Witness Name: Adam Benson Clarke
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Exhibits: ABC/38– ABC/40
Dated: 28 October 2026

THE LAMPARD INQUIRY

THIRD SUPPLEMENTARY STATEMENT OF ADAM BENSON CLARKE

IN RESPONSE TO PROPOSED CHANGES TO STATUTORY AND MANDATORY RESUSCITATION TRAINING IN ENGLAND

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1. This supplementary statement sets out RCUK's position on the proposals described in NHS England's "**Gateway 2 Summary Pack: Resuscitation**" **(NHSE028075_TS-13-Gateway-2-Summary-Pack-Resuscitation) (the "Gateway 2 Pack")** and relevant oral evidence given to the Inquiry on 6 October 2026. It should be read alongside my previous statements.

2. RCUK supports proportionate reform that improves consistency, competence and use of resources. However, NHS England's oral evidence expressly proposes reducing immediate and advanced life support (ILS / ALS) competency-based training and replacing it with high-quality basic life support (BLS). Our primary concern is patient safety: how the intermediate capabilities required in mental health inpatient services, beyond BLS but below full advanced life support, will be preserved. Staff wellbeing is a related concern, particularly where staff would be expected to manage emergencies without sufficient preparation.

3. The Gateway 2 Pack (slide 11) records RCUK as the subject-matter expert and records the need for further engagement. NHS England's oral evidence also describes close collaboration with RCUK and support for the reforms. RCUK values this relationship, has engaged with NHS England during this work, and welcomes NHS England's commitment in oral evidence to continued collaboration as the detailed

model and competencies are developed. However, the proposals set out in the Gateway 2 Pack were not substantively co-developed with RCUK, and RCUK had not endorsed the proposed model. We are concerned that the descriptions may give an inaccurate impression of the extent of RCUK's involvement in, or endorsement of, the proposed model. RCUK's engagement should not be understood as endorsement of the model as currently described.

4. RCUK recognises that the Gateway 2 Pack is a summary document and would not be expected to contain a complete curriculum, assessment framework or implementation plan. NHS England's oral evidence describes planned mental health resuscitation response training, team allocation and scenario training. These are welcome intentions and there is common ground between this approach and RCUK's emphasis on role and risk-based capability. However, the material reviewed does not yet establish who will hold the necessary intermediate capabilities, how those capabilities will be maintained and assessed, or whether the resulting arrangements will preserve the capabilities required in mental health inpatient services. Their adequacy should be demonstrated before existing training requirements are reduced.

5. The proposed audience model (slide 6) divides the workforce into three broad groups:
    - Non-clinical and non-patient-facing staff: a 15-minute module on commencing CPR and using a basic AED, repeated every six years.
    - Patient-facing clinical staff, described as approximately 68% of NHS staff: a 60-minute e-learning module and a 15-minute situational judgement test annually, with branching for adults, paediatrics, neonatal and high-risk departments and sectors; annual assessment of competency; and three-yearly update training for new content.
    - Resuscitation teams and qualified nurses in emergency care, described as approximately 2% of NHS staff: 15 hours of advanced life support training, a one-hour situational judgement test, annual assessment of competence and update training when guidelines change.

6. The Gateway 2 Pack also examines automated manikins, considers the role of AEDs, and proposes changes to resuscitation practitioner roles and national leadership arrangements. RCUK's position as set out in this supplementary statement focuses

principally on the implications for safe initial assessment and emergency treatment in mental health inpatient services.

7. As set out in my previous statement, staff responding to deterioration or cardiac arrest in mental health inpatient services require capabilities that extend beyond BLS. According to their role and the service's response arrangements, these include recognising and assessing deterioration, initiating appropriate treatment, summoning further help and working effectively as a team. Given that a substantial proportion of cardiac arrests in mental health settings occur as a consequence of asphyxia, it is particularly important that appropriately trained staff have capabilities in intermediate and advanced airway skills including airway adjuncts, bag-mask ventilation, oxygen administration and insertion of a supraglottic airway. These capabilities are particularly important while awaiting ambulance or acute hospital support.

8. Existing RCUK Quality Standards recommend ILS-level training as a minimum standard for staff who deliver or are involved in rapid tranquillisation, physical restraint and seclusion. RCUK welcomes the indication that this would be retained within NHSE's future Core Skills Training Framework (CSTF) update.

9. Staff expected to manage deterioration and cardiac arrest need preparation that reflects their responsibilities, available equipment and access to further help. In mental health settings, location and response logistics may require staff to provide immediate care for a period before emergency services arrive. ILS-level training equips staff with skills to manage this interval, particularly airway management and ventilation. Inadequate practical preparation may compromise patient safety and leave staff feeling underprepared during an emergency. Evaluation of the proposed model should therefore consider staff preparedness and wellbeing alongside patient safety.

10. RCUK supports determining training requirements through staff responsibilities, clinical setting, patient population and local risk assessment, within a consistent national framework. Mental health-specific training should address emergencies associated with ligature, hanging and restrictive interventions, alongside physical deterioration. It should build on existing provision and maintain the practical capabilities required in these settings.

11. RCUK supports NHS England's ambition to train staff to deliver high-quality basic life support, as international evidence demonstrates an association between the quality of resuscitation and patient outcomes. However, basic life support comprises a series of psychomotor skills that are most effectively learned through practical, hands-on training using a resuscitation manikin. In RCUK's experience, the proposal outlined by NHS England to provide BLS training to non-patient-facing staff through a 15-minute video, without hands-on practice, is unlikely to be sufficient to achieve or maintain competence. The proposed retraining interval is also inconsistent with the published evidence on skill retention, which supports a low-dose, high-frequency approach to maintaining resuscitation skills. Evaluation should establish whether the proposed approach delivers sustained educational benefit and represents effective use of staff time and resources.

