NHS
Health Education England

Review of the Core Skills Training Framework (CSTF)

CSTF Review Summary Report

March 2022

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1 Report summary

1.1 Introduction and overview of the Core Skills Training Framework (CSTF)

Health Education England (HEE) is responsible for workforce planning, education and training, and workforce development and transformation across England. As set out in HEE's mandate from the Department of Health and Social Care (DHSC), both NHS England & Improvement (NHSE/I) and HEE work closely with one another to deliver the commitments outlined in the NHS Long Term Plan. This includes enabling staff to move more easily from one NHS Employer to the other, reiterated in the NHS People Plan 2020/21.

The Enabling Staff Movement programme is designed to help meet this commitment. Currently, given differences in the interpretation of national requirements, there is variation in the policies, processes, practices, or standards – including training – of employing organisations. This training already represents a huge resource commitment across the NHS, including time spent by staff completing it. Variation in interpretation of learning requirements and training delivery can result in staff duplicating this training as they move between organisations, putting additional strain on NHS resources and capacity.

A core foundation to support the Enabling Staff Movement programme is the 'Trusted Frameworks' workstream, looking at ways to evolve key national standards and frameworks into a 'trusted framework' with shared definitions, requirements and processes. This aims to increase confidence that all involved have met the required obligations.

The Core Skills Training Framework (CSTF) – a key part of the Trusted Frameworks workstream – is an enabler of the portability of statutory and mandatory training across the NHS. The aim of the CSTF is 'to enable consistency in the core content of statutory and mandatory education and training'[1] by creating a set of documents and processes that support organisations align to the same standard and content.

The UK CSTF was launched by Skills for Health in 2013. Since October 2019, Skills for Health (SfH) and HEE have worked in collaboration to manage the CSTF for NHS Trusts in England, which currently comprises 11 statutory and mandatory subjects. e-learning for healthcare (elfh), part of HEE, also develops and manages national training packages aligned to the subjects in the CSTF.

This review has been commissioned by HEE to develop initial recommendations – based on feedback and insights from stakeholders – to improve the CSTF, its development and delivery, in line with the agreed ambitions for the CSTF and wider objectives of the Enabling Staff Movement programme.

[1] Health Education England (2020): Guidance for Employers of NHS Staff on Statutory and Mandatory training during COVID-19 Outbreak. Available at: https://portal.e-lfh.org.uk/LearningContent/LaunchFileForGuestAccess/622656

1.2 Scope and approach to this review

The report represents the first phase of a review of the CSTF (the version used in England only). It captures both stakeholder views of, or experience with, the CSTF in its current form; and recommendations from stakeholders to inform the direction of future work or research.

Despite significant engagement from stakeholders across the NHS, it should be noted that engagement to date may not be seen as representative, and therefore may not reflect the multitude – or even the majority – of views across the NHS. Any action taken to develop the CSTF based on the recommendations alone should be cognisant of this, and the national level and clinical sponsorship required to ensure the CSTF is fit for purpose.

Specifically, this review focuses on:

1. The current **scope** and **effectiveness** of the CSTF.
2. **Barriers to alignment** / adoption of the framework, and how to best achieve the consistent use of the CSTF by all NHS organisation within England going forward.
3. The applicability or appropriateness of the core **subjects**, **levels,** and **refresher** periods currently in the CSTF to the needs of all NHS organisations.
4. Insights regarding standards for / standardisation of the learning **outcomes** and delivery of **training** for the core subjects.
5. **Quality assurance**, management, and oversight (**governance**) of the framework going forward.

This review does not include analysis of any other learning frameworks, nor does it make recommendations in relation to the specific content of the CSTF's subjects, learning outcomes, guidance, or training delivery standards. All recommendations are informed by the views of stakeholders and should be thoroughly considered and implemented directly by HEE and partners.

A variety of methods were used to assimilate the observations and recommendations in this review. These included:

- regular engagement with the review's project team and the CSTF Steering Group.
- 1:1 engagement with key stakeholders, including from HEE, Skills for Health, NHSE/I, NHS Employers, DHSC and the Care Quality Commission (CQC); representatives from NHS Trusts, as well as government representatives from the other three countries (29 1:1 sessions in total);
- two surveys, focusing on:
    - all NHS staff, gathering views on statutory and mandatory training and how improvements could be made (2169 responses from across Trusts and regions); and
    - People Professionals (staff involved in Human Resources (HR), Learning and Development (L&D), Organisational Development (OD) or those involved in an organisation's management team), asking for views on behalf of their organisations to share views on, for example, alignment to the CSTF, the delivery of training and how the framework could be improved (100 responses).

- follow-up focus group sessions with Trusts fully or partially aligned to the CSTF (four sessions) and 1:1 sessions with Trusts that are not officially aligned (two sessions); and
- high-level desktop research, including of approaches to standardised, mandatory learning or assessment in other industries.

1.3 Overview of the CSTF

1.3.1 The CSTF in operation

Several organisations are involved in developing and managing the CSTF, the aligned national training packages and the underlying data sharing arrangements, as captured in the Electronic Staff Record (ESR) system. These organisations and their involvement in the CSTF and its development or delivery are summarised briefly in Table 1.

Organisation	Key ongoing role in relation to the CSTF
HEE	HEE funds and jointly 'owns' the CSTF with SfH (England version only).
SfH	Jointly 'owns' the CSTF (England) with HEE. SfH ensures the content is up to date and relevant for CSTF (with input from Subject Matter Experts - SMEs); produces training aligned to the CSTF; manages process for declaring alignment; and maintains the CSTF webpages, documents, and Directory.
e-LfH HEE	e-Learning for Healthcare HEE (e-LfH) produce national, free to access e-learning which meets the learning outcomes of the framework, with input from SMEs.
ESR team (NHS)	Support sharing of staff training data between organisations via the Electronic Staff Record (ESR) and the Inter Authority Transfer (IAT) process. *Note that not all NHS organisations use IATs and some will use it in different parts of the hire process, i.e some may run an IAT before and others after, a new joiner has commences.*

Table 1: Key ongoing involved in the operation of the CSTF

1.3.2 Composition of and alignment to the CSTF

Composition of the CSTF

The CSTF is comprised of several documents, as set out in Table 2. As mentioned, in its current form the CSTF includes standards and guidance for 11 subjects, some of which have different levels of training as required for different staff groups.

The framework is reviewed and updated annually by SfH. The current latest version of the England framework is version 1.1, which was published in June 2021.[2]

[2] Skills for Health (2021): Core Skills Training Framework (England) Statutory/Mandatory Subject Guide. Available at: https://skillsforhealth.org.uk/wp-content/uploads/2021/07/CSTF-Eng-Subject-Guide-v1.1.pdf

Alignment to the CSTF

Alignment to the CSTF is currently voluntary and is confirmed through a self-declaration process.

To be considered 'aligned' to the CSTF, organisations must undergo a self-assessment process, comparing their training content or delivery standards (including refresher periods) to those set out in the CSTF. Key documents used to support this self-assessment are set out in Table 2.

Document name	Purpose
Statutory and mandatory Subject Guide	Sets out the detailed requirements for each statutory / mandatory subject, including key learning outcomes; required frequency of refresher training; links to relevant legislation and guidance; and suggested standards for training delivery.
Mapping tool	Tool for organisations to map their training to the CSTF learning outcomes for each subject, supporting self-assessment of alignment.
Declaration of Alignment	Used by organisations to formally declare their alignment to the CSTF. This shows the CSTF subjects / levels to which they are aligned, the format of delivery, the organisation refresher period, and the name of the accountable person(s) within the organisation.
Readiness Assessment Tool	A checklist of recommended activities for organisations seeking to align to the CSTF.
Guidance for data recording and portability	Brief outline of ESR and the National Competencies (as aligned to the CSTF).

Table 2: Composition of the CSTF. Source Guidance & Download, Skills for Health[3]

Organisations will then 'declare' their alignment to all or some of the subjects in the CSTF (including the respective levels to which they are aligned) and submit this declaration to SfH. SfH may ask for further information where required to clarify these declarations. Once complete, SfH publish a Directory of aligned (or partially aligned) organisations on its website, including identifying the subjects or levels to which organisations are currently aligned.[4]

Alignment is designed to be an annual process: organisations are meant to self-declare each year that they are aligned to the latest version of the CSTF (as it is also updated annually). However, where this has not occurred, the Directory identifies the version of the CSTF to which the organisation has most recently declared alignment and the date of their most recent declaration.

[3] Skills for Health: Guidance and download. Available at: https://skillsforhealth.org.uk/info-hub/cstf-england-guidance-and-download/

[4] Skills for Health: CSTF Aligned Healthcare Providers. Available at: https://cstfdirectory.skillsforhealth.org.uk/#tx_org_search=

As at September 2021, according to the Directory, there were 199 out of 221 NHS Trusts declared to be aligned or partially aligned to a version of the CSTF. However, during the review, several organisations reported that they are using the CSTF learning outcomes but have not formally declared alignment (with some NHS Trusts having subsequently reached out to SfH to commence this process) or mentioned that they were in the process of alignment. This number may therefore be subject to change in the short term.

According to data from SfH, of those 199 Trusts who are aligned:

- **8%** of NHS Trusts are aligned to the England version 1.0, the latest major version of the CSTF (February 2020);
- **13%** of NHS Trusts are aligned to the UK version 1.6 (June 2019); and
- **79%** of NHS Trusts are aligned to the UK version 1.5 (October 2018) or previous.

