MINISTRY OF HEALTH
SCOTTISH HOME AND HEALTH DEPARTMENT

Report
by the Working Party on
Ambulance Training and Equipment
Part 1—Training

LONDON
HER MAJESTY'S STATIONERY OFFICE
1966

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MEMBERSHIP OF THE WORKING PARTY

E. L. M. Millar, ESQ, M SC, M D, DPH (Chairman)

MEMBERS

Dr. J. K. Anderson\(^1\), M B, CH B, J P
J. H. Daykin, ESQ
Lt. Gen. Sir Alexander Drummond\(^2\), KBE, CB, LL D, FRCS, DL O
Dillwyn Evans, ESQ, B Sc, M B, FRCS
H. K. Griffith, ESQ, FRCS
W. S. Lewin, ESQ, M S, M B, FRCS
P. S. London, ESQ, MB E, M B, FRCS
R. Marshall\(^3\), ESQ
E. A. Pask, ESQ, OBE, MA, MD, FFA
Dr. T. B. Priestley, MRCs, LRCP, DO
N. L. Rowe, ESQ, FDSRCS (Eng) MRCs, LRCP
Dr. A. D. Stoker, TD, M B, B CH
Dr. W. E. Thomas, B Sc, M B, CH B, DPH
V. Whitaker, ESQ, OBE
N. A. Woodruff\(^4\), ESQ

SECRETARY

H. Herzmark, ESQ (Ministry of Health)

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\(^1\) Dr. Anderson was appointed in place of Dr. G. Buchanan, BL, LRCP, DPH, DLM, DTM & H, DPA who resigned because of ill health in October 1963.

\(^2\) Lt. Gen. Sir Alexander Drummond was appointed in place of Dr. J. S. McLintock, MB CH B, DPH who resigned in October 1963.

\(^3\) Mr. Marshall was appointed in place of Mr. J. A. Brown who resigned because of ill health in November 1964.

\(^4\) Mr. Woodruff was appointed in place of Mr. F. A. Richardson who retired from the London Ambulance Service in June 1964.
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INTRODUCTION

The Right Hon. Kenneth Robinson, M P
Minister of Health

The Right Hon. W. Ross, M B E, M P
Secretary of State for Scotland

1. We were appointed by your predecessors in September 1963, with the following terms of reference:

   "To advise on the revision of the guidance given by the Ministry of Health and the Scottish Home and Health Department on the equipment and the training of staff in the ambulance services provided under the National Health Service Acts; to recommend, in the light of recent developments in accident surgery, what should be included in post-entry training and the form this training should take; and to prepare a model manual if this is thought desirable."

2. We held our first meeting on 4th October 1963, and in all have held 18 meetings.

3. We have devoted these meetings mainly to the subject of training and have left the subject of equipment for detailed consideration later. We have in the course of our enquiries and deliberations been aware of the urgent need for greatly extended training programmes for ambulance staff and we have decided to report separately on training in order that consideration may be given without delay to the means of providing the training which we recommend.

4. We invited written evidence from all organisations which submitted such evidence to the Sub-Committee on Accident and Emergency Services of the Standing Medical Advisory Committee of the Central Health Services Council and have received evidence from many of these organizations and from certain other organisations and individuals. A list of these is at Appendix IX and includes some who gave evidence on equipment only. We take this opportunity of expressing our appreciation of the great assistance rendered by all those who prepared written evidence. We are unable in this Report to mention severally all the detailed information and suggestions put to us but we wish to record how helpful these have been in enabling us to formulate our conclusions.

5. In order to obtain information on the length of service and deployment of staff in the ambulance service and future plans in this respect we asked local health authorities in England and Wales and the Scottish Home and Health Department to complete a questionnaire, the results of which are reproduced at Appendix V.

6. We are conscious of the wide differences in organisation between local authorities. These are due partly to the way the service has grown up, but the needs to be met, the nature of local voluntary effort and the terrain of operation have all contributed to this. While local circumstances and the particular accident hazards encountered should be reflected in the local training offered to ambulance staff, we are convinced that modern conditions necessitate a training that, in its major aspects, should be common to all ambulance staff and be evaluated according to a common standard.
7. While the organisation of the service is outside our terms of reference we were impressed during our enquiries by the close connection between organisation on the one hand and training and equipment on the other and we therefore propose a Central Ambulance Services Council to advise on all aspects of the ambulance service with Standing Committees on Training, Equipment and perhaps Organisation. We are also convinced that a proper career structure is necessary to attract recruits into the service.

8. The meetings of the Working Party have been most interesting in that, with the very diverse backgrounds of its members, some have placed emphasis in one direction and some in another. This has exercised the patience and skill of Mr. H. Herzmark, our Secretary, and he is to be congratulated upon welding all our ideas and observations into a coherent whole. Mr. Herzmark has been most ably assisted by Mr. H. W. S. Ward. The wide experience and knowledge of Mr. T. G. Mullen, the Adviser on Ambulance Services to the Ministry of Health, have been of supreme value in formulating our enquiries and guiding the discussions which arose from them. A number of officials of the Ministry of Health, the Welsh Board of Health and the Scottish Home and Health Department have also given valuable assistance and to them we are also indebted.

9. Although our Report is unanimous two of our members have had misgivings about the extent of the training we propose and have put in an addendum on this point.

10. We now have the honour to present our Report on the training of ambulance staff. For ease of reference we open with a summary and a list of recommendations.

Signed E. L. M. Millar (Chairman)
J. K. Anderson
J. H. Daykin
Alexander Drummond
Dillwyn Evans
Harold K. Griffith
W. S. Lewin
P. S. London
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V. Whitaker
N. A. Woodruff

H. Herzmark (Secretary)
SUMMARY

The need for training
1. The need for training of ambulance staff has to be considered against a background of an expanding service, provided in a variety of ways to meet changing needs.