12. The proposed training for the majority (68%) of patient facing staff is described as comprising e-learning and situational judgement tests. Whilst these educational approaches can support knowledge and decision-making, they cannot alone establish practical competence. The indicative time allocations for training fall short of the time required to develop competence in the range of practical and team-based skills needed to manage effectively the first few minutes of an in-hospital cardiac arrest. The Gateway 2 Pack's references to hands-on training and annual competency assessment are welcome. However, in RCUK's experience, the proposed time allocation for practical training is unlikely to be sufficient to develop and demonstrate competence in the required skills. Before training requirements are substantially reduced, the proposed arrangements should be validated to ensure staff can demonstrate the clinical and team skills required of them, supported by opportunities for practice, feedback, appropriate assessment, remediation and quality assurance.

13. The proposed training intervals require an explicit educational and clinical rationale. The ERC 2025 Resuscitation Education Guidelines **[Exhibit ABC/38]** and RCUK 2025 Resuscitation Education Guidelines **[Exhibit ABC/39]** support spaced learning to improve acquisition and retention of competencies. The ERC guidelines additionally consider repetition of relevant resuscitation competencies at least annually reasonable, while acknowledging uncertainty about optimal frequency.

14. The retraining intervals for non-patient facing staff should be clarified as different intervals are cited across, and within, the presented evidence to date; this should be clarified. In either case, the proposed interval requires justification against the educational principles described above. Infrequent training is unlikely to deliver the confidence, willingness and practical competence needed for staff to intervene effectively in cardiac arrest. Existing online resources offer opportunities for more frequent reinforcement, alongside appropriate practical learning.

15. For patient-facing clinical staff, annual assessment and three-yearly content updates should be supported by sufficient simulation to maintain competence. Assessment should identify gaps and lead to appropriate feedback, further practice and reassessment. The frequency and content of training should reflect clinical responsibilities, exposure to emergencies and the capabilities required to provide safe care.

16. Prevention of cardiac arrest must remain integral to the model. Its importance is already recognised within ILS-level training, which equips staff to recognise deterioration, initiate appropriate interventions to prevent cardiac arrest where possible, and respond if cardiac arrest occurs. The Gateway 2 Pack describes deterioration training as a standalone intervention for areas identified as requiring it, or as an additional module, leaving uncertainty about who would receive it.
    Any replacement model should preserve this integrated approach and ensure that all staff responsible for recognising and responding to deterioration receive appropriate training, supported by clear escalation arrangements.

17. Projected efficiencies should account for the complete cost of maintaining safe capability, including practical training, assessment, equipment, remediation and implementation. Reduced training time does not, by itself, establish equivalent effectiveness or a net saving in time or cost effectiveness.

18. RCUK supports feedback technology and short, frequent practical training, consistent with the 2025 Resuscitation Education Guidelines **[Exhibit ABC/39]** and the ILCOR "**Ten Steps Toward Improving In-Hospital Cardiac Arrest Quality of Care and**

Outcomes" recommendations **[Exhibit ABC/40]**. Automated manikins may contribute to this provision, but feedback on chest compression performance does not, by itself, demonstrate competence in assessing deterioration, managing an airway, providing ventilation or coordinating an emergency response. Implementation should establish which competencies each intervention develops and assesses, and how remaining requirements will be met.

19. Equipment and training decisions must be considered together. Staff expected to provide immediate care need access to appropriate equipment and competence in its use. External emergency response is essential, but its availability does not remove the need for appropriate immediate capability among staff caring for the patient before that support arrives. In mental health services awaiting ambulance support, reliance on ambulance equipment must not leave staff unable to provide the airway management, ventilation and other immediate interventions required before that support arrives.

20. The Gateway 2 Pack proposes reviewing the roles and minimum numbers of resuscitation practitioners, including provision for resuscitation coaching and support for staff, survivors and co-survivors. These functions are not necessarily core competencies of every resuscitation practitioner, and some may be more appropriately provided by other recognised, suitably qualified healthcare professionals.
Before responsibilities are extended, their allocation and the investment needed in training, staffing and supervision should be assessed, together with the effect on existing education, governance and quality improvement functions that support patient safety.

21. The material reviewed does not establish whether the redesigned model will be appropriately piloted and robustly evaluated before existing requirements are materially reduced. RCUK considers such piloting and evaluation necessary given the proposed reduction in existing training. Evaluation should include mental health inpatient services, particularly those without immediate on-site resuscitation experts, and assess whether staff retain the capabilities needed to recognise deterioration, prevent cardiac arrest and provide effective immediate treatment.

22. Evaluation should include baseline measures, practical and team performance, implementation costs, resource requirements and consequences for staff wellbeing. There should be clear arrangements for modifying or stopping elements that do not perform as intended or raise patient safety concerns.

23. In summary, RCUK asks that any future model:
    - places patient safety first
    - preserves the intermediate capabilities required by staff who need more than BLS
    - defines and assures practical training, assessment and maintenance of competence appropriate to mental health inpatient care
    - validates its clinical, workforce and financial assumptions through appropriate piloting and robust evaluation
    - is developed through substantive collaboration with RCUK and relevant multidisciplinary expertise.

24. RCUK remains committed to working constructively with NHS England and other stakeholders to develop and evaluate the model. We support the shared ambition to improve resuscitation care and use resources effectively. Before existing training requirements are materially reduced there should be sufficient assurance that replacement arrangements will preserve the capabilities needed to protect patients and ensure staff wellbeing by preparing them for the emergencies they are expected to manage.

Statement of Truth

I believe the content of this statement to be true.

Signed: [I/S]

Adam Benson Clarke

Dated: 28 October 2026