Therefore, training delivered in nearly four fifths of the Trusts who are aligned, is to an earlier version of the framework may not be in accordance with any updates post 2018.

1.4 Introduction to Key observations

To provide greater clarity and awareness on the overall end to end processes surrounding the CSTF for the purposes of this review, a 'service map' has been developed which identifies the 'as is' and the key organisations and activities or processes at each stage of the CSTF in operation. These stages have been classified in the map as:

- **Framework Management** – including updates by SfH and elfh;
- **Organisational Alignment** – including self-declaration of alignment;
- **Framework Delivery** – including delivery of the CSTF content via training at the respective organisations; and
- **Framework Data Sharing** – staff training information shared often (although not always) via ESR.

A number of issues or 'pain points' throughout the development, management and delivery of the CSTF were already well-known. These were tested with stakeholders, in addition to seeking wider views on the future direction of the CSTF and how best to improve statutory and mandatory training for health and care staff. Table 3**Error! Reference source not found.** outlines some of the key challenges or observations set out in the service map (Figure 1)**Error! Reference source not found.**.

No	Challenge/ Observation
1	A formal decision-making pathway or criteria-based framework for managing requests for or verifying additions to the framework (including subjects) does not currently exist. The framework is only updated annually.
2	Some subjects in the framework have different nominated SMEs supporting SfH or elfh with content clarification, and there is no formal alignment on updates to the framework and updates to the training, the latter follows on from the former.
3	NHS organisations are not currently required to provide evidence in support of the quality of their delivery of the CSTF, and there is limited dialogue with organisations managing the framework.

4	'Equivalence' issues: Alignment to the CSTF is voluntary through a self-assessment process, with limited formal, external verification / audit process to quality assure or to test these alignments, and no formal requirement to re-declare alignment periodically / annually.
5	There is no standardised mechanism to measure the efficacy / outcomes of training or knowledge acquisition, nor metrics to measure ongoing performance.
6	Not all organisations within England are aligned (or even partially aligned) to the CSTF, yet they can still self-select National Competencies in the ESR as applicable to staff.
7	Some organisations do not use ESR: training is recorded via other electronic means, or on paper.
8	As the National Competencies in ESR are not locked for use by CSTF-aligned organisations, role holders at a staff members' new organisation (Organisation 2) may have to check the CSTF-alignment of their former organisation (Organisation 1) in the SfH Directory, to confirm if they will actually accept the competencies awarded.
9	'Inheritance' issues: Staff who must complete Level 2 training are sometimes also then required to complete Level 1 training at Organisation 2, due to lack of standardisation of training delivery, organisational reporting on compliance with Level 1 and coherence in relation to 'stacking'.
10	When staff move between organisations, the role holder at Organisation 2 can choose to not honour the refresher period specified in the CSTF-aligned National Competencies in ESR (or for other competencies awarded in ESR, such as the 'MAND' competencies used by non-aligned Trusts). They can therefore request that the staff member repeats particular training as part of their onboarding, before the previously designated refresher date.
11	Role holders can also amend staff's National Competency records to reflect their own organisation's refresher training periods (even if not aligned to the CSTF, and despite guidance advising them not to do this).

Table 3: Overview of key challenges or observations

Review of the Core Skills Training Framework (CSTF)

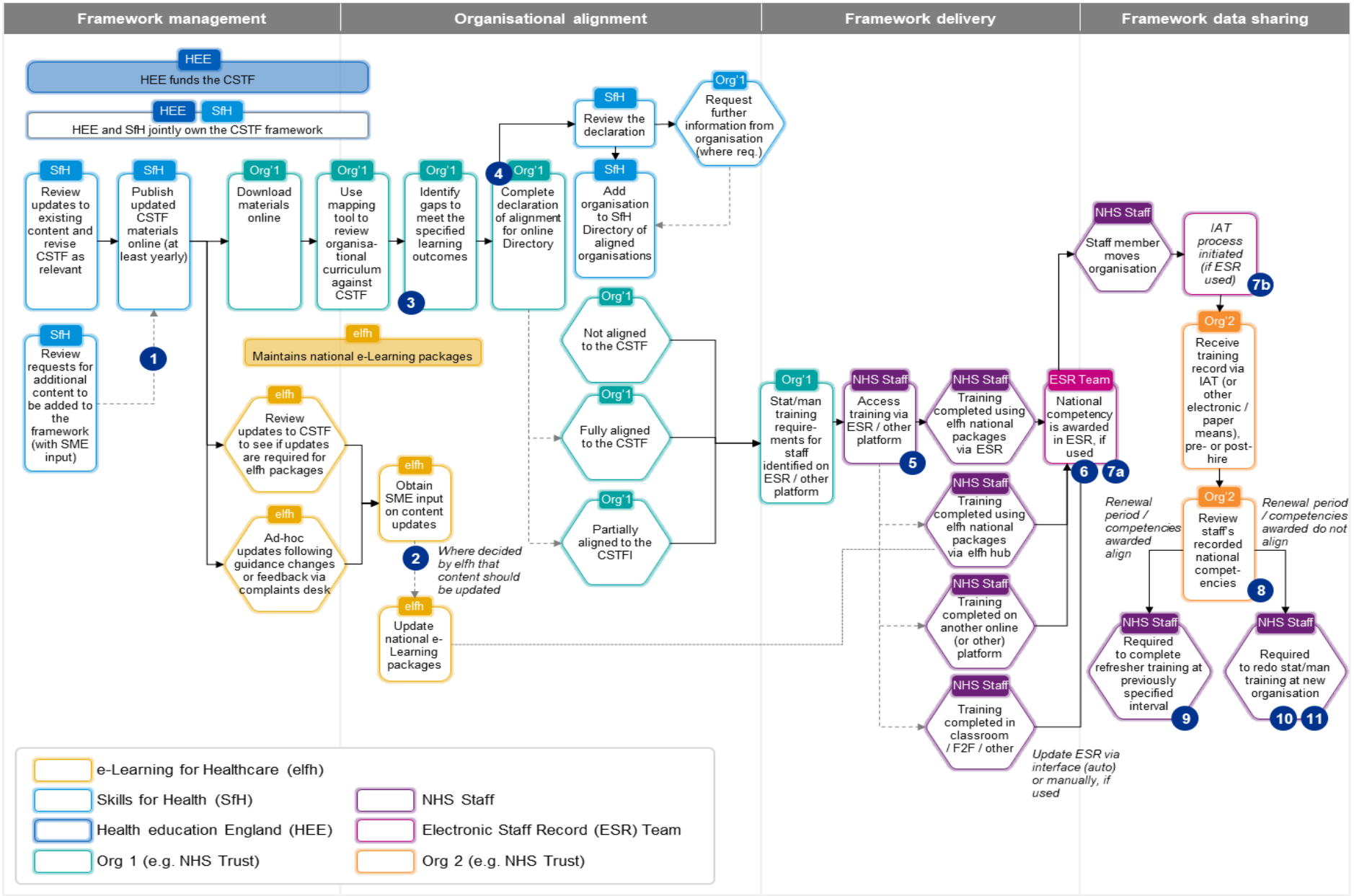

Figure 1: Service map of the CSTF in operation. Source: SfH/HEE stakeholders

1.5 Key observations

Key observations were made in relation to each of the five main scope areas of the review. Observations have been summarised below and in Table 4 (mapped to the tender specification areas). Overarching observations are as follows:

1. In relation to alignment to the CSTF, only 8% of NHS Trusts (who are aligned to the CSTF) are currently aligned to the most recent version of the framework which means that Trusts may not be using the most up to date learning outcomes to develop training content. Noting that the latest version of the CSTF was not promoted, with Trusts being informed that action to update alignment was not yet required in order to reduce their burden during the pandemic (and in light of this review), other ongoing reasons for lack of alignment may also be because:
    - alignment is currently a **confusing** process for many of the Trusts. This can lead to Trusts being – unknowingly – aligned to the wrong version of the CSTF; and / or
    - the **minimum standard** required for alignment to the latest version may be higher than is practical or feasible / viable for many Trusts. For example, to be considered fully aligned they must meet the learning outcomes for all subjects, whereas for some subjects they may wish to deliver locally specific content instead, which may not align to the learning outcomes, this means they are not fully aligned. Moreover, the intensity of meeting specific refresher periods is particularly difficult for larger organisations with tens of thousands of staff to train.
2. Alignment to the CSTF – including the associated declaration, training updates and data sharing processes – drives significant **workloads** for People Professionals at the respective NHS organisations. Alongside this, the completion / delivery of statutory and mandatory training is currently only assessed at national level by the CQC from a compliance perspective and there is little focus on ensuring the quality or efficacy of learning through, for example, considering way to monitor sustained enhanced awareness or changes in staff **behaviours**.
3. Many who use or engage with the CSTF apply a level of interpretation when using the learning outcomes. As well as using national packages like elfh, designed to be in accordance with the CSTF, NHS Trusts (often to meet the expectations of SMEs) deliver additional and local content. This, and other factors, can lead to staff at aligned organisations undertaking statutory and mandatory training in addition to what is required by the CSTF for all staff – resulting in significant volumes of over-training, according to staff engaged for this review.
4. Discrepancies in how the CSTF is interpreted and delivered across NHS organisations, with the Trusts' respective subject matter experts (SMEs) often determining this to a large degree. This influences the ability of the CSTF to encourage trust between organisations and thus increase the portability of staff training records. This is also reinforced by the current lack of quality assurance activities in the context of the CSTF, albeit it was acknowledged that any new activities must be proportional and not add significant extra burden on Trust learning and development staff.
5. Acknowledging the above, there is real enthusiasm amongst those engaged for this review – including Trust representatives – to develop the CSTF into something that is more robust and transparent, set at a level for all staff, allows measurement, adds value and is easier to deliver. In the context of trusted Frameworks, it is imperative that HEE and partners work quickly to remedy the issues identified in this review.