2. Training facilities with few exceptions are inadequate. Very few authorities provide systematic training. First aid training is normally the same as that offered to the general public; it is not sufficiently intensive and is not taught in relation to the demands of the service. Other necessary subjects, such as radio telephony, are not covered except in the courses provided by very few authorities. The evidence received was well nigh unanimous in recommending that training facilities should be improved.

3. 80% of ambulance driver-attendants carry out the full range of duties and even those who are engaged primarily on either emergency work or work with out-patients may find themselves transferred to other work. A common basic training would therefore be appropriate to all ambulance drivers and attendants and this would also be appropriate to some control room staff. Officers and instructors should know everything that the ambulance driver-attendant should know.

4. Ambulance staff should have the training needed for their prime task: to transport patients to treatment centres without avoidable deterioration or unnecessary delay. They must have sufficient background knowledge to make certain vital decisions with confidence and act accordingly, particularly in the light of changes in the patient's condition, to be able to recognise and report helpfully on various aspects of the case and work generally in accordance with the policy of the accident and emergency services in the locality. As hospital facilities become centred on district general hospitals and as accident and emergency units are concentrated at fewer centres, special problems are likely to arise during the longer journeys which will sometimes be necessary.

5. Ambulance crews require a thorough and intensive training in first aid (with which the voluntary first aid organisations should be associated) with substantial periods of practical work but they also require training in additional subjects, both general and technical as well as para-medical,* as set out in Appendix II. This training in our view should be directed towards the various situations which ambulance crews are likely to face, and should emphasize the practical application of knowledge.

The scheme of training
6. To enable ambulance staff to fulfil the demands made on them the following training programme is recommended in addition to essential local training:

(a) The Basic Training
   8 week training courses for new entrants (including 2 weeks for civil defence) followed by a year's operational duties during which they will have at least a week's secondment to an accident and emergency

*Para-medical training consists of medical, nursing and hygiene procedures, knowledge of which is essential to ambulance staff in addition to first aid.
department of a selected hospital, and a test at the end of the year, after which a new entrant with satisfactory reports from the hospital and the employing authority will receive an “Ambulance Services Proficiency Certificate”.

(b) **During a transitional period of three years**

(i) The proficiency certificate to be awarded to ambulance staff of more than five years’ service with no requirement to take the course or tests, if the employing authority gives a satisfactory report.

(ii) Courses of varying length for ambulance staff with less than five years’ experience, whether or not they elect to qualify for the proficiency certificate. It is suggested, for example, that ambulance staff with more than two years’ but less than five years’ service might take, say, a four weeks’ course but otherwise follow the same programme as new entrants and that staff with less than two years’ service might follow the same programme as new entrants, taking the full 8 week course.

(c) **After the transitional period**

(i) An advanced course of four weeks for potential officers and instructors leading to an “Ambulance Services Advanced Certificate”, Part A to cover advanced competence in first aid and para-medical subjects and Part B to cover general ambulance subjects and civil defence. It should also be possible to take Part A alone of this Certificate and many might take this Part by locally provided classes. There should be some form of recognition for those who obtain Part A of this Certificate.

(ii) Refresher courses, as decided by the Council we propose, —we suggest a week (with an additional week for civil defence) every three years.

(d) An additional course of one week for control room staff.

(e) A three week course for instructors.

**Central Ambulance Services Council**

7. There is a need for a body to foster the training of ambulance staff and maintain standards. There is also a need for a body to keep under review the equipment requirements of the service. Although the organisation of the service is outside the terms of reference of the Working Party it is suggested that one body might be responsible for advising Ministers on both training and equipment and on other matters of interest to the ambulance service. A Central Ambulance Services Council is therefore proposed to advise the Health Ministers on all aspects of the ambulance service with Standing Committees on Training, Equipment and perhaps Organisation. This Council should be representative of organisations of employers and ambulance staff, hospital administration, voluntary first aid organisations, and educational and medical interests, particularly the appropriate Royal Colleges.
Training Places

8. 500 to 600 training places will be necessary at any rate during the transitional period, which we assume will take three years. These places should preferably be provided by a single national school. Alternatively they could be provided by a few regional schools based on combinations of Regional Hospital Board areas.

Manual

9. The ambulance service needs a comprehensive manual and this should evolve under the auspices of the Council from the experience of the training proposed and the use of Instructors’ Notes, which should be produced as soon as possible.
LIST OF RECOMMENDATIONS

1. The basic training required by ambulance staff—i.e. concentrated practical training in first aid presented in the setting of the ambulance service, paramedical training and training in non-medical subjects—should be given systematically as soon as possible after entry into the service. (Paragraph 11).

2. Courses specially designed for ambulance staff are required. (Paragraph 11).

3. The voluntary first aid organisations should continue to be associated with the training of ambulance staff. (Paragraph 12).

4. The Central Ambulance Services Council which we propose in Recommendation 53 below should consult with the voluntary first aid organisations when devising the first aid element in the training courses proposed below. (Paragraph 12).

5. The Council should invite the voluntary first aid organisations to inaugurate their own Ambulance Services First Aid Certificates and to award them as appropriate to ambulance staff who have successfully completed the courses mentioned above. (Paragraph 12).

6. A common basic training should be available to all ambulance staff. (Paragraph 14).

7. Certain members of the control room staff would be better equipped if they took the same course as driver-attendants receive. (Paragraph 16).

8. Officers and instructors should have completed the full training available to driver-attendants. (Paragraph 17).

9. Ambulance crews should have sufficient background knowledge to be able to make certain necessary decisions with confidence and act accordingly, particularly in the light of changes which may occur in the patient’s condition, to report helpfully on the case and work in accordance with the policy of the accident and emergency service in their locality. (Paragraph 21).

10. Although the basis of the care provided by ambulance crews is a thorough knowledge and a practical mastery of first aid, their training should differ in range from that of other first aiders. They require instruction in additional subjects, set out in Appendix II, and should receive a thorough and intensive training in first aid with substantial periods of practical work. This instruction should be directed towards the various situations which ambulance crews are likely to face, and should emphasize the application of knowledge. (Paragraph 24).

