Witness Name: Thomas Simons

Statement No.: 1

Dated: 28 August 2026

LAMPARD INQUIRY

FIRST WITNESS STATEMENT OF

THOMAS SIMONS

I, Thomas Simons, of NHS England, Wellington House, 133-135 Waterloo Road, London, SE1 8UG, will say as follows:

1. NHS England welcomes the Lampard Inquiry, fully supports its work and is grateful for the opportunity to participate. We are committed to assisting the Inquiry and learning from the evidence provided to it, as well as its findings.

2. I want to extend my deepest sympathies to the families, friends, and carers of those who have lost loved ones or have been affected by the issues under review in this Inquiry. The events have had a profound and lasting impact, and we remain committed to listening with care, learning from what is shared and turning those lessons into meaningful change.

Background

3. I am currently the Chief Human Resource and Organisational Development Officer for Workforce, Training and Education at NHS England, a position I have held since late 2020. In this role I have led large-scale change, service transformation and improvement across HR services. As part of this role, I was involved in the development and publication of The Future of NHS Human Resources and Organisational Development Report, which sets out a ten-year strategy for Human Resource and Organisational Development services across the NHS.

4. Prior to this I have held senior Human Resource and Organisational Development positions across a number of NHS organisations. I was Executive Director of Human Resource and Organisational Development at Chelsea and Westminster NHS Foundation Trust (2019-2020), where I also held the role of Human Resource and Organisational Development Lead for the North West

London Integrated Care System during the first two waves of the Covid-19 pandemic.

Approach to the Rule 9 Request

5. This corporate witness statement was drafted on my behalf, and with my oversight and input, by the external solicitors acting for NHS England in respect of the Rule 9 request received on 24 July 2026 (the "**Rule 9 Request**"). The Rule 9 Request goes beyond matters which are within my own personal knowledge. As such, this statement is the product of drafting after communications between those external solicitors and a number of senior individuals in writing, by telephone and video conference. I do not, therefore, have personal knowledge of all the matters of fact addressed within this statement. However, given the process here described, I can confirm that all the facts set out in this statement are true to the best of my knowledge and belief.

6. This corporate statement has been produced following a targeted review of documents collated to date. In the time available, it has not been possible to review every potentially relevant document, and it is highly likely that relevant documents exist that have not been reviewed or cannot be located. This corporate statement is therefore accurate to the best of our knowledge, but we cannot exclude the possibility that it will require updating as further evidence emerges through our ongoing process of internal investigation and document review. NHS England will, of course, notify the Inquiry as soon as practicable if information comes to light that would have been included in this statement if it was known to us before the deadline for its production.

7. References throughout this statement to ‘NHS England’ and ‘we’ represent the voice of the organisation.

The NHS in England

8. In accordance with the framework established by Parliament, the NHS in England is not one organisation. It consists of thousands of organisations, including commissioners, regulators and service providers (including NHS bodies such as NHS Trusts), each with their own distinct role. The publicly ("NHS") funded health service (excluding public health) in England comprises primary care, secondary care, tertiary care, mental health and community health.

9. Many bodies hold contracts with the NHS and are part of the publicly funded health service, such as GP practices, independent hospitals and community rehabilitation providers, but not all are NHS bodies. For the most part, the term ‘NHS’ is used as an umbrella term to mean all those performing their services pursuant to NHS funding and contracts. All providers of NHS funded care (whether they are public or independent sector providers) employ and manage their workforce; there is not a centrally employed ‘NHS workforce’. Providers are responsible for ensuring they have appropriately qualified staff and adequate staffing levels.

10. In this statement where there are references to 'the system' I refer to the NHS and non-NHS organisations who provide NHS-funded health services to patients, commissioners of those services, and applicable regulators.

11. Following the transfer of Health Education England's ("**HEE**") functions to NHS England on 1 April 2023,1 all key national activities provided by HEE and NHS England have been brought together into the Workforce, Training and Education Directorate.

12. A full description of the NHS in England can be found in the First Witness Statement of Duncan Burton dated 26 March 2025, at paragraphs 25 to 191.

Statutory and Mandatory Training: current arrangements

13. The background to the Statutory and Mandatory Training Programme has been set out in the Second Witness Statement of Clare Panniker dated 15 July 2026, at paragraphs 381 to 384.