Set out below is a summary of the key headlines, mapped to each of the respective specification areas.

	Agreed areas for exploration	Key headlines from analysis
Scope and effectiveness	What is working well and what are the missed opportunities of the framework? Exploring views regarding efficacy of the framework	• **Support** for overarching goal of the framework, but very few organisations aligned to latest version of framework. • Majority of People Professionals confident that CSTF supports delivery of **safe services** • Opportunities to **expand** CSTF scope across UK, and to other workforces (e.g. volunteers, contractors, students).
Barriers to alignment	Understanding barriers to adoption	• **Alignment is difficult** for many NHS Trusts to understand, attain and may be set at a level above what is required for all staff (clinical and non-clinical). • Alignment currently drives significant **workloads** within organisations.
Content, levels and refresher periods	Clarifying the criteria for why subjects are placed in the framework Understanding refresher periods	• CSTF prescribes in detail some requirements but provides **less clarity** on others particularly re training needs for certain staff roles or Trust types. • Opportunities for learning outcomes and / or subjects to be **revised or combined** *(Initial process / criteria for review has been developed)*. • Refresher periods in particular are a **barrier** to alignment for Trusts.
Training delivery and assessment	Exploring other industries for best practice Considering range of training methods	• **Discrepancies** in how the CSTF is interpreted and delivered (via training) across NHS organisations, with additional / local content often included and different methods used. • This influences the ability of the CSTF to **encourage trust** between organisations and thus increase the portability of staff training records. • National training packages may not fully reflect innovative practices used in **other jurisdictions**.
Quality assurance, management and governance	Looking at how to increase organisational confidence in the framework	• Limited clarity over who **owns** the CSTF (IP and policy) as well as who will fund ongoing arrangements. • Difficult to encourage trust amongst organisations currently as there **is limited verification and QA** of activity at a national level.

Table 4: Summary of report mapped to specification

1.6 Recommendations

As noted, the research and engagement activities undertaken as part of the review represent only the initial phase of the review of the CSTF, the training requirements to deliver the framework and the relevant underlying governance, management, and quality assurance

structures. Where insight from these stakeholder interactions has been unequivocal on the issues, risks, and observations, and has provided clear direction, the recommendations are direct on the ownership, activities, and timeline for implementation. Where evidence from engagement activities or analysis of survey findings is not conclusive, this has been noted and the relevant recommendations have been drafted to suggest further engagement with NHS staff, or additional consideration by HEE and partners ahead of any amendments to the CSTF. To this end, the report sets out overarching recommendations to progress the next phase of the review (refer to Section 2 of this summary report). These overarching recommendations are supported by detailed recommendations across each of the main scope areas, all of which help to address the issues identified in the report (refer to Table 4) and map to or provide further detail on how to achieve the overarching recommendations.

Several recommendations are also interdependent or interrelated: it may be that some recommendations become less significant as others are progressed, which is why it has been suggested that the Steering Group immediately review and prioritise the relevant recommendations (see overarching recommendation 7), so that this determination can be made. For example, Recommendation 31, regarding ongoing delivery of the CSTF and subcontracting relationships, is dependent on the outcomes of recommendations 28, 29 and 30 regarding leadership decisions, intellectual property (IP) and business case development.

1.7 Concluding remarks

In the context of enabling staff movement and Trusted Frameworks, once a responsible body has been agreed, defining alignment, and determining the extent to which it is feasible, viable and desirable as currently defined to adopt the CSTF for all Trust types and all staff is a priority. The suite of recommendations in the report are premised on several assumptions relating to the future landscape and that, in particular, HEE will continue to play a role in the governance and leadership of the CSTF. Where appropriate, the report references risks and interdependencies and provides HEE and partners with opportunities to consider various ways in which to address observations and issues identified by stakeholders as part of this first phase of the review of the CSTF.

Many of the recommendations are currently silent on roles and responsibilities, particularly in relation to which organisation should ‘lead’ or ‘sponsor’ the relevant recommendations and subsequent actions; when this should be done; how and by whom. Currently, there are several factors that have limited the ability to identify those who will be responsible for making decisions regarding the implementation of the recommendations going forwards. It is suggested that this must be agreed as a matter of priority, given the risks associated with having a national training framework for 1.5 million healthcare staff that may not be considered fit for purpose. When considering the recommendations and the forward plan for addressing the issues and risks identified.

To conclude, it is important to recognise that progressing these recommendations – as agreed and / or prioritised – will support HEE and partners to move the CSTF programme forward: to help to realise the ambitions of the Enabling Staff Movement programme; allow focus on efficacy and not just the completion of learning; and secure the engagement and buy-in of NHS organisations, who are at the core of delivering the training to NHS staff across England.

2 Report recommendations

2.1 Introduction to the report recommendations

As noted, the research and engagement activities undertaken as part of the report represent only the initial phase of the review of the CSTF, the training requirements to deliver the framework and the relevant underlying governance, management, and quality assurance structures. A set of ten overarching recommendations to progress the next phase of the review are set out in Section 2.3 of this document. Implementation of each of these overarching recommendations, in conjunction with the 40 detailed recommendations based on stakeholder engagement and observations, included at appendix 1, will support further targeted work in each of the five core areas: effectiveness and scope; barriers to alignment; content, levels and refresher periods; training and assessment; and quality assurance, governance and management.

Many of the recommendations are interdependent, and the adoption of one will have an impact on others. For example, if HEE chooses to revise learning outcomes, and / or mandates the use of a national training package, this may affect any approach to quality assurance and verification and the requirements asked of NHS organisations to ensure trust, which is seen as so intrinsic to the core the Enabling Staff Movement programme. All future decisions taken by HEE and partners need to acknowledge this and the likely disruption that this may cause, alongside the likely benefits, so that a proportional, risk-based model may be designed.

2.2 Detailed recommendations

Set out in appendix 1 are the 40 detailed recommendations, as identified and matched to the key observations throughout the report. These have been developed based on stakeholder views and suggestions raised during the review. A number of these recommendations also assume that HEE will take part in, or lead, the development of the CSTF going forward. These detailed recommendations have also been assessed by the CSTF Review Steering Group to help determine the order of priority, supporting notes of those discussions are included in the table.

2.3 Overarching recommendations

Overarching recommendations	Description	Linked detailed recommendations (see Appendix 1)
1. HEE leadership, Executive level governance and reporting to inform future direction and decision making	• In light of engagement with HEE Regional Directors and ODG in January and February 2022 on the progress / outcomes of the review and proposed next steps, agree further dates to engage. • Seek direction for any immediate decisions to be made, per each of these overarching recommendations HEE's future role and sponsorship of the CSTF.	2. Agree body to mandate alignment to the CSTF 28. Agree CSTF policy leadership and framework 29. Establish best future CSTF IP ownership 31. Determine position regarding ongoing delivery / subcontracting relationships
2. Steering Group engagement and review	• In lieu of alternative arrangements, the CSTF Steering Group on recommendation from the HEE Enabling Staff Movement Lead to review recommendations in the report and prioritise those to take forward (drawing on HEE Executive-level guidance in early 2022 and insights from working groups: see VI). • Based on Executive-level guidance, develop a plan for 2022/23 and a roadmap beyond this for the ongoing review of the CSTF and agree revised objectives, aligned to the Enabling Staff Movement programme. This will include support for the development of the revised overarching governance body. • Continue close engagement with NHSE/I in the context of other developments in the Trusted Frameworks workstream considering their future role post-merger with HEE and what changes this may entail). This should include reviewing draft Trusted Framework material, particularly where there is alignment or overlap with the recommendations in the report (such as in the context of quality assurance).	33. Establish CSTF overarching governance body

3. Case for change / benefits case	• Complete a high-level case for change / outline business case to support the proposed outcomes of this first stage of the review. This will be important to inform any decisions taken by HEE in conjunction with its partners and help frame the key research questions. • In conjunction with NHSE/I, and considering decisions regarding the scale of change, agree the timeline for undertaking a full economic benefits analysis to develop further the case for change in support of any major overhaul of the CSTF, in line with the recommendations in the report. • This should include financial analysis, benefits of improved learning outcomes and efficacy of training, patient benefits analysis and assessment of the opportunity costs of training, as well as the costs and benefits of any change of leadership, governance and day-to-day management of the CSTF which may have staffing implications.	1. Identify, quantify, and communicate CSTF benefits and relevance 30. Develop a business case and benefits framework
4. Agree governance and use of the CSTF policy and learning outcomes	• Guided by the recommendations in the report, HEE and partners (including senior management for SfH) to agree governance of the CSTF going forward (drawing on an initial case for change and later cost-benefit analysis to determine financial resources required to support any major changes and identifiable benefits – see above). • This will also need to include determinations regarding renewal of the SfH CSTF contractual arrangements. • As governance is confirmed and the scope of future work determined, it will be important to consider the scale of change and therefore the forward CSTF policy principles and drivers in areas such as: • UK wide scope; • expansion to other workforce groups: students, social care, volunteers, contractors; • in conjunction with Trusted Frameworks, development of guidance / clear requirements for NHS Trusts on alignment; • clear guidance on how to support staff in statutory and mandatory training and how to develop training materials; and • engagement with staff and People Professionals on whether to mandate the use of specific training materials / packages or assessment types.	3. Standardise CSTF development and use UK-wide 4. Increase NI and Scottish national level engagement 6. Review CSTF and Care Certificate overlap 7. Consider expansion of CSTF to volunteer and / or contractor workforce 8. Explore revision of professional regulator education requirements to better align to the CSTF 9. Formalising and reinforcing CSTF alignment definition and arrangements 10. Confirmation of requirement to align to the latest version of the CSTF