11. Some training should take place in hospital under the direction of the medical staff. (Paragraph 25).

12. Most ambulance training should be the same throughout Great Britain and there would be advantage, both in the quality of the instruction offered and in the standardisation of achievement, if training took place in a relatively small number of schools and if an Ambulance Services Proficiency Certificate were awarded by a central body to those who had reached a required standard of competence. (Paragraph 26).
13. Certain special attributes are listed as essential in a new entrant to the ambulance service. (Paragraph 28).

14. A new entrant should be regarded as on probation until the full certificate is obtained. (Paragraph 29).

15. A new entrant should wear ambulance uniform distinguishable from that worn by trained ambulance staff. (Paragraph 29).

16. A new entrant should proceed as soon as possible to a training school to take a course which should lead to Part I of an "Ambulance Services Proficiency Certificate" and be completed within six months of his joining the service. (Paragraph 29).

17. If the new entrant is unable to join a course immediately he should start to receive local training. The items to be covered are suggested in Appendix I. (Paragraph 30).

18. If the delay should prove to be prolonged a new entrant should be encouraged to take a first aid course arranged by the voluntary organisations and be prepared as far as possible for the training school course. (Paragraph 30).

19. Until he has attended a training school a new entrant should not be given responsibility except within specified limits. (Paragraph 30).

20. The course for Part I of the certificate should last eight weeks, four on first aid and para-medical subjects, two on general ambulance subjects, and we have assumed two for civil defence. The subjects to be covered are shown in Appendix II. (Paragraph 31).

21. If successful in written and practical tests a new entrant should be awarded Part I of the proficiency certificate. (Paragraph 32).

22. If a new entrant who is unsuccessful is not recommended for or is unwilling to make a further attempt he should be regarded as unsuitable for the ambulance service. (Paragraph 33).

23. On obtaining Part I trainees should be employed on the full range of operational duties provided that when on accident and emergency work they are accompanied wherever possible by an ambulance man holding the full proficiency certificate. (Paragraph 34).

24. In the interval between taking Part I of the certificate and the full certificate trainees should be seconded for at least a week to an accident and emergency department of a hospital, and possibly to other departments or other types of hospitals, selected by the Council we propose in Recommendation 33. (Paragraph 35).

25. Twelve months after obtaining Part I a trainee should be tested by a Board; if successful, and if he has satisfactory reports from the hospital and his authority, he should be awarded the "Ambulance Services Proficiency Certificate". (Paragraph 37).

26. Transitional arrangements should apply in the first three years—

   (a) The proficiency certificate should be awarded to staff with five years' service if a satisfactory report is received from the employing authority.
(b) Staff with less than five years' experience and staff with five years' experience but without a satisfactory report should be sent on a training course the length of which might vary according to their experience, for example, staff with less than five but more than two years' experience might take a four weeks' course; staff with less than 2 years' the same course as new entrants. (Paragraph 40).

27. An "Ambulance Services Advanced Proficiency Certificate" should be awarded to potential officers and instructors who have passed an advanced course of four weeks, Part A of which would cover advanced competence in first aid and para-medical subjects and Part B general subjects and civil defence. (Paragraph 41).

28. Part A of the certificate should be available to staff who are not thinking in terms of promotion but are concerned with further proficiency in first aid and para-medical subjects, without necessarily attending a course. (Paragraph 42).


30. Control staff should take a specialised additional course of one week. The scope of the course is given in Appendix IV. (Paragraph 43).

31. Potential instructors who have an advanced certificate, five years' experience, and are recommended by their authority, should take a three weeks' course including intensive revision and instruction in teaching methods, etc., and be awarded the "Ambulance Services Instructors Certificate". (Paragraph 45).

32. The extent to which refresher courses are required and the way they should be provided should be a matter for the Council proposed in Recommendation 33. These should be at least one week every three years. (Paragraph 46).

33. To advise the Health Ministers on all aspects of the ambulance service there should be a Central Ambulance Services Council with Standing Committees on Training, Equipment and perhaps Organisation. (Paragraph 47).

34. The functions of the three Standing Committees are described in paragraphs 48, 49 and 50.

35. The Central Ambulance Services Council should be broadly representative of the various interests that have a contribution to make such as employers' organisations, organisations representing ambulance staff, hospital administration and voluntary first aid organisations as well as educational and medical interests, particularly the appropriate Royal Colleges. (Paragraph 51).

36. The Examination Sub-Committee of the Training Committee should be entirely composed of acknowledged experts on the subjects taught, particularly doctors who are expert in accident surgery and ambulance officers who have particular knowledge of training. (Paragraph 52).

37. It would be reasonable to take 20 students in a class as an average figure. (Paragraph 57).

38. A training year should have 40 weeks. (Paragraph 58).
39. There should be two instructors per class with a 50% qualified reserve in the ambulance services. (Paragraph 59).

40. It is envisaged that during the first three transitional years 500 to 600 training places will be required (30 to 40 for the Scottish Ambulance Service). (Table 1 of paragraph 60 and paragraph 61).

41. It is envisaged that after the first three years rather more than half the number of training places will be required for new entrants and potential officers and instructors. If refresher courses of one week every three years are held at training schools, and a similar week for civil defence, most of the places would be taken. The balance could be put at the disposal of ambulance driver—attendants who have shown an aptitude for first aid and who are sponsored by their employing authority to take Parts A and B of the “Ambulance Services Advanced Proficiency Certificate”. (Paragraph 61).

42. 240 control staff would need training for each of the three transitional years, 35 a year after that. (Paragraph 62).

43. 90 instructors are needed including 6 for the Scottish Ambulance Service. (Paragraph 63).

44. A single national school would clearly be able to provide the best service according to the criteria outlined in paragraph 64. (Paragraph 67).

45. If the establishment of a single national school is impracticable, the recommended alternative would be a few regional schools based on combinations of Regional Hospital Board areas. (Paragraph 68).