Core Skills Training Framework

14. Training is informed by legislative and regulatory requirements, as well as national and local policies and guidance, and the Core Skills Training Framework (the "**CSTF**") **[Exhibit TS/01]**. Each employing organisation will develop and maintain its own local policy taking account of these requirements and guidance and drawing on the expertise of local Statutory and Mandatory ("**StatMand**") Training Leads[2] and local subject matter experts.

15. The CSTF is the principal national framework for statutory and mandatory training across providers of NHS services in England. It was first developed in 2013[3] to support greater consistency in statutory and mandatory training across

[1] The statutory functions of HEE were transferred to NHS England on 1 April 2023 pursuant to the Health Education England (Transfer of Functions, Abolition and Transitional Provisions) Regulations 2023.
[2] StatMand training leads are responsible for overseeing, coordinating and assuring statutory and mandatory training within their organisation.
[3] The CSTF has been updated since it was first developed, with the latest version being produced in partnership between HEE and Skills for Health in 2021.

the health sector, promote quality in training delivery and reduce unnecessary duplication of learning. It applies to employees across an organisation, covering staff employed in both clinical and non-clinical roles. The NHS Standard Contract sets out the following requirement: "t*he Provider must have in place systems for seeking and recording specialist professional advice and must ensure that every member of Staff receives...professional leadership appropriate to the Services, each in accordance with Good Practice and the standards of their relevant professional body (if any), and having regard to the Core Skills Training Framework...*"

16. The CSTF envisages that employing organisations will use the framework to inform their local training needs analysis, risk management arrangements and training matrices. The CSTF recognises that role, responsibility, work context and local risk factors will influence the level and nature of training required for by different staff groups.

17. The CSTF establishes minimum standards by identifying relevant learning outcomes, target audiences, refresher requirements and training delivery standards for each subject area.

18. The majority of the core subject areas in the CSTF derive from statutory training requirements. Although resuscitation training is not a specific statutory requirement, NHS England recognises it is a key patient safety issue. Its inclusion in the CSTF reflects the longstanding recognition across the healthcare system that staff must be appropriately trained to respond to medical emergencies and cardiac arrest.

19. Training delivered on specific topics may also be informed by standards and guidance issued by a range of bodies, including Government departments, NHS England and expert organisations. For example, Resuscitation Council UK ("**RCUK**") have developed resuscitation training that is widely used across the health sector, and these are linked in the CSTF **[Exhibit TS/02; TS/03; TS/04]**.

20. The CSTF currently comprises 11 core subject areas: Conflict Resolution; Equality, Diversity and Human Rights; Fire Safety; Health Safety and Welfare; Infection Prevention and Control; Information Governance and Data Security; Moving and Handling; Preventing Radicalisation; Resuscitation; Safeguarding Adults; and Safeguarding Children. Collectively, these subjects establish a nationally recognised framework for statutory and mandatory training and are intended to provide a consistent baseline of learning outcomes across the healthcare workforce.

21. To support organisations in respect of staff training requirements, the CSTF outlines the recommended target audiences for each subject. In respect of resuscitation the recommendation is set out below:

Subject	**Audience**	**Required frequency of refresher training or assessment**	**Comments on training delivery**
Resuscitation	Level 1: Non-clinical staff, dependent upon local risk assessment or work context.	1 year	A variety of methods can be used for annual updates (including E-Learning).

	Level 2: Staff with direct clinical care responsibilities including all qualified healthcare professionals. Level 3: Registered healthcare professionals with a responsibility to participate as part of the resuscitation team.	1 year 1 year	At levels 2 and 3, practical instruction i.e. 'hands-on' simulation training and assessment is recommended for clinical staff.

22. In addition, the CSTF specifically provides that "registered healthcare professionals involved in the administration of rapid tranquillisation in the care of patients with disturbed mental functioning should undertake Adult Immediate Life Support training." This reflects recognition within the framework that certain clinical environments and patient groups may require additional or role-specific resuscitation competencies.

23. The CSTF recognises that local risk assessments may identify the need for additional learning, supervision, practical exercises or measures to assure competence, and that responsibility for determining these requirements rests with individual employing organisations.