		21. Guidance for NHS organisations on supporting staff to complete statutory and mandatory training 24. Mandating the use of national training packages 25. Supporting NHS Trusts through the development of accessible learning materials 27. Further engagement required on specifying assessment approaches
5. Establish target state operating model and day-to-day management structures and QA	• Drawing on the case for change and benefits analysis and IP ownership / leadership determinations, develop the day-to-day management structure and high-level target operating model. • This should include the staffing / resourcing requirements, high-level technology architecture, relationships and accountabilities with partners, reporting and data capture framework, as well as the quality assurance model, use of SMEs and protocols for making amendments, and use of appropriate levers to encourage participation.	15. Formal protocols for agreeing amendments to the CSTF framework 32. Agree revised CSTF operating model 36. Formalise selection and input of SMEs to the framework 37. Agree proportional quality assurance approach 38. Identify and confirm levers for increasing alignment
6. Forward communication and engagement strategy and plan	• HEE and SfH, in conjunction with NHSE/I, to develop a forward communications strategy and plan – considering the range of stakeholders, their interest and influence, preferred channels, regularity of engagement and key messages. • Initially, HEE and partners should issue communications to all NHS Trusts so as to update them on next steps and to confirm their expectations on the status and use of the CSTF in the short to medium term and provide them with a direct line of communication to HEE should they require further information or if they have additional questions. • HEE should develop a community of interest group with those engaged as part of the review to thank them for their contributions to date in focus groups	5. Engage DHSC social care policy leads 11. Communicate the definition of alignment and process of alignment regularly 13. Support Trusts with clear guidance on staff role training designation 34. Develop and roll-out forward plan and communications strategy and plan

	and 1:1 engagement and to use as a pool of interested organisations to sense check emerging findings / pilot any initiatives.	35. Pursue further ICS engagement and involvement
7. Form small working groups to further prioritise the detailed recommendations for action and develop the forward plan	• Establish working groups (with ToR) for each of the five scope areas, to further assess and prioritise the recommendations (deprioritising the 'nice to haves'), as well as to establish key interdependencies with recommendations in other scope areas. These may consist of representatives from HEE and partners, as well as educationalists, nominated SMEs and a representative sample of Trust People Professionals. • Based on discussions with working groups, establish a roadmap for progression of each of the prioritised recommendations, mindful of equality, diversity and inclusion considerations and where further analysis may be needed.	39. Further review of equality, diversity and inclusion aspects of the CSTF 40. Monitor concurrent reviews and proposals related to data recording and sharing, as relevant to the CSTF
8. Root and branch review of the current and potential future CSTF subjects and learning outcomes and the efficacy of learning	• Develop a policy position regarding amendments to the current CSTF learning outcomes and subjects (drawing on the recommendations in the report) to guide a specific content-based review over the next six months, informed by educationalists, clinical and SME input as well as the decision-making pathways set out in the report. • This review should also focus on the how the efficacy of learning is considered in the context of the CSTF going forward. • Develop a holding position whilst a review of the CSTF subjects and learning outcomes is underway (if agreed, per the recommendations in the report), to communicate interim expectations to NHS organisations regarding alignment to the CSTF and the subjects or learning outcomes over the next six months.	12. CSTF learning outcome review and revision 14. Recognition of training needs of specific NHS Trust-types 16. New subject additions to the CSTF 17. Combining and/ or removing subjects 18. Develop a revised minimum standard for meeting CSTF learning outcomes for all staff, regardless of role 19. Engage with organisations to confirm optimum approach to training and assessment for those subjects with cumulative levels 20. An evidence-based review and revision of refresher periods,

		considering adult learning techniques 22. Greater specification of training approaches 26. Support organisations to consistently measure efficacy of learning to ensure the outcomes of learning are met and training packages may be updated in light of user feedback
9. Review of elfh national packages	• In the immediate term, consider potential amendments to the content of the national elfh packages considering the recommendations in the report, such as limiting content and assessment related to areas such as legislation or content which all staff may not need to be aware of, or including more first-person examples. • In the medium term, pending the outcome of the review of learning outcomes or other relevant recommendations in the report have been progressed, update the national packages in line with any required amendments to the CSTF (following the decision-making pathways that have been developed)	23. Undertake a review of elfh website, training, and assessment approaches
10. HEE and partner independent review of survey results	• HEE and partners to undertake review of survey findings obtained for this review in detail to identify any nuances not specified in the report that may be relevant to these or other activities which HEE and partners are involved in.	

Table 5: Overarching recommendations

3 Proposed plans and next steps

3.1 Proposed Governance for the next phase (2022/2023)

Now that the initial CSTF review phase is complete and recommendations clear, the programme will move into a change management phase, with two main workstreams as detailed below. New governance for this phase is currently being explored. Once confirmed it will be established as a matter of priority and should be in place/ready to operate by no later than the end June 2022. All elements of this section are currently 'proposed' and are subject to change.

3.2 Proposed workstreams and grouped recommendations

Workstream	Recommendations to be taken forward
1. CSTF Leadership & Governance Reform	33. Establish CSTF overarching governance body 2. Agree body to mandate alignment to the CSTF 24. Mandating the use of national training packages 28. Agree CSTF policy leadership and framework 1. Identify, quantify, and communicate CSTF benefits and relevance 30. Develop a business case and benefits framework 34. Develop and roll-out forward plan and communications strategy and plan 40. Monitor concurrent reviews and proposals related to data recording and sharing, as relevant to the CSTF
1a - CSTF Contract Reform Subgroup (this includes areas which are likely to be included in the contract to deliver the CSTF going forward)	29. Establish best future CSTF IP ownership 32. Agree revised CSTF operating model 31. Determine position regarding ongoing delivery / subcontracting relationships 37. Agree proportional quality assurance approach 38. Identify and confirm levers for increasing alignment 9. Formalising and reinforcing CSTF alignment definition and arrangements 10. Confirmation of requirement to align to the latest version of the CSTF 11. Communicate the definition of alignment and process of alignment regularly 13. Support Trusts with clear guidance on staff role training designation 21. Guidance for NHS organisations on supporting staff to complete statutory and mandatory training 39. Further review of equality, diversity and inclusion aspects of the CSTF
1b. CSTF Expansion & Engagement Subgroup	8. Explore revision of professional regulator education requirements to better align to the CSTF 35. Pursue further ICS engagement and involvement 4. Increase NI and Scottish national level engagement 6. Review CSTF and Care Certificate overlap

(this workstream may not commence immediately and may follow when progress is made on the other 3 workstreams)	7. Consider expansion of CSTF to volunteer and / or contractor workforce 5. Engage DHSC social care policy leads 3. Standardise CSTF development and use UK-wide
2. CSTF Content & Delivery Reform	**Content:** 26. Support organisations to consistently measure efficacy of learning to ensure the outcomes of learning are met and training packages may be updated in light of user feedback 15. Formal protocols for agreeing amendments to the CSTF framework 36. Formalise selection and input of SMEs to the framework 12. CSTF learning outcome review and revision 14. Recognition of training needs of specific NHS Trust-types 16. New subject additions to the CSTF 17. Combining and/ or removing subjects 18. Develop a revised minimum standard for meeting CSTF learning outcomes for all staff, regardless of role 20. An evidence-based review and revision of refresher periods, considering adult learning techniques **Delivery:** 19. Engage with organisations to confirm optimum approach to training and assessment for those subjects with cumulative levels 27. Further engagement required on specifying assessment approaches 25. Supporting NHS Trusts through the development of accessible learning materials 22. Greater specification of training approaches 23. Undertake a review of elfh website, training, and assessment approaches

3.3 Roadmap

The recommendations will be reviewed by the relevant working groups and a roadmap with timescales should be in place by the end of June 2022, this will be published alongside this report and updates on the progress of this work on the Enabling Staff Movement page of the HEE website.

3.4 CSTF Review Full Report

The full CSTF Review report was not developed to publish or share widely, however, the full report or relevant sections, will be shared with the working groups taking forward the recommendations, and can, in some cases, be made available on request. To request a copy of the report e-mail enablingstaffmovement@hee.nhs.uk with your request and a rationale for your request and this will be considered.

