/LD learning intervention with content to address the learning needs for staff working in these environments.

Competencies

Competencies that all NHS staff need to have:

1. Able to summon help in an emergency (e.g. 999 or 2222 in hospital).
2. Able to confidently commence CPR in any environment.
3. Able to place and use AED.

Additional competencies are relevant to some specific staff groups, these are set out on later slide.

Resuscitation

Delivering quality care

Competencies for all

Resuscitation

Over 13,000 cardiac arrests happen every year in healthcare organisations with about 50% successfully resuscitated.

Competency	What I must do as a staff member	What I must do as a manager	What I must do as an SME/Lead Executive	What we must do as the board director
Able to summon help in an emergency (e.g. 999 or 2222 in hospital).	- I act by summoning help when someone is choking, having a cardiac arrest or anaphylactic shock. - I report the emergency using the appropriate system.	- I ensure my team is trained and prepared to summon help in emergency situations. - I support them in understanding escalation procedures. - I ensure my team is trained and confident in commencing CPR. - I support ongoing training and readiness. - I ensure my team is trained and confident in using AED devices. - I support access to equipment and escalate needs.	- I review staff readiness to summon help, investigate emergency incidents, and report findings. - I recommend improvements to emergency response protocols. - I review CPR training programmes and recommend improvements. - I ensure staff are equipped and confident to perform CPR. - I review AED equipment and advise on suitability. - I analyse needs and present business cases to senior leaders for improved resources.	We oversee the implementation of a safety management systems approach, govern responses to safety metrics, commission improvements, embed a culture of continuous learning, ensure resource allocation to reduce harm, and govern organisational responses to business cases, prioritising risks and commissioning mitigating actions based on organisational needs.
Able to confidently commence CPR on an adult in any environment.	I act by confidently starting chest compressions when I encounter someone having a cardiac arrest.			
Able to place and use AED.	I act by confidently using an AED device when I encounter someone having a cardiac arrest.			

Resuscitation

Delivering quality care

Additional competencies for some

	Competency	For staff in scope	Audience
Deteriorating patient	Able to effectively escalate concerns around the deteriorating patient.	• I confidently escalate concerns when I see a patient whose health is deteriorating.	• Clinical nursing / HCSW / Midwives / AHPs / medics / Community clinical staff / Paramedics
Anaphylaxis response	Able to identify and take immediate action where a person is experiencing an anaphylactic reaction.	• I identify where a patient is going into anaphylactic shock and take appropriate action.	
Choking response	Able to identify and take immediate action where a person is choking	• I identify where a patient is choking and take appropriate action.	
Airway management	Able to manage airways and breathing in specific clinical settings.	• I ensure that the airways are kept open and I use appropriate equipment.	• Staff in high-risk areas e.g. A&E, CCU, ITU, paramedics • Staff in mental health or community setting without cardiac arrest team
Cardiac arrest algorithms	Able to apply algorithms used in cardiac arrest management.	• I am able to apply algorithms used in cardiac arrest management.	• Staff in high-risk areas e.g. A&E, CCU, ITU, paramedics
Leading resuscitation response	Able to lead the team in a cardiac arrest medical emergency.	• I confidently lead the team when there is a cardiac arrest, anaphylaxis or choking.	• Resuscitation team members
Responding to self-harm	Able to respond to the different self-harm incidents that potentially lead to cardiac arrest.	• I immediately respond to self-harm incidents that may lead to cardiac arrest.	• Mental health workers / Paramedics / A&E

Reflections & Contributions

- RCUK
- Members of Task & Finish Group

Plain slide with subhead and bullets

Asks of stakeholders

StatMand Reform - Case for
Inclusion Feedback Form -
Resuscitation



Please complete the
feedback form by close of
business 26th January

Q&A

Next steps

- **Feedback by COP Monday 26th January**
- **March 2026 launch new framework.**
- **2026**
 - Development of new learner content
 - Piloting new content
 - Amend any related policy and guidance
 - Progress on non-learning interventions
 - Transition Task & Finish Group into wider Community of Practice
- **By April 2027**
 - Launch new content with associated policy and guidance

Plain slide with subhead and bullets