46. Selected schools might run courses for control staff. (Paragraph 69).

47. One or more of the schools might provide a course for instructors. (Paragraph 69).

48. One of the schools might act as a forum for the discussion of problems concerning training and equipment and other matters of interest to the ambulance service. (Paragraph 69).

49. The ambulance service needs a comprehensive manual and this should evolve under the auspices of the Council from the experience of the training proposed and the use of Instructors’ Notes, which should be produced as soon as possible. (Paragraph 70).
REPORT ON TRAINING

The present organisation of the ambulance service

1. The ambulance service is provided in England and Wales by local health authorities (County Councils, County Borough Councils and the Greater London Council) under Section 27 of the National Health Service Act, 1946, and in Scotland by the Secretary of State under Section 16 of the National Health Service (Scotland) Act, 1947, field responsibility being exercised by a Joint Committee of the St. Andrew’s Ambulance Association and the Scottish Branch of the British Red Cross Society acting as agents of the Scottish Regional Hospital Boards. It has developed out of services which before 1948 were provided by various authorities—the hospitals, some local authorities, and voluntary bodies, notably the Order of St. John, the St. Andrew’s Ambulance Association, and the British Red Cross Society acting either independently or as agents of local authorities.

2. Whilst most local health authorities provide their services directly, some have agency arrangements with voluntary bodies, but in only very few instances is the bulk of the service provided under such arrangements. In the discussion below the agency service is regarded as part of the local authority service. The largest service in England and Wales has been that of the London County Council, which employed nearly 1,000 men and 400 vehicles, and the service of the Greater London Council is larger still, employing some 2,500 men and 1,000 vehicles. Some large county boroughs and urbanised counties also have large services, but many authorities have quite small services, the average of the 46 less urbanised counties being 61 men and 32 vehicles and of the 66 smaller county boroughs being 29 men and 12 vehicles.

3. In 1963/64 the services in England and Wales employed over 12,000 men† and 5,000 vehicles to carry out over 18 million patient-journeys* and in Scotland over 850 men and 600 vehicles to carry out over 1½ million patient-journeys.* Of these the great majority (80%) were for hospital out-patients, some 14% were for hospital admissions, discharges and transfers, 1.5% were for maternity patients, and 4.5% for accidents or sudden illness outside the home. In addition, some ambulance services provide transport for journeys to training centres and special schools (a total of over a million journeys in 1963/64), although in other areas this work is done by transport from other departments of the local authority or by hired transport.

4. Although hospital out-patients make up so high a percentage of the demands, the major expenditure, which is for salaries and wages, is divided almost equally between out-patient and other work. This is because for out-patient work the service has to be available for only about 50 hours each week, whereas for other work it must be available for the full 168 hours of each week. In addition many authorities have found it possible to use the Hospital Car Service (a service of volunteer car owners) for some of their out-patients.

†As only a small percentage of ambulance staff are women (see Appendix V Table II) the masculine gender has been used throughout this Report. Our observations apply however equally to both sexes.
*A patient-journey is a single journey made by each person in an ambulance. Thus a return from a visit to hospital is counted as a second journey.
5. The emergency work which, with the addition of some admissions and transfers of seriously ill patients, involves in all about a million patients a year, differs in character from the rest of the work. In this work ambulance staff may be called upon to give major assistance to the patient, including life-saving techniques, often throughout the journey, while in a great deal of their remaining work only minor assistance is required.

6. The possibility of separating these aspects of the service has therefore often been considered, and a few authorities with concentrated populations have found it expedient to provide a separate accident section of the ambulance service, although even in these services staff on general ambulance work are expected to undertake emergency work to which they may be diverted by radio. The Sub-Committee on the Accident and Emergency Service* considered this question and came to the conclusion that with the existing organisation the balance was in favour of improving training and equipment throughout the ambulance service rather than the establishment of a separate accident ambulance service.

7. The organisation of the ambulance service differs from authority to authority not only for the reasons given above—size of the service, degree of agency participation and extent of use of the hospital car service—but also because of other factors such as density of population, the distribution of hospital facilities, the nature of recruitment and even the topography of the area. Some of these factors will affect training. The problems will be different in a county borough having a central ambulance station from those in a rural county having small stations, with one or two ambulances, separated from each other by ten to twenty miles.

8. It is clear from Cmnd. 1973—Health and Welfare, the Development of Community Care—and from the Revision to 1973-74 that ambulance authorities expect an expansion of their services to deal with the increasing demands arising from developments in medical care, of the order of 20% over ten years, though with considerable variation between authorities.

9. Thus, the need for training of ambulance staff and the equipment of the service have to be considered against a background of an expanding service, provided in a variety of ways to meet changing needs, although consideration of the ways in which the service should develop to meet these needs is not within the terms of reference of this Working Party.

10. We made enquiries about the training facilities available at present to ambulance staff and learned that only a very small number of authorities provide facilities for the systematic training of new entrants or offer more than sporadic hours of refresher training at the local ambulance station. In the great majority of services the only classes which ambulance staff have been required to attend are those provided by the St. John Ambulance Association, the St.

*Report of the Sub-Committee on Accident and Emergency Services of the Standing Medical Advisory Committee of the Central Health Services Council, 1962, paragraphs 98 to 100.
Andrew's Ambulance Association and the British Red Cross Society and many services require only the minimum course. The possession of a valid first aid certificate from one of these societies or from the Institute of Certified Ambulance Personnel, the Greater London Council or Civil Defence is necessary to qualify staff for full pay.

11. In general these first aid classes have not however provided a sufficient number of hours of concentrated practical training for a new entrant to the ambulance service, nor has this practical training been presented in the setting of that service. There are also difficulties of attendance, and ambulance staff on shift work may miss some of the classes. Moreover there is much else apart from first aid that a man must learn if he is to become an efficient member of the ambulance service (see Appendix II: para-medical and non-medical training). In most cases ambulance staff have only acquired the knowledge they need slowly by experience, which may have been unsupervised and without the aid of organised teaching, and we consider it desirable that this basic knowledge should be taught systematically as soon as possible after entry into the service. We concluded that training courses specially designed for ambulance staff are required and we discuss these in detail in paragraphs 13 to 21 below.