4 Glossary

Abbreviation	Term
CSTF	Core Skills Training Framework
CQC	Care Quality Commission
DHSC	Department of Health and Social Care
DOH	Department of Health
elfh	elearning for healthcare
ESR	Electronic Staff Record
FBC	Full Business Case
HEE	Health Education England
HR	Human Resources
HRD	Human Resources Director
IAT	Inter-Authority Transfer
ICS	Integrated Care System
IP	Intellectual property
KPIs	Key Performance Indicators
L&D	Learning and Development
LMS	Learning Management System
NES	NHS Education for Scotland
NHSE/I	National Health System England/Improvement
OBC	Outline Business Case
OD	Organisational Development
ODG	Operational Delivery Group
QA	Quality assurance
SfH	Skills for Health
SME	Subject Matter Expert
ToR	Terms of Reference

Table 6: Glossary

Appendix 1 – Detailed recommendations

No	Priority	Detailed Recommendation	CSTF Steering Group Comments (Feb 2022)
Scope Area 1: Effectiveness and scope			
1	High	**Identify, quantify, and communicate CSTF benefits and relevance:** Ensure that the national, local, and individual staff benefits of the CSTF (both financial and non-financial) are well-understood, defined, and quantified, to inform all determinations about its future use or the resources required to support its ongoing development and management. This will also likely help People Professionals to promote alignment with the CSTF in discussions with their SMEs and Boards. Further, as close to 20% of learners also identified that they do not think that the subjects and training are relevant to them in their day-to-day roles, include learning outcomes in the CSTF regarding raising awareness and improving understanding about how the subjects (such as Prevent Radicalisation or the Safeguarding subjects) are relevant to them. This should be combined with work with elfh to consider how the national packages may also be amended to ensure that this relevance is brought to life with contemporaneous, first-person examples, which are relatable for staff in the NHS.	Agree fully with the recommendation, to support alignment to the latest version of the framework, this should be a high priority.
2	High	**Agree body to mandate alignment to the CSTF**: In the context of a Trusted Framework, determine which national body may be best placed to mandate and potentially therefore QA and enforce (in conjunction with others), alignment to the CSTF: for example, this may be HEE as part of the subsequent review of the HEE education contract, NHSE/I as sponsors of the Trusted Frameworks, or the CQC (if their mandate was extended to include review of the quality of statutory and mandatory training, noting their capability and resource concerns). This is to ensure that NHS Trusts at Board level are aware of the importance of meeting the CSTF's requirements. This would likely increase alignment to and thus the effectiveness of the CSTF nationally, although amendments to the minimum standards required of those aligned to the framework and the adoption of	Agree we should further explore 'mandating' and determine if we are enforcing 'requirement to comply' to a baseline of training for all staff only and focus on using any levers – this will largely be driven by the work on a Trusted Framework (TFs) so continue to link closely with NHSE/I on this work. We need a strong evidence base to support any mandating and some flexibility where competency can be demonstrated. Refreshers should also be at baseline

		other recommendations in this review – including the content of the learning outcomes or the refresher periods – would likely need to change before alignment is considered both feasible and viable for many Trusts.	level, which allows orgs to refresh more often if evidenced and justified – again this will be a feature of the TF.
3	Low	**Standardise CSTF development and use UK-wide**: Connect with colleagues in Scotland, NI or Wales to share best practice and garner their support for developing standardised mandatory training across the UK, prior to moving forward with England only decisions. Greater national standardisation would further increase portability of staff, whilst also minimising duplication of effort in the respective countries. Funding would likely be required to support this.	Agree we should continue to engage and bring along but remain focused on England – the UK version is still available for all nations.
4	Low	**Increase NI and Scottish national level engagement:** Engage NI and Scotland to explore a co-developed CSTF and / or suite of national training packages, using the CSTF as a basis for this. Both Scotland and Northern Ireland stated that COVID-19 has delayed their adoption of a similar framework to England and that they would welcome discussing opportunities and sharing learnings. In particular, understand appetite to be involved in the imminent revisions to the learning outcomes in both countries and whether they would consider pooling / providing additional financial investment in the development of training content / packages and modules.	Agree, as recommendation 3.
5	Low	**Engage DHSC social care policy leads**: As DHSC develops its approach to support the social care workforce as part of its commitments set out in the White Paper 2021, it will be important for HEE and DHSC to understand and continue to share best practice. This may likely focus on the work underpinning the development of the CSTF and alignment to the framework, as well as respective ongoing workforce developments given the two-way mobility of the health and social care workforces.	Agree we should continue to engage and ensure alignment for the future with social care where appropriate.
6	Low	**Review CSTF and Care Certificate overlap:** Recognising the degree of overlap between the CSTF and the Care Certificate, in the medium to long term consider whether it may be appropriate to develop more aligned, agnostic learning outcomes for the CSTF, or introduce a means by which to recognise mutual prior learning for certain subjects in each sector. This will likely help to increase the portability of certain competencies and thus mobility for staff working across sectors, although note key practical considerations (such as the use of ESR by the social care workforce).	Agree, as recommendation 5.

7	Low	**Consider expansion of CSTF to volunteer and / or contractor workforce:** There are significant numbers of volunteers and contractors working in the NHS who do not fall under the remit of needing to complete statutory and mandatory training. This may represent a missed opportunity to standardise training for many people working within the broader health system. HEE and partners to consider whether it is appropriate to expand the scope of the CSTF to include the volunteer workforce or contractors who work with the NHS, noting key practical complexities (such as the use of ESR by these workforces). Note that the CSTF may also in time be expanded to ICSs.	These groups can use the CSTF now (seen as a benchmark for agencies) but need to consider whether to make that a requirement going forward. We also need to consider the message if don't make this standard for all. Time could be a barrier to these groups, and a dedicated project resource would be needed to take this forward if/when we do.
8	Medium	**Explore revision of professional regulator education requirements to better align to the CSTF:** To prepare healthcare students (i.e., doctors and nurses in training) for placement rotations, a number complete training in areas such as information governance or safeguarding, although not all are aligned to the CSTF. Engage with the regulators (i.e. the Nursing & Midwifery Council, the Health and Care Professions Council and the General Medical Council) to understand whether it may be appropriate to build into the overarching requirements of education providers – HEIs, deaneries etc. – express provision to align to the CSTF any core skills and mandatory training offered to healthcare professionals in training / students, so that prior to any placement rotation all learners have completed training aligned to the National Competencies. Note, however, key practical considerations (the use of ESR to these groups). **Response from GMC indicates that:* ***Undergraduate Education (UE)** - We do not direct specific content in undergraduate curricula; however, schools must demonstrate to us that they meet both the outcomes and our standards. We published our new Outcomes for graduates (OfG) in 2018 after extensive consultation with stakeholders in medical education and training. OfG does not include anything with regards to employers mandatory training, that would be outside of our remit in UG education (because we do not direct specific content).*	This recommendation may already be in place but could be emphasised or communicated better to help with uptake. See GMC response*.

		Postgraduate Education (PE) *-* *Our Generic professional capabilities (GPC) describe the essential capabilities which underpin professional medical practice and are a fundamental part of all postgraduate training programmes. The framework was published in 2017, alongside Excellence by design (EbD) which sets out the standards all postgraduate curricula in the UK must meet. The framework sets out the core professional values, knowledge, skills, and behaviours that all doctors should be aware of. By the end of specialty training, students are expected to be capable of applying and adapting to a range of clinical and non-clinical contexts. In these sets of guidance, we do say the following:* *In Generic Professional Capabilities guidance, p9 under Domain 1 Professional values and behaviours, we state: Our guidance outlines the expectations for doctors' professional responsibilities, including their duty of care to their patients. Doctors have a wide range of other professional responsibilities, relating to their roles as an employee, clinician, educator, scientist, scholar, advocate, and health champion. These responsibilities include demonstrating the following expected professional values and behaviours, including 'maintaining their continuing professional development and completing relevant statutory and mandatory training' and, in Excellence by Design guidance, p10 under Principles for all curricula we say 'The curriculum, therefore, should also include other relevant guidance, expectations and requirements for the provision of safe and effective learning, such as mandatory training required to address safety themes.'*	
Scope Area 2: Barriers to alignment			
9	High	**Formalising and reinforcing CSTF alignment definition and arrangements:** The guidance provided to NHS organisations in relation to alignment requires further clarity and reinforcement prior to the introduction of Trusted Frameworks. For example, many are aware of the need to update annually, but are not doing so and there are some Trusts across England who have never declared alignment and do not regularly engage with SfH. The definition of alignment also requires further review to ensure that it is	Agree and we can define further what that is, including sharing data and using national competencies etc.