Statutory and Mandatory Training Reform: optimise, rationalise and redesign

24. The transfer of HEE's functions to NHS England provided an opportunity to significantly simplify Statutory and Mandatory Training **[Exhibit TS/05]**, with clear national guidance and support, to optimise efficiency and focus on outcomes, whilst reducing the unnecessary burden on staff. Statutory and Mandatory Training is subject to extensive governance arrangements. However, these arrangements are currently focused primarily on compliance with training requirements, rather than on evaluating the effectiveness -of the training delivered and the desired outcomes.

25. NHS England is leading a programme of work on the optimisation, rationalisation, and redesign of Statutory and Mandatory Training in partnership with the Department of Health and Social Care (the "**DHSC**"), the Care Quality Commission (the "**CQC**"), Health Services Safety Investigations Body ("**HSSIB**") and NHS Resolution, to ensure clear collective policy and guidance is available in relation to this topic. This commitment was set out in NHS England's 2024/25 Priorities and Operational Planning guidance.

26. In its April 2024 letter, NHS England stated its intention to reform the existing approach to Statutory and Mandatory Training through the development of a new non-professional StatMand framework by December 2024 and a new professional StatMand framework by the end of June 2025 **[Exhibit TS/06]** to replace the CSTF. These initial target dates subsequently proved to be too ambitious, reflecting the greater complexity of the reform programme than had originally been envisaged.

Optimise and rationalise stages

27. The optimisation and rationalisation stages of Statutory and Mandatory Training involved:

    a. optimising alignment to the CSTF and identifying reasons for non-alignment **[Exhibit TS/07]**;

    b. allowing transfer of previously completed, and up to date training, between organisations;

    c. identifying variation in refresher training course frequency;

    d. producing templates to demonstrate best practice for local oversight committees **[Exhibit TS/08]**; and

    e. producing a national people policy framework for mandatory learning for organisations to adopt and adapt as necessary to standardise local policy arrangements **[Exhibit TS/09]**.

Redesign

28. NHS England is seeking to ensure that national requirements relating to resuscitation and other statutory and mandatory subjects are proportionate, and focused on improving outcomes to develop and periodically assess workforce competence. The programme includes specific consideration of resuscitation competencies within mental health settings and reflects NHS England's commitment to supporting a workforce that is competent, prepared and able to respond effectively, including to emergency situations.

29. The redesign programme aims to move from a focus on completion of training towards a focus on improving outcomes and workforce competence,

recognising that education forms only one part of a broader staff and patient safety strategy. Ultimately, it has focused on identifying the actions and behaviours staff require to perform safely and effectively, with the objective of preventing and reducing harmful incidents thereby improving staff and patient safety outcomes.

30. The redesign element of the programme is nearing completion, and has involved:

a. understanding the intended outcomes that mandatory training has aimed to improve;

b. building an evidence base regarding the cost and effectiveness of current nationally mandated training; and

c. developing a new governance framework; and requiring each existing and proposed new topic to prepare and present a "Case for Inclusion", informed by broad stakeholder engagement, to support consideration for inclusion within the new Nationally Mandated Skills Framework, which is intended to supersede the CSTF.

31. As part of the redesign, NHS England focused on the need to improve outcomes (primarily related to preventing and reducing harm) whilst building a safe and competent workforce that provides safe care and meets statutory obligations. NHS England and national partners are committed to providing clear national leadership together with collective guidance in this complex area of work. This has involved:

a. establishing a clear and common understanding of the statutory obligations across a range of topics;

b. starting with intended outcomes in mind to ensure that all possible interventions (both training and non-training) are considered and that work has been guided by safety management models used across other industries and in patient safety. This ensures consideration is given to the whole ‘work system’, i.e. people work in environments, using equipment, following policies, protocols and rules, as part of a team and culture that is influenced by leaders, managers and expert colleagues;

c. ensuring that, where a competence requirement exists, it is clearly defined, assessable and supported by a framework of responsibilities that sets out the respective roles of individual workers, managers, subject matter experts and organisational leaders;

d. establishing a new framework that sets out the expected competencies that all staff must demonstrate and those additional competencies that some staff need to demonstrate across a range of topics. Importantly, the list of topics reviewed is limited to those that all, or nearly all, staff need to be competent in. The same assurance process is now to be followed for any future topics where mandatory learning is proposed including those that only some staff need to be competent in;