12. Nevertheless we consider that the voluntary first aid organisations should continue to be associated with the training of ambulance staff. These organisations have made major contributions to the development of first aid techniques and the provision of a first aid training for the general public, and will continue to do so. In addition, understanding and confidence between ambulance staff and the public, which is essential to efficiency, will benefit from preserving continuity and uniformity in the teaching of first aid and the recognition of first aid qualifications. We therefore urge that the Central Ambulance Services Council, which we propose in paragraph 47 below, should consult the St. John Ambulance Association, the St. Andrew's Ambulance Association and the British Red Cross Society when devising the first aid element in the training courses which we propose in paragraphs 31 to 42 and 44 to 46 below, and that the Council should invite the voluntary first aid organisations to inaugurate their own Ambulance Services First Aid Certificates and to award them, as appropriate, to ambulance staff who have successfully completed these courses in recognition of their having qualified in first aid within the setting of the ambulance service.

Training requirements

13. Amongst the evidence which we received the point was made that there ought to be a specialised training for various functions such as control room work, officers' duties and instruction. We also considered whether some staff, because of the limited nature of their assignments—transporting out-patients to hospital clinics or groups of mentally subnormal children to training centres—would require a less extensive training.

14. From the enquiry we made of local health authorities it emerged that about 80% of their ambulance crews are engaged on both accident and emergency work and on out-patient and similar work. Only about 10% are never or rarely employed on accident and emergency duties and only 10% are engaged mainly or solely on these duties (see Appendix V). We therefore concluded that it would
not be appropriate to devise a less extensive training for any one group because, as individuals, they might well find themselves transferred to accident and emergency or out-patient work as the case may be. A common basic training should be available to all ambulance staff.

15. We also considered whether control room staff should take the same training as staff who might expect to be employed on accident and emergency work. For this purpose control room staff can be divided into three categories. First, there are those with administrative, clerical, typing and telephone duties who are not directly concerned with operational control. Second, there are those who, while concerned with operational control, are acting in a subordinate capacity and rarely have operational decisions to take; they may however be promoted or have to act on their own in emergency. Finally there are the supervisors and other staff who take the bulk of the operational decisions and who have to give instructions to ambulance crews and deal with operational enquiries from crews.

16. We recognise that in some services some of the staff in the control room have not had experience in the field and that such staff are making an excellent contribution to the service. We nevertheless consider that members of the control room staff who fall into the third category mentioned above and some of those in the second category would be better equipped for their task if they knew from practical experience the implications of the instructions which it is their job to pass on and that it would therefore be advantageous for these staff to hold Part I of the Ambulance Services Proficiency Certificate (see paragraph 32). We also considered whether any additional training for control room staff is necessary and this is discussed in paragraph 43 below.

17. The same arguments apply even more strongly to operational officers and instructors, (i.e. excluding technical officers employed on such duties as vehicle maintenance and stores) and we consider that they should have completed any training available to driver-attendants. We discuss in paragraphs 41 and 44 below whether any additional training is necessary.

18. For the reasons given above we decided to devise a basic scheme of training that should be common to all operational members of the ambulance service, whatever their duties may be, and to consider what additional specialised training may be required for instructors, control room staff and potential officers.

19. We considered the training implications of the work done by ambulance crews and have come to the conclusion that these could conveniently be divided into duties requiring a general training (including such matters as care of equipment and vehicles, radio-telephony, lifting, conduct towards patients and their relatives, liaison with other services) and duties which require a first aid and para-medical training. While the evidence submitted to us showed differences of opinion as to the scope of the training that should be offered, these differences were not significant in relation to the general training. We have, however, found it necessary to give close consideration to the principles underlying first aid and para-medical training for the ambulance service.
20. The prime task of the ambulance service is to transport patients to and from treatment centres without avoidable deterioration and without unnecessary delay, while ensuring their comfort and well-being. With acutely ill or severely injured patients the crew of an ambulance must be competent to apply life-saving measures where necessary. Ambulance staff have thus to strike a balance between doing too much and too little, moving too fast or too slowly, in circumstances in which calm is essential. Only a thorough training with a realistic and practical approach can produce the balanced attitude of mind which is necessary for acting wisely within accepted limitations.

21. While the nature and scope of the training of ambulance crews should reflect the essentially practical nature of the work that they do, theory should not be neglected. In our view crews should have sufficient background knowledge and understanding to make important decisions correctly and with confidence and to act accordingly, particularly in the light of changes which may occur in the patient’s condition; to be able to recognise and report helpfully on other relevant matters such as the circumstances of the accident, treatment given, and the patient’s response; they should work in accordance with the policy of the accident and emergency service in their locality. We believe that in this way the effects of injuries, particularly, would be reduced and some lives saved. We also took into account the fact that, as hospital facilities become centred on district general hospitals and as accident and emergency units become concentrated at fewer centres, the care of emergency cases is likely to present special problems during the longer journeys that will in some instances be necessary.

22. Our recommendations are based on the present arrangements whereby ambulance drivers and attendants are normally interchangeable, but we would hope that the Council which we propose would consider afresh whether the functions of driving and attending in one individual need remain a feature of the organisation of the service in all areas.

The scheme of training

23. In Appendices I to IV we make detailed recommendations on the subjects to be covered by the training we propose, and they correspond closely with the suggestions submitted by the majority of the people we consulted. These recommendations reflect the essentially practical and limited character of the medical side of the work of ambulance crews. We have had regard to what can be done for a patient before he can be seen by a doctor and also what can be done under medical instruction when a doctor calls an ambulance. For example, although the simple techniques of ambulance nursing are essential, we have not envisaged a kind of attenuated training in nursing. Ambulance staff must also be good drivers, good radio telephonists and be familiar with the local authority, general practitioner and other services.