		clear: for example, whether alignment to refresher periods is a requirement to be defined as 'aligned'. Of the 15 Trusts who are aligned to the latest version of the CSTF (as at September 2021), only seven are aligned to all the 11 CSTF subjects. HEE and partners, alongside the introduction of Trusted Frameworks, should formalise / refresh the current alignment process by (for example): • reinforcing the importance of complying and meeting the requirements of alignment; • asking Trusts as part of their annual quality accounts process to make a further declaration of compliance; • allocating an annual window of time within which Trusts should re-declare their alignment and specifying a timeframe on when this first declaration should be done; • confirming the number of subjects to which Trusts are required to align to meet the definition of alignment; and • specifying which responsible officer should submit the Declaration of Alignment. This will need to be undertaken in conjunction with other recommendations – such as those relating to refresher periods and the review of learning outcomes and a revised minimum level – but it would ensure that all Trusts have clear expectations in terms of when and how they should be aligning, and what they should be aligning to. This would also provide a foundation for other recommendations related to quality assurance and validation of alignment by a national body, as well as ensure readiness for the introduction of Trusted Frameworks.	
10	High	**Confirmation of requirement to align to the latest version of the CSTF:** Of those organisations who are aligned to a version of the CSTF, only 8% of NHS Trusts are aligned to the latest version (England version 1.0, 2020). 80% of NHS Trusts have not declared alignment since at least 2018. Revised guidance / requirements on alignment should be issued and communicated, or further holding communications sent out in lieu. For instance, due to the current pandemic pressures on the NHS, as part of this communication on guidance HEE may seek to delay any requirements for alignment and first engage with NHS Trusts regarding their ability to align to the latest version	Agree, with regards timing of this, we could be bold, as most trusts expect this, but we would need give reasonable notice, a lead in time and ensure it is as workload light as possible, being clear what it means for organisations. How we communicate is also important, include more of our 'offer' nationally and the

		of the CSTF, around organisational capacity to align to all the stated refresher periods included in the latest version CSTF. This could allow organisations to provide insights and for HEE to track where there are known training gaps and capacity constraints. NHS Trusts could then provide rationales and timeframes on when they would be able to align, and / or the support they would require for this.	additional support we might be able to provide (in time).
11	High	**Communicate the definition of alignment and process of alignment regularly:** Following a review of the current definition of alignment, the definition should be communicated to all NHS organisations, along with (as appropriate) the requirement to align annually to the latest version of the CSTF (e.g., communicating this, along with regular changes or CSTF updates, via ESR 'push' updates to all ESR Virtual Private Databases from IBM / ESR). Confirmation of receipt and the provision of two named contacts should be requested, to confirm that organisations are aware and understand the requirements and implications of alignment. This will help develop a two-way communication channel between the CSTF management team and NHS organisations.	Agree and ensure a process for 'chase ups' of re-alignments where agreed timescales are not met.
Scope Area 3: Content, levels, and refresher periods			
12	High	**CSTF learning outcome review and revision:** Considering stakeholder feedback on the phrasing, volume, ambiguity, and lack of educationalist input into the current suite of learning outcomes, undertake a thorough review of all CSTF subject learning outcomes and revisit and revise through engagement with educational SMEs, industry SMEs and People Professionals, as well as in accordance with the revised governance structures. *This work should take account of stakeholder feedback received during the initial review, which included, for example, removing the words 'understand', 'know' and 'be familiar with' from the learning outcomes, and standardising the style and number of learning outcomes across each of the subjects in the CSTF. It will be for the group taking this forward to determine and evidence what is and isn't actuated upon*. This will help support the adoption of several other recommendations in relation to alignment and re-definition a revised level for all staff.	Agree.

13	High	**Support Trusts with clear guidance on staff role training designation:** People Professionals identified that it is sometimes not clear on which roles / groups to which each of the levels or subjects apply. This leaves a level of subjectivity at Trust level, which can be confusing and lead to under- or over-training. The CSTF Subject Guide should be updated, through engagement with SMEs and People Professionals, to specify which roles certain levels apply to and to include clear guidance and definitions for NHS staff roles to inform the allocation of training requirements, in accordance with the revised governance structures.	Agree, this also generates queries to the E-LfH helpdesk, but how we do this may be complicated, may need to apply 80/20 rule and seek a way that is not 'job title' led. Carefully consider who is best placed to lead this work and the recommendation on stacking learning will be challenging but we can look for solutions.
14	Medium	**Recognition of training needs of specific NHS Trust-types:** In conjunction with the review of learning outcomes and subjects, there are two options to address the training needs of specific Trust types. As stakeholder feedback was not conclusive on this issue, HEE and partners should agree whether to: a) For specific subjects, make amendments or annotations to the learning outcomes to recognise the variable needs of specific Trust types and better facilitate alignment. Specific examples referenced by stakeholders included Conflict Resolution (learning outcomes not appropriate for situations at mental health Trusts) and Fire Safety training in the context of a ward and hospital (less applicable for ambulance Trust staff). b) Revise the framework to include core learning outcomes (for all Trusts), additional learning outcomes (for certain Trust types) and role-specific learning outcomes (tying into Recommendation 13, above).	Agree, and there may be a 3rd option, which is to be clearer on the fact its only level 1 learning outcomes which are required for all staff, regardless of trust type and other local training needs.
15	High	**Formal protocols for agreeing amendments to the CSTF framework:** Amendments to the CSTF are currently undertaken by SfH on a case-by-case basis. There is limited documented policies and procedures which formalise this process. The example formal decision pathways included in the report should be agreed – with changes made as required – to outline thresholds, key criteria, and governance processes for amendments to the subjects or specific content in the CSTF, to ensure that this is evidence-based and there is sufficient scrutiny and a clear rationale for all amendments.	Agree.

16	High	**New subject additions to the CSTF:** As a result of imminent legislation, government priorities and stakeholder feedback, several new subjects have been identified as potential additions to the framework. The most popular in both surveys conducted for this review is Mental Health Awareness. There were concerns expressed by stakeholders throughout this review that adding more subjects to the CSTF may make it more unmanageable for NHS organisations and staff, and compound some of the other issues identified in the report. This risk may be mitigated by adding additional learning outcomes to existing subjects to address new material, rather than adding separate new subjects in their entirety to the CSTF. In this context, and in accordance with the agreed formal amendment process (refer to Recommendation 15), there are the following options: a) include Mental Health Awareness only in the CSTF as a priority for now, either as a separate subject or by including additional learning outcomes within an existing subject (such as Health, Safety and Welfare), noting that Learning Disability and Autism may also be a mandatory addition to the CSTF soon. Alongside this, undertake further engagement with People Professionals and NHS Staff around the additional subjects that were seen as popular subject additions, so as to understand the rationale and service need; or b) include Mental Health Awareness, Health, Wellbeing and Selfcare, Environmental Sustainability, Learning Disability and Autism and Dementia Awareness in the CSTF – either as independent subjects, or as supplementary learning outcomes to existing subjects (refer to Recommendation 17) – noting that these reflect the top three preferences for stakeholders engaged for this review.	Agree.
17	High	**Combining and / or removing subjects:** Survey feedback showed that nearly a third of People Professionals feel that several subjects could be combined. As part of the root and branch review of the current a future CSTF subjects, combine subjects that share key learning outcomes, principles, or other similar content so as to reduce the volume of training that NHS staff are required to undertake, in line with the proposed subject amendment pathway (revised as agreed – refer to Recommendation 15). As a first step,	Agree.

		based on feedback from stakeholders throughout this review there should be focus on combining: • Safeguarding Adults and Safeguarding Children; or • Safeguarding Adults and Safeguarding Children and Preventing Radicalisation together (rather than removing the latter entirely, noting that 63% of All Staff survey respondents were of the view that the subject was not useful for them). A further option would be to combine Health, Safety and Welfare with Fire Safety, which several organisations thought could be merged given they both cover core elements such as risk assessments.	
18	Medium	**Develop a revised minimum standard for meeting CSTF learning outcomes for all staff, regardless of role**: To ensure that all staff have a consistent base level of knowledge across all subjects, and to increase the likelihood of alignment with the CSTF by all NHS organisations – and in the absence of progressing other recommendations, such as the mandating of national packages – potential to introduce a revised minimum standard for alignment: a 'Level 0' that is achievable for all NHS organisations. This should be set below the requirements currently set out for the existing CSTF Level 1 subjects. Level 0 may include, for example, a reduced list of learning outcomes, or provide clarity on the aspects that staff really need to know: taking out elements such as the derivation of the training in legislation; and focusing on the indicators of risk and how to behave in likely scenarios, thus rationalising the knowledge, skills, and behaviours. As part of this Level 0, consideration could be given to having a list of core national minimum requirements which are transferable between organisation, with a separate, likely shorter list of local content / learning outcomes which would form part of local inductions (refer also to Recommendation 14). This knowledge would not transfer between organisations. This reflects comments from some organisations that it is difficult for them to ask staff to sit the volume of training required to meet the current refresher periods and therefore align to the CSTF (due to, for example, the size of their staff population), or the fact that they will continue to diverge from the existing learning outcomes to ensure they can continue to train staff on local content specific to their organisation.	Agree with some reservations about a new Level 0, careful consideration to how we can be clearer about minimum level to potentially avoid a need for a level 0.