e. establishing an approach that involves periodic formal assessments of competence, with supporting learning materials for those new to the NHS or that are not able to demonstrate competence, supplemented by local risk assessments, local learning needs analysis to target knowledge,

skills or competency gaps in addition to those defined in the new framework. This will result in the use of a broad range of communications and education delivery methods to further build knowledge, competence and emergency readiness. Whilst these will be locally defined, a national library is being created so that providers can easily share and utilise those created by other NHS organisations;

f. considering all available approaches to developing competence, including communications, organisational development interventions, simulation, drills, skills laboratories, e-learning, in situ training and classroom-based learning;

g. establishing a consistent approach across all topics to improve the experience of staff and simplify delivery and assurance;

h. considering multiple viewpoints through multi-disciplinary oversight including medical and clinical leads, executives, subject matter experts, education experts, staff side representatives and patient voice;

i. ensuring that the investment of staff time is proportionate to the expected improved outcome, as is the case with any other investments across the NHS;

j. avoiding duplication and making best use of available resources by adopting a 'do once nationally' approach wherever possible;

k. ensuring a balance between national standardisation and local implementation by considering different settings, staff groups and other relevant factors; and

l. designing governance arrangements to ensure the ongoing review, evaluation and improvement of the framework and its content.

32. The redesign programme has considered all nationally mandated subjects that are relevant to all staff and has established governance arrangements through which future requests for nationally mandated training requirements will be assessed **[Exhibit TS/10; TS/11]**. The governance arrangements will allow future proposals for nationally mandated training requirements to be consistently assessed, taking account of intended outcomes, staff and patient safety management models including the whole work system, any competency gaps, the proposed investment of staff time and proposed method of assessment and learning.

33. As part of this work, NHS England has sought to establish clearer distinctions between statutory requirements arising from legislation or regulation, and nationally mandated requirements.

34. NHS England has actively sought feedback from providers regarding whether nationally developed learning resources adequately reflect the differing operational environments in which services are delivered. This has included specific consideration of feedback from mental health, learning disability, community and specialist providers that certain training requirements may need to account for the particular risks, patient needs and operational circumstances encountered within those settings.

35. To support the redesign work, task and finish groups were established for each topic to consider and develop the case for inclusion and the most effective interventions to improve safety outcomes, not just training **[Exhibit TS/12]**. For

example, for resuscitation, the review explored a range of proposals including a competency-based approach to assessment, increased focus on the recognition and management of deteriorating patients, the targeting of advanced life support training to higher-risk clinical roles, and the development of a dedicated learning intervention for staff working in mental health and learning disability settings. This included content relating to ligatures and other causes of cardiac arrest more commonly encountered in those environments. The proposals were then presented to the National StatMand Assurance Board to consider the case for the topic's inclusion **[Exhibit TS/13]**. Resuscitation was subsequently agreed as a topic to be included in the new framework. The framework's approach to resuscitation is set out below.

New framework and resuscitation

36. The updated training framework is intended to support a balance between national consistency and local accountability. Nationally defined competencies and guidance will provide a common foundation across NHS funded services, whilst employing organisations will continue to assess local risks and determine any additional competency requirements and learning necessary for their particular patient groups, workforce and care settings.

37. To give effect to this approach, an updated framework has now been developed to replace the CSTF. It has been developed jointly by NHS England, the DHSC, the CQC, the HSSIB, NHS Resolution and a range of expert and staff stakeholders. NHS England has endorsed the framework, which is now undergoing final approval from ministers prior to publication[4].

[4] NHS England will share the published version of the updated training framework with the Inquiry once it is available.

38. It adopts a competency-based approach under which competencies are defined nationally and staff are required to demonstrate them through formal assessment. Assessment methods and learning modules are currently being developed to support staff in acquiring and demonstrating those competencies. The programme recognises that competence may be developed through a range of approaches, including training, practical exercises, simulation, local learning activities and other safety interventions.

39. New national competency assessments and learning materials are expected to be introduced on a phased basis, with implementation scheduled to be by April 2027, with iterations and additions to follow.