24. Although the basis of the care provided by ambulance crews is a thorough knowledge and a practical mastery of first aid, their training should differ in range from that of other first aiders. They require instruction in additional subjects, set out in Appendix II, among which are the care of outpatients and the handling of cases of infectious disease. We would expect
ambulance crews, many of whom will make almost daily use of first aid techniques, to receive a thorough and intensive training in first aid with substantial periods of practical work. This instruction should be directed towards the various situations which ambulance crews are likely to face, and should emphasize the application of knowledge.

25. We recommend that some training should take place in hospital under the direction of the medical staff. Much of the evidence submitted to us was in favour of such training and we attach great importance to it. First, it enables the new entrant to see how a casualty is received in hospital. Second, he gains a better understanding of the effects of disease and injury and how to deal with them. This hospital experience, together with knowledge of the general practitioner services, would enable him to understand his place in the whole scheme of the patient’s care.

26. We also consider that, while there might be minor variations in the knowledge that an ambulance man may have to acquire in order to meet local circumstances, most of his training should be the same throughout Great Britain. There would therefore be advantage both in the quality of the instruction offered and in the standardisation of achievement if training took place at a relatively small number of schools (see paragraphs 64 to 68 below) and if an Ambulance Services Proficiency Certificate were awarded by a central body to those who had reached a required standard of competence. Our detailed proposals for the organisation of the training leading to this certificate are discussed below.

27. Our attention has been drawn to the fact that, under the Civil Defence (Ambulance) Regulations, 1949, local authorities have a statutory duty to “train the members of the staff of the ambulance services provided under section 27 of the Act..............in duties as ambulance drivers and attendants or other ambulance duties to be performed in the event of hostile action or a threat of hostile action.” Although the civil defence training does not form part of our remit, we consider that it would avoid duplication of effort if this training were to take place at the same establishments and on the same occasions as the other ambulance training we propose and we have made provision accordingly, estimating the total length of courses and the total facilities required to include periods for civil defence training.

New entrants

28. We are aware of the importance that ambulance authorities attach to selection. We would nevertheless like to take this opportunity of recording our view of what special attributes should be considered essential. These are:

(a) Satisfactory performance in an aptitude test, including a short written test and dictation, sufficient to assess whether a man is able to write down messages correctly, give reports on cases, and do simple arithmetic and whether he is otherwise suitable for sending to a training school.

(b) Satisfactory performance in a driving test on an ambulance or similar vehicle. It is assumed that the applicant will already hold the appropriate driving licence and have a good driving record.
(c) A satisfactory medical examination with particular attention to 
eyesight and fitness to lift and handle patients.

A first aid certificate of a voluntary organisation would be regarded as an 
added advantage.

29. A new entrant should be regarded as being on probation until he has 
obtained the full Ambulance Services Proficiency Certificate, which is described 
in paragraph 37 below. He should wear ambulance uniform which should be 
distinguishable from that worn by trained ambulance staff. He should proceed 
as soon as possible to a training school to take a course leading to Part I of 
the Ambulance Services Proficiency Certificate and we would hope that he would 
complete the course within six months of joining the service.

30. If the new entrant is unable to join a course immediately he should start 
to receive the local training (the items to be covered are suggested in Appendix 
I). If the delay should prove to be prolonged he should be encouraged to take a 
first aid course arranged by the voluntary organisations and be prepared as far 
as possible for the training school course. During such time it would be reason-
able to employ him on the kind of work for which some authorities make 
arrangements with contractors, e.g. the transport of mentally subnormal 
children to training centres. Care should be taken that he should not be put in a 
position in which he is called upon to exercise skills he does not possess. If, 
however, he holds a valid first aid certificate issued by the voluntary organisa-
tions or the equivalent the above restrictions would not apply, except that he 
would not intentionally be employed on accident and emergency work other 
than in a supernumerary capacity.

The Ambulance Services Proficiency Certificate

31. The course, which should take at least 8 weeks, should consist of approxi-
mately:

(a) 4 weeks—first aid and para-medical subjects

(b) 2 weeks—general ambulance subjects

(c) we have assumed in addition 2 weeks civil defence training.

The subjects to be covered are shown in Appendix II.

32. Before the end of the course the new entrant would be required to take 
written and practical tests and, if successful, would be awarded Part I of the 
Ambulance Services Proficiency Certificate.

33. If he is unsuccessful the training school should recommend whether he 
should be allowed to take the tests again with or without further formal in-
struction. If he is not recommended for or is unwilling to make a further attempt, 
he should be regarded as unsuitable for further employment in the ambulance 
service.

34. On obtaining Part I of the certificate a trainee, to gain experience, should 
be employed on the full range of ambulance duties. In order that he can be 
guided in his experience when on accident and emergency work he should be 
accompanied, whenever possible, by an ambulance man holding the full pro-
ficiency certificate.
35. Within 12 months of obtaining Part I of the Ambulance Services Proficiency Certificate and in accordance with paragraph 25 above, a trainee should spend a period in the accident and emergency department of a hospital and possibly in other departments or other types of hospitals. The hospital or hospitals should be approved by the Council which we recommend in paragraph 47 below. We would suggest that if it is to fulfil its function the period in hospital should be whole-time for at least a week, recognising that the Council may wish to review this period in the light of experience.

36. During these 12 months the trainee should receive any local training that he has not completed before going on the course (see paragraph 30 and Appendix I).

37. Twelve months after obtaining Part I of the certificate the trainee should appear before a board appointed by the Council for oral and practical tests (of which a written test might form a part) based on his experience gained on operational duties during the preceding 12 months. If the board are satisfied that he has achieved the required standard they should recommend to the Council the award of the full proficiency certificate provided he has obtained satisfactory reports from the approved hospital and his employing authority.

Transitional arrangements for existing staff

38. For existing staff we consider that special arrangements will be necessary according to the length and nature of their experience and these are detailed below.