19	High	**Engage with organisations to confirm optimum approach to training and assessment for those subjects with cumulative levels:** Survey feedback and focus group engagement highlighted that there are currently inconsistencies in approaches to training for staff who are required to (and have undertaken) multiple levels of CSTF training. For instance: • one organisation may feel that completing Level 3 training is evidence that a staff member has demonstrated competencies in Levels 1, 2 and 3; • however, other organisations may require staff to complete all levels of training, so a staff member (new or existing) who is required to complete Level 3 training may also have to undertake Levels 1 and 2 training. As stakeholder feedback throughout this review was inconclusive on this matter, HEE and partners should engage further with organisations to develop clear guidance and approach to training and assessments for subjects with cumulative levels. Policy should be developed as the learning outcomes are reviewed and the approach to a revised minimum standard is considered. This guidance should also include clear instructions on how to manage refresher periods related to cumulative learning.	Agree, but we also need to consider reporting implications in ESR if we go ahead with cumulative levels.
Scope Area 4: Training delivery and assessment			
20	High	**An evidence-based review and revision of refresher periods, considering adult learning techniques:** All CSTF subjects since February 2020 have a required refresher period. The subjects within the CSTF have different refresher periods; the origin of these can be traced back to either a CSTF precedent (through SME designation), national guidance or national councils. In conjunction with the review of learning outcomes (Recommendation 12) and considerations regarding the setting of a revised minimum standard for the CSTF and all staff (Recommendation 18), it would be prudent to undertake an evidence-based review of the set refresher periods, engaging with NHS Trusts (i.e. to incorporate organisational capacity constraints into the review), considering adult learning techniques and potentially piloting the impact of these in specific staff groups and for	Agree.

		specific subjects where learning fade may have the biggest impact. Options for reform could include, for example: • maintenance of the status quo continuing to have different refresher periods for each subject; • standardising a set refresher period for all subjects (e.g., two years); • disbanding with refresher periods for all / specific subjects; • reviewing the refresher periods, mindful of national guidance, but in collaboration with clinical leads and trusts to determine what may be appropriate on a subject-by-subject basis; or • removing / revising and extending refresher training and / or assessment for some or all subjects, if the evidence indicates that there are other learning techniques – for example, using regular information cascades to learners – that better support staff to continue to meet / maintain the currency of learning objectives (refer to Recommendation 22). In addition, there are several subjects where, according to SfH, there is no specific national guidance to support the refresher period mandated. This affects Trust's perceptions on alignment and these subjects should be prioritised for review. These subjects are: Equality, Diversity and Human Rights, Health, Safety and Welfare, Infection Prevention and Control, and Conflict Resolution. The revision of refresher periods for all or some subjects requires national level clinical leadership and ownership and direction by HEE. Stakeholders engaged as part of this review had mixed perspectives on the appropriate approach to take and therefore a decision should be taken by the Steering Group, informed by SMEs and in conjunction with other recommendations in the report. on the most appropriate way forward.	
21	Medium	**Guidance for NHS organisations on supporting staff to complete statutory and mandatory training:** Several free text responses from the 'All Staff' survey noted that they felt that they do not receive any or enough organisational support to complete statutory and mandatory training. Further, only 40% of survey respondents said they were allocated time	Agree.

		during their working day to complete this training. As part of the next phase of developing the CSTF, develop national level recommendations and advice on how organisations can better support staff to complete statutory and mandatory training. This could include ring-fencing computers at certain times for training purposes or providing portable electronic devices to loan to staff to complete training in their preferred location; ensuring that SMEs provide any classroom-based sessions at several different times to help facilitate attendance; or providing paper-based training materials for those with limited access to IT facilities (refer to Recommendation 25). This will likely help to build consensus in service on what 'good looks like'; organisations can develop processes to meet this.	
22	Medium	**Greater specification of training approaches:** The CSTF currently comments on the training delivery but does not prescribe modes of training. In conjunction with Recommendation 24, the following is recommended: • *Provide practical approaches to refresher training where 'knowledge' components can be skipped if not required*: Survey feedback showed that staff had differing views in relation to refresher training (42% feel only an assessment is required, whereas 46% feel training with or without assessment is required) and that the current approach of offering different options suits the range of learner requirements. In line with the review of refresher periods (refer to Recommendation 20), review the refresher assessment and training approaches informed by further staff engagement and SME input. Then specify (as appropriate) in the CSTF where certain subjects or learning outcomes may not require both refresher knowledge-based training and assessment. • *Mandating modes of training:* In lieu of a decision not being taken to mandate a particular learning package (refer to Recommendation 24), mandate specific modes of training in the CSTF Subject Guide, drawing on input from nominated SMEs and People Professional engagement (including responses to the People Professional survey). Specified modes of training delivery could support the standardisation of training across organisations and increase trust in the transfer of National Competencies.	Agree.

23	High	**Undertake a review of elfh website, training and assessment approaches:** Numerous observations from stakeholders about the clarity, relevance, length, and efficacy of the national packages support recommendations to pursue: a) *National approach to supporting the delivering of local training content:* Explore how to allow the amendment of national training materials so as to include local content as required (or host these on the elfh learning hub), recognising that some training i.e. Moving and Handling or Fire Safety may not be portable and nationally relevant. b) *Use feedback from People Professionals to review packages:* Use the feedback from the People Professionals survey and engagement, consider the extent to which this informs any future changes to training packages. For example, suggestions during focus group engagement with People Professionals included visually amending the style / look of the online assessments (so they feel less repetitive for staff undertaking learning) and enabling the functionality for local content to be embedded into the packages (as noted above). c) *Undertake a review of elfh national packages and assessment approach:* Determine what is relevant 'core' knowledge for NHS staff and as part of this appraisal, review the assessment question banks, pass marks and ordering of questions with the relevant SMEs and educationalists to support the development of assessments that assess knowledge of key skills rather than facts or figures, drawing on examples in other jurisdictions. Pilot amended learning packages / assessments with educationalists and NHS staff to ensure content is engaging and maintains attention and that assessment recognises all staff variable cognitive abilities to recall/process/understand information. (Refer to Recommendation 27 regarding approaches to assessment.) d) *Deploying novel forms of learning for statutory and mandatory training:* There are a number of different novel forms of learning which stakeholders referenced as part of this review, including microlearning, virtual reality, bitesize learning and scenario-based interactive learning. As part of the development of national packages,	Agree, to consider - this could be done ASAP or could be timed accordingly with the work to review the content/ learning outcomes of the framework.

		incorporate these and others based on engagement with People Professionals. Develop a business case for pilot trial(s) that tests training packages that draw on these forms of learning and consider whether there are impacts on efficacy and learning gain. e) *Undertake a review of the elfh learning portal to help improve the learner journey and minimise confusion over learner content:* Feedback from surveys and 1:1s noted that the names of the training packages on the elfh website should be reviewed, given staff confusion. Review of the elfh learning hub could help to target challenges related to user-experience; any changes to the hub could then be user-tested with pilot organisations.	
24	Medium	**Mandating the use of national training packages:** Survey results indicated that there is majority support for the concept of mandating the use of training packages, as is the case in Wales: 32% of organisations engaged said that mandating certain national training packages would be "very useful", and 28% said it would be "useful". This was also supported, to an extent, in focus group discussions with People Professionals. Stakeholders indicated that there would be more support for this if other recommendations regarding the elfh national packages were progressed, including updating the packages to reflect contemporary content and learning approaches, as well as adapting them to enable the addition of local content by Trusts and their SMEs as appropriate or relevant (refer to Recommendation 23, for example). The exclusive use of national packages would also ensure that all organisations could deliver training in accordance with the required learning competences and would minimise learning development costs (i.e. e-learning production, SME time, learning team administration) at all Trusts. On this basis, certain training packages should be mandated for national use once they have been updated in line with other recommendations in the report (including ensuring there are more accessible forms of national training than just e-learning, in line with Recommendation 25). However, exclusions from this national mandate should be, for example, Fire Safety or Moving and Handling, both of which may not be portable or contain	Needs further consideration before agreeing mandating, this can be considered with recommendation 2.

		significant amounts of nationally relevant content (refer to Recommendation 23). Various options on how this may work in practice include, for example: • nationally mandated approach through revised elfh national training packages; • licensing a private provider to develop and deliver training packages, for example SfH; or • recognising the move to ICS, accredit provider(s) of learning materials, individual NHS Trusts at a local level in a region.	
25	Medium	**Supporting NHS Trusts through the development of accessible learning materials:** There is limited national-level training material provision in alternative formats other than e-learning. According to feedback by People Professionals during focus group engagement, HEE should undertake specific engagement with staff to support development of additional national materials, with a particular focus on materials for staff with learning disabilities, language barriers and limited access to technology. Further engagement, co-development of training materials with certain staff groups and testing of materials specifically related to this would be required to ensure learning materials are designed in accordance with specific learner requirements for these groups.	Agree.
26	Medium	**Support organisations to consistently measure efficacy of learning to ensure the outcomes of learning are met and training packages may be updated considering user feedback:** The achievement and measurement of learning efficacy is vital to ensuring training supports individuals to meet required expectations and have awareness in specific areas. However, most organisations are not measuring the efficacy of statutory and mandatory training, and instead are focusing on compliance. There is no national guidance / data collection requirements to support organisations on how they should do this. Drawing on current examples across the NHS, HEE and partners should develop guidance and metrics to support all organisations to consistently measure the efficacy of statutory and mandatory training in a standardised approach. This will also support the development of future training packages, and, if scoped correctly, the use of learning feedback and other metrics will allow comprehension for example of what learning modes, delivery techniques and assessment types encourage learning efficacy for	Agree.

		statutory and mandatory training by learner groups / subjects. In time, and as part of any quality assurance framework, any national body may wish to collate this information centrally.	
27	High	**Further engagement required on specifying assessment approaches:** As shown in the data collected from People Professionals, while multiple choice questions are the most utilised method of assessment (82% of learners who responded to the question selected multiple choice questions) other approaches, particularly for subjects such as Moving and Handling and Resuscitation, tend to use different assessment approaches (i.e. observation of performance, attendance pass mark or scenario case study). To consider standardisation of assessment types, a further comprehensive engagement exercise to review in detail the assessment approaches by subject would likely be required, in conjunction with the review of learning outcomes, to better understand the most appropriate assessment methods for each of the CSTF subjects. Any determinations from this review would likely also need to be supported with further evidence of learning efficacy, which is not currently collected by most organisations (only by 27% of organisations surveyed).	Agree, multiple choice questions receive feedback on being 'tick box exercises' on social media.
Scope Area 5: Quality assurance, management, and governance			
28	High	**Agree CSTF policy leadership and framework:** In accordance with the Enabling Staff Movement programme, agree the commitments and sponsorship of CSTF policy within HEE and the roles of other national bodies as appropriate (such as NHSE/I, NHS Employers) to identify lines of accountability and support any potential expansion / extension of involvement in CSTF management and oversight. Both clinical and educational sponsorship of the CSTF will be important going forward, as stakeholders throughout this review commented on the importance of these different learning perspectives to ensure that the learning outcomes and training materials are pitched at the right level. This will likely also help to support more robust and transparent decision-making, in terms of the recommendations in the report, as well as to clarify resource and funding requirements and sources.	Agree.