40. The new framework recognises that staff working within mental health services may be required to respond to emergencies that are less commonly encountered in other healthcare settings. Reflecting this, the resuscitation component includes competencies relating to the management of individuals requiring resuscitation following self-harm that has resulted in, or may lead to, cardiac arrest.

41. Under the new framework, all staff are expected to demonstrate the following resuscitation competencies:

    a. ability to summon help in an emergency (for example, by calling 999 or 2222 in a hospital setting);

    b. ability to confidently commence cardiopulmonary resuscitation on an adult in any environment;

    c. ability to place and use an Automated External Defibrillator;

d. additional role-specific competencies outlined in the new framework include:

i. ability to identify and take immediate action where a person is experiencing an anaphylactic reaction;

ii. ability to manage airways and breathing in specific clinical settings;

iii. ability to effectively escalate concerns relating to a deteriorating patient;

iv. ability to identify and take immediate action where a child or baby is experiencing an anaphylactic reaction, is choking or is unable to breathe;

v. ability to apply algorithms used in cardiac arrest management;

vi. ability to lead a team during a cardiac arrest medical emergency; and

vii. ability to respond to different self-harm incidents that have the potential to lead to cardiac arrest.

42. The full set of proposed resuscitation competencies are set out in Annex 1. How these competencies will be assured is set out at Annex 2.

43. NHS England has worked closely with RCUK throughout the redesign process to date and is committed to working closely with them further as the new competency assessments and learning materials are developed. NHS England is also looking to strengthen this partnership further to improve outcomes which may involve collaborating:

a. on the National Cardiac Arrest Audit, which provides valuable data on cardiac arrest events and outcomes, and offers further opportunities to strengthen learning and drive improvements in practice;

b. to consider how to standardise and simplify equipment including Automated External Defibrillators; and

c. to evaluate the potential use of resuscitation manikins, that could provide staff with access to 24/7 skills laboratories where they can practise resuscitation skills and receive automated assessment and competency recording.

STATEMENT OF TRUTH

I believe that the facts stated in this witness statement are true. I understand that proceedings may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief of its truth.

Signed: **[I/S]**

Dated: 28 August 2026

Annex 1

Nationally Mandated Skills Framework: Resuscitation

Not being able to breathe due to choking, anaphylaxis or cardiac arrest can happen to anybody, anytime and any place. Emergency response and immediate action can save lives.

The competencies below help to avoid such incidents before they happen and help to improve outcomes when they do.

<u>Competencies for all</u>

- Able to summon help in an emergency (for example, 999 or 2222 in hospital).
- Able to confidently commence cardiopulmonary resuscitation (CPR) on an adult in any environment.
- Able to place and use automated external defibrillator (AED).

These competencies apply as follows:

What are my responsibilities as a staff member

- 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 act by confidently starting chest compressions when I encounter someone having a cardiac arrest.
- I act by confidently using an AED device when I encounter someone having a cardiac arrest.

What are my responsibilities as a manager

- I ensure my team is trained and prepared to summon help in emergency situations.
- I support my team 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.

What are my responsibilities as a subject matter expert and /or lead executive

- 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.

What are our responsibilities as the board

- 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.

Additional competency for managing concerns for the deteriorating patient

- Able to effectively escalate concerns around the deteriorating patient.

What are my responsibilities as a clinical nurse, health care support worker, midwife, allied health professional, medic or paramedic

- I confidently escalate concerns when I see a patient's health is deteriorating**.**

Additional competency for anaphylaxis response

- Able to identify and take immediate action where a person is experiencing an anaphylactic reaction.

What are my responsibilities as a clinical nurse, health care support worker, midwife, allied health professional, medic or paramedic

- I identify where a patient is going into anaphylactic shock and take appropriate action.

Additional competency for airway management

- Able to manage airways and breathing in specific clinical settings.

What are my responsibilities as staff in a high-risk area or community setting without a cardiac arrest team

- I identify where a patient is going into anaphylactic shock and take appropriate action.

Additional competency for paediatric resuscitation

- Able to identify and take immediate action where a child or baby is experiencing an anaphylactic reaction, is choking or unable to breathe.

What are my responsibilities as clinical staff working as a paramedic, in the emergency department, paediatrics and/or neonatal

- I identify where a child or baby is going into anaphylactic shock or choking or unable to breathe and take appropriate action.