39. In our view it would be appropriate to accept staff as proficient who had spent five years on operational duties in the service, provided they had acquired sufficient experience of accident and emergency work. We therefore recommend that the Council should award the full proficiency certificate to such staff without requiring them to take the course or the tests proposed above, provided the employing authority gives a satisfactory report. We would expect that some 90% of these staff would receive the proficiency certificate in this way. We would hope that the Council will lay down well in advance the date by which ambulance staff will have had to complete the five years’ experience necessary to qualify.

40. Staff who have spent less than five years on operational duties and staff who have five years' service but do not receive a satisfactory report should be sent on a training course the length of which might vary according to their experience. For example, staff with less than five but more than two years' operational service should take a course of, say, four weeks; other staff with less than two years' operational service should take the same course as new entrants. While there should be no compulsion it is hoped that almost all would take the tests set by the training schools and go on to take the Ambulance Services Proficiency Certificate, without which they would not be eligible for promotion and might require continued supervision on accident and emergency work.

The Ambulance Services Advanced Proficiency Certificate

41. In our view there is a case for an advanced certificate which would raise further the standard of accident and emergency work and, indeed, the efficiency of the service as a whole.
of the whole ambulance service. This certificate could consist of two parts, Part A to cover advanced competence in first aid and para-medical subjects and Part B to cover general ambulance subjects and civil defence. Potential officers and instructors who would be expected to achieve a high level of competence both in first aid and in their knowledge of the organisation of the service, should take a four week course leading to the certificate, the equivalent of two weeks of which should be devoted to first aid and para-medical subjects, one week to general ambulance subjects, and one week, we may assume, to civil defence.

42. We think, however, that it should be open to staff who are not aiming at immediate promotion but are concerned with improving their performance as first aiders to gain further proficiency in first aid and para-medical subjects. They might be sponsored by their authority for a course leading to Part A alone of the advanced certificate or could qualify for this Part without necessarily attending such a course, perhaps by attending locally provided classes. We recommend that driver-attendants who have obtained this qualification should receive some recognition for their achievement. Many of these may subsequently be considered by their authority for promotion or appointment as instructors and it should be open to them to complete the full certificate by taking Part B alone.

**Control Staff**

43. In paragraph 16 above we express our view that certain categories of control staff should have the basic training available to ambulance drivers and attendants. We also considered whether additional training is necessary. We decided in favour of additional training, because the efficiency of the service depends more on control room operations being performed correctly than on any other single factor. In particular, the improvements in providing ambulance transport for patients attending hospitals advocated in the Report on Out-Patients' Departments and the Ambulance Service* require not only the co-operation of hospital transport officers but the existence of an ambulance service control staff that is thoroughly familiar with hospital appointment and transport procedures. We therefore recommend that control staff should take a specialised course of about a week in control work, and the scope of the course is given at Appendix IV.

**Instructors**

44. The quality of instruction will play a major part in the success of the training scheme we propose, and the ability to present the subject will be as important as knowledge and experience. We therefore recommend that instructors should attend a course comprising a study of teaching techniques including visual aids, methods of testing competence and casualty simulating, as well as intensive revision of the syllabuses of the proficiency and advanced proficiency certificates. No civil defence instruction will need to be given as the Home Office already has facilities for training Ambulance and First Aid Section instructors.

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*Hospital O & M Service Reports—8. (H.M.S.O. 1964).*
45. In our view the course should take about three weeks and should only be open to staff who—

(a) hold the "Ambulance Services Advanced Proficiency Certificate"
(b) normally have completed at least 5 years' service,
(c) are recommended for the course by employing authorities.

An Instructors' Certificate in Civil Defence would be an advantage.

At the commencement of the training scheme it will of course be necessary to train a cadre of instructors who will not have the Ambulance Services Advanced Proficiency Certificate.* The "Ambulance Services Instructors' Certificate" should be awarded by the Council to successful candidates.

Refresher courses

46. Refresher courses will be necessary in order to keep ambulance staff abreast of new developments and enable them to renew their knowledge of the various aspects of their work. The extent to which such courses will be required and the way in which they are provided will be a matter for the Council. It should however be noted that after whatever period is considered necessary for completing the training of staff in post with less than five years' service—and we suggest three years—a large number of training places will become available and the Council may feel that these should be used to provide places for refresher courses of at least a week for all staff every three years. The first to attend should be staff who have received the full proficiency certificate only because of more than 5 years' satisfactory experience (see paragraph 39).

Central Ambulance Services Council

47. Throughout our deliberations on training we were concerned with the need to establish a standard which would command respect. This will require for its achievement not only a national training scheme with certificates that are centrally awarded but also a body to establish and maintain standards. In considering how the service should be equipped we were aware of the need to keep this aspect of the service, including the design of ambulance vehicles, continuously under review, and it seemed to us that this again calls for a central body. In addition, although the control and use of the service is not within our terms of reference, we were conscious of demands for a central body that could advise Ministers on this subject. This has led us to the conclusion that a Central Ambulance Services Council should be set up to be responsible for advising the Health Ministers on all aspects of the ambulance service. This body might well have a Standing Committee for each of its main interests: training, equipment and perhaps organisation.

48. The functions of the Training Committee would be to make recommendations for the provision of adequate training facilities and for the maintenance of standards of training at an appropriate level. The Committee would have before it suggestions by Regional Hospital Boards as to the hospitals which could undertake the training of ambulance staff and would arrange for visits

*We were privileged to see the training facilities at the Field Training Centre, R.A.M.C., Mytchett, and we would hope that these might be available for this purpose.
by representatives of the Council before deciding whether to recommend approval. It would be responsible to the Council for nominating interviewing boards to hold the tests for the full proficiency certificate and recommending the award of certificates to successful candidates. The assessment and co-ordination of the various tests would probably require an Examination Sub-Committee.