29	Very High	**Establish best future CSTF IP ownership:** Review the CSTF contract and associated arrangements to confirm greater clarity in terms of future contractual arrangements and the commissioner supplier roles (including licensing). Once determined, this will likely inform how future reviews of the learning outcomes are undertaken, for example, or who may sign off any amendments to the learning outcomes.	Agree, current contract due to end in September 2022 so must be addressed ASAP.
30	High	**Develop a business case and benefits framework:** To ensure HEE and partners are fully aware of the likely costs and benefits of developing and investing in any new CSTF operating model, a business case (supported by a benefits framework) should be produced, providing an evidence base for any changes and to allow transparent decision-making. This business case will support and underpin any required actions, additional resources and likely returns, and set a framework for the future measurement of these.	Agree.
31	Very High	**Determine position regarding ongoing delivery / subcontracting relationships:** Based on leadership decisions, the IP review and business case outcomes, determine if it is feasible, desirable, and viable for HEE to: a) take over the day-to-day management of the CSTF at the end of the existing contract with SfH; b) renew (and potentially revise) the contractual arrangements with SfH; Any decisions should be informed by the business case as well as the practicalities of HEE taking over the day-to-day management of the CSTF, likely performance and day to day intensity of the management of the CSTF, related leadership and management of the elfh national packages (and synergies), Any alternative would require the development of a new operating model (discussed overleaf).	Agree, as per recommendation 29.
32	Very High	**Agree revised CSTF operating model:** The overarching operating model, the day-to-day management of the framework and the roles and responsibilities of various national level bodies requires further definition. Once the overarching leadership and governance arrangements are agreed, define, and agree the revised vision, operating model, and headline strategy / objectives for the future CSTF programme. This will ensure that the key bodies and organisations are aware of roles, responsibilities, and accountabilities and what the programme wants to achieve, how it will do this, by when, using which levers and via which channels.	Agree, as per recommendation 29..

33	High	**Establish CSTF overarching governance body:** There is currently no constituted governance body to oversee the CSTF review, apart from the Steering Group, which is more akin to a discussion and engagement forum. As part of the establishment of the operating model and once IP ownership of the learning outcomes and leadership of the CSTF policy is clarified, set up a governance body with the delegated authority to make decisions relating to the framework and / or the national packages, with appropriate representation (from HEE and partners, SMEs and both clinical and non-clinical representatives from Trusts, for example) and ToR to enable this body's agile and effective operation. Again, this will help support more robust and transparent decision-making, and better facilitate the consideration and progression of other recommendations in the report.	Agree.
34	Medium	**Develop and roll-out forward plan and communications strategy and plan:** Once CSTF policy leadership and national clinical sponsorship has been agreed and recommendations assessed and prioritised, agree the three- and six-month roadmap and headline milestones. A communications and engagement plan informed by the agreed operational delivery approach should be prepared. The communications strategy will need to be targeted to the respective stakeholder groups and Trust types to ensure appropriate messaging and encourage engagement and buy-in to the CSTF development; key messages may also need to be agreed with NHSE/I to align with those relating to the Trusted Framework workstream.	Agree.
35	Low	**Pursue further ICS engagement and involvement:** To ensure regional buy-in and comprehension of the importance and impact of statutory and mandatory training hold discussions with ICS leadership in early to mid-2022 to identify how they be involved and support in driving forward alignment of the CSTF across their regions. In the longer term, pending the outcome of these discussions, consideration may be given to expanding the CSTF to include other organisations outside of health sitting within ICSs (noting practical considerations e.g., use of ESR by organisations within the ICS).	Agree, low priority related to allowing time for ICSs to develop.
36	High	**Formalise selection and input of SMEs to the framework:** There is currently limited formal processes for the appointment, use of and review of SMEs to inform the development of the CSTF and the elfh national packages. There should be work to formalise the 'tenure' of joint SMEs to	Agree, this needs to take place before the review of learning outcomes and packages as per recommendations 16, 17 and 20.

		support with updates to both the framework learning outcomes and the national packages (as set out in the decision-making pathways), and increase engagement with the new governance body. Looking to, for example, Wales for how this may work in practice, this may include establishing a panel of SMEs with representatives nominated or appointed from across Trusts nationally. This will likely increase transparency and consistency between updates to the learning outcomes and the national packages, as well as the development of local learning and therefore help to enhance trust in both across the NHS.	
37	Very High	**Agree proportional quality assurance approach:** Noting the positive response from stakeholders regarding the introduction of proportionate quality assurance measures to improve trust in the delivery of the CSTF across NHS organisations (just under half the People Professional respondents supported validation of alignment by a national body, for example), agree the details of the future quality assurance approach to test further with stakeholders. Consideration may need to be given as to how this may be phased in, and the burden that this may place on NHS Trust learning teams. In addition, this may be impacted by a number of recommendations raised as part of this review: for example, if a decision is taken to mandate national packages, the degree / focus of quality assurance may look quite different. The introduction of Trusted Frameworks will also have a big impact as this will set out expectations for quality assurance. The quality assurance approach will need to consider some of the following areas as part of any next stage of engagement: *Standards* • standards against which to quality assure the delivery of statutory and mandatory training (including in relation to compliance; the accuracy of the CSTF-alignment declaration; and the efficacy of learning); • whether these standards should be assessed on a pass / fail basis or a scale; *Assessment approach* • whether continuous monitoring, risk-based review or annual cyclical reviews are required;	Agree, very high rating is related to current contract ending in Sept 2022, as it would be ideal for new approach (once agreed) to be included in new contract.

		• where declarations of compliance may be made in conjunction with other Trust overarching responsibilities, for example their Quality Accounts; • how reviews are undertaken, including a combination of peer reviews, self-assessment, internal audits, reviews by independent third parties or reviews by HEE regional or ICS teams and / or CQC (noting reservations expressed by CQC regarding its position to quality assure education or training delivery beyond compliance-related considerations); *Outcomes* • recognition of how the outcomes of quality assurance activities will be shared and used by organisations; • cascading of best practice; and • generation of publicly available reports attribution of ratings. There may also be appetite to follow a risk-based approach based on prior performance or reliance on other assurance sources with high performing NHS Trusts earning autonomy from any quality assurance regime. Of note, there may also need to be consideration into how to review / accommodate requirements of specific Trust-type allowances (as appropriate), and whether the requirements should be the same for aligned versus partially or non-aligned organisations, recognising their interim compliance state (where relevant). This framework should be designed based on decisions informed by the cost-benefit analysis, and consideration of the extent to which the data available enables a risk-based, proportionate approach to quality assurance, as well as any other risks associated with taking on a national level activity of this nature and scale.	
38	Very High	**Identify and confirm levers for increasing alignment:** To support quality assurance activities, assess the full suite of levers (and associated penalties) that may be appropriate and used to ensure alignment or assure the quality of training being delivered at NHS organisations going forward, including the need to introduce any additional levers. The introduction of Trusted Frameworks will define and therefore impose a legally enforceable requirement on NHS Trusts, however the specifics of this and the bodies	Agree, very high rating is due to planned introduction of TF from April 2022.

		involved in defining and enforcing this requirement need to be defined in line with other recommendations in the report. Some levers already exist (including CQC compliance-related review of the delivery of statutory and mandatory training as part of their Well-Led inspections); new levers will likely be dependent on decisions regarding whether alignment to the CSTF will be mandated for all NHS organisations in future (such as in the HEE education contract). Consideration should also be given to what penalties maybe appropriate to apply (if any) to those who are not aligned, and how these may be enforced.	
39	Medium	**Further review of equality, diversity, and inclusion aspects of the CSTF:** As noted, whilst an equality, diversity, and inclusion assessment of the breadth of respondents to this survey was originally envisaged, the HEE information governance arrangements did not permit the collection of this data, so in agreement with HEE this was not included. Future engagement – as driven by the revised governance body and management teams – should look to address this aspect of the CSTF and consider how it may be factored into quality assurance assessment and mechanisms in future.	Agree.
40	Medium	**Monitor concurrent reviews and proposals related to data recording and sharing, as relevant to the CSTF:** As noted in the report, there are several reviews and proposals aimed to address data recording and sharing issues identified by stakeholders in the context of ESR, the IAT process and National Competencies, for example. This should continue to be monitored as a parallel workstream – including through ongoing engagement with NHSE/I – to determine any key dependencies or proposals of relevance for the recommendations in the report.	Agree.

Table 7: Detailed recommendations

Information on the membership of the CSTF Steering Group will be made available on request. If you would like to find out more, have comments or views to share, or, would like to get involved please e-mail enablingstaffmovement@hee.nhs.uk.