Additional competency for the application of cardiac arrest algorithms

- Able to apply algorithms used in cardiac arrest management.

What are my responsibilities as a staff member in high-risk areas

- I am able to apply algorithms used in cardiac arrest management.

Additional competency for leading resuscitation response

- Able to lead the team in a cardiac arrest medical emergency.

What are my responsibilities as a member of the resuscitation team

- I confidently lead the team when there is a cardiac arrest, anaphylaxis or choking.

Additional competency for responding to acts of self-harm

- Able to respond to the different self- harm incidents that potentially lead to cardiac arrest.

What are my responsibilities as a mental health staff, paramedic and accident

and emergency staff

- I immediately respond to self-harm incidents that may lead to cardiac arrest.

Annex 2

Assuring competence

Everyone working or volunteering in the NHS is expected to demonstrate all these competencies **all** of the time. Keeping people safe and preventing harm is a constant activity that **all** need to be proactively involved in.

Anybody, especially managers, noticing these competencies not being demonstrated appropriately at any time, should remind colleagues of their importance and, if necessary, raise safety concerns to line managers, topic leads or freedom to speak up guardians, if behaviour persists.

All NHS organisations are required by statute and regulation, to ensure their workforce is safe and competent. More details of statutory obligations requiring training are provided at FutureNHS.

Boards must assure themselves that everyone working or volunteering within their organisation are demonstrating these competencies. If not, it is incumbent on managers, topic leads, service leads and executives to support colleagues and take necessary actions to keep colleagues, patients and the public safe from harm.

Risk Assessments

Each work setting and service is exposed to a wide variety of potential risks. Risk assessments are integral to ensuring safety and quality of care and some are statutory obligations.

Key components of risk assessments include:

- **Risk identification**: recognising potential risks and hazards.
- **Risk assessment:** evaluating the likelihood and impact of identified risks.
- **Risk control:** Implementing measures to mitigate risks and prevent occurrence.
- **Monitoring and reporting:** Continuous tracking of risks, reporting and monitoring.

- **Incident management:** Responding to incidents and learning from them.

Please refer to the relevant risk management policy for each topic (for example, HTM for fire safety).

Learning Needs Analysis

Learning needs analysis is a broad approach to identify gaps in knowledge, skills and behaviours and consider how gaps are best filled. When looking to prevent harmful incidents or being prepared for an emergency, the way that work is done by the whole team in given settings or services needs to be considered.

Learning needs analysis should:

- Improve communications, for example, reminders and alerts.
- Identify formal learning, for example, elearning and classroom training.
- Suggest other methods of building competence (for example, supervision and safety huddles).

Work systems

Whilst undertaking risk assessments and learning needs analysis consideration should be given to systems of work. There is a range of guidance and models one of which is System Engineering Initiative for Patient Safety (SEIPS).

Example activities that might come from risk assessments, learning needs analysis and work system reviews include:

- changes to routine processes, tasks and practices and/or policies
- changing equipment or other tools
- changes to work schedules and workload assignment
- notices and signage around the workplace, with simple reinforcing messages
- easy access to information so people don’t have to remember everything
- use of alerts and periodic reminders, for example, screensavers, banners etc
- short stories and case studies using various media to highlight what can go wrong
- spot checks and/or audits - to identify risks, learning needs or weakness in

work systems
- drills, simulated exercises
- bite sized learning for significant changes, for example, short 2-5 minute elearning.

Further guidance is available on FutureNHS.

Assessment of competence

New competence assessments, involving situational judgement tests to simulate real life situations, will be launched by April 2027, alongside new national learning content.

Everyone working and volunteering in the NHS in England is required to **formally demonstrate their skills once every 3 years by passing the assessments provided**. With additional competencies only required for those defined.

Only those new to the NHS, or those who are unable to demonstrate competence, will be required to complete the new learning content.

Where local learning needs analysis identifies knowledge, skills or competence gaps beyond those defined in this framework, it is for local employers to determine whether locally mandated learning is required, with the relevant subject matter expert presenting recommendations to the local Mandatory Learning Oversight Group (MLOG). Local MLOGs will need to determine what records are kept.