49. We shall be reporting separately on equipment but we envisage at this stage that the Equipment Committee would keep future developments under review and make recommendations on the design of ambulances and the kind of equipment that should be used in the ambulance service, and it might well need to set up sub-committees on particular subjects, with powers to co-opt outside experts.

50. The functions of the Organisation Committee would be to keep under review all matters relating to the control and use of the service.

51. We consider that the Central Ambulance Services Council, like other bodies concerned with advising Ministers on supervising training in the local authority field, should be broadly representative of the various interests that have a contribution to make, such as employers’ organisations, organisations representing ambulance staff, hospital administration, and voluntary first aid organisations as well as educational and medical interests. We are particularly concerned that the appropriate Royal Colleges should be represented.

52. It would be for the proposed Central Ambulance Services Council to appoint the committees that would be necessary to look after its various interests. We would however urge that the Examination Sub-Committee of the Training Committee should be composed entirely of acknowledged experts in the subjects taught and particularly should include doctors who are expert in accident and emergency work and ambulance officers who have particular knowledge of training.

Organisation of training

53. In considering the provision that would have to be made we have distinguished between a transitional period (which we would suggest should be three years) and what can be considered the normal pattern of training.

54. During the transitional three years we would envisage the following:
(i) 8 week courses for new entrants;
(ii) 8 week courses for some of the staff in post (for the purpose of estimating training places we have assumed that these would be taken by staff with less than two years’ operational service);
(iii) shortened courses for staff with more than two years’ but less than five years’ service and for the 10% of staff with five years’ experience which we estimate in paragraph 40 as not likely to receive the Council’s certificate without taking the course (for the purpose of estimating training places we have assumed courses of 4 weeks).
55. The normal training pattern would follow after the three transitional years and would include courses for the Ambulance Services Advanced Proficiency Certificate and any refresher courses, thus—

(i) 8 week courses for new entrants;
(ii) advanced courses of 4 weeks for potential officers and instructors, say 1% of total staff;
(iii) refresher courses of at least one week every three years, a possibility envisaged in paragraph 46;
(iv) courses for staff seeking Parts A or B of the advanced certificate who are sponsored by their employing authority as suggested in paragraph 42 (2 weeks).

56. There will also be courses for control staff and instructors starting at an early stage and the arrangements for these are discussed in paragraphs 62 and 63 below.

57. We considered the size of classes which would be appropriate for this training. The practical nature of the training makes it important that classes should not be large, even though there are aspects of the training such as formal lectures which could be given to large numbers. We therefore concluded that it would be reasonable to take 20 students in a class as an average figure.

58. We considered the number of training weeks that schools could devote to courses during a year and from the experience of establishments running courses of this kind we concluded that a 40 week training year would be a reasonable minimum.

59. We consider that two instructors per class will be needed. Within the ambulance service there should be half as many again who might be called upon as replacements when required.

60. We have formed an estimate of the number of training places required from the information received from local health authorities and the Scottish Home and Health Department given in Appendix V. Since 1963/64 was the most recent year for which full information was available during our deliberations, we have taken that year as the base year for making our estimates, although we realise that the training scheme may not be fully under way until 1966/67 or later. Similarly we have assumed for the various periods of experience stipulated in Table I below an operative date at 1st April, 1963. Thus we have taken 1963/64 as the first year of the three year transitional period which we propose in paragraph 53 and 1966/67 as the first year for which the normal training pattern will operate. Table I below deals with the transitional three years having regard to the considerations set out in paragraphs 39, 40 and 54 above, and Table II below deals with the normal pattern and the considerations set out in paragraphs 41, 42, 46 and 55 above. Details of the calculation involved are given in Appendix VI.
### Table I — Transitional Period

<table>
<thead>
<tr>
<th></th>
<th>England and Wales</th>
<th>Scotland</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>8 week courses</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(i) Average number of new entrants in each year</td>
<td>...</td>
<td>1,408</td>
<td>82</td>
</tr>
<tr>
<td>(ii) Average number of staff with less than two years' experience in each year</td>
<td>...</td>
<td>751</td>
<td>54</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Places required</td>
<td>432</td>
<td>27</td>
<td>459</td>
</tr>
<tr>
<td><strong>2,159</strong></td>
<td>136</td>
<td>2,295</td>
<td></td>
</tr>
<tr>
<td><strong>4 week courses</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(iii) Average number of staff with more than two but less than five years' experience in each year</td>
<td>...</td>
<td>983</td>
<td>72</td>
</tr>
<tr>
<td>(iv) Average number of staff with more than five years' experience estimated as not receiving the certificate</td>
<td>...</td>
<td>249</td>
<td>13</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Places required</td>
<td>123</td>
<td>8</td>
<td>131</td>
</tr>
<tr>
<td><strong>1,232</strong></td>
<td>85</td>
<td>1,317</td>
<td></td>
</tr>
<tr>
<td><strong>Total number of places required</strong></td>
<td>...</td>
<td>555</td>
<td>35</td>
</tr>
</tbody>
</table>

### Table II — Normal Pattern

<table>
<thead>
<tr>
<th></th>
<th>England and Wales</th>
<th>Scotland</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>(i) New entrants—numbers</td>
<td>...</td>
<td>1,245</td>
<td>88</td>
</tr>
<tr>
<td>Places required for 8 week course</td>
<td>...</td>
<td>249</td>
<td>18</td>
</tr>
<tr>
<td>(ii) 4 week advanced certificate course—numbers</td>
<td>...</td>
<td>144</td>
<td>9</td>
</tr>
<tr>
<td>Places</td>
<td>...</td>
<td>14</td>
<td>1</td>
</tr>
<tr>
<td>(iii) Refresher courses—numbers</td>
<td>...</td>
<td>3,863</td>
<td>248</td>
</tr>
<tr>
<td>Places required for one week courses</td>
<td>...</td>
<td>97</td>
<td>6</td>
</tr>
<tr>
<td><strong>Total number of places required</strong></td>
<td>...</td>
<td>360</td>
<td>25</td>
</tr>
<tr>
<td><strong>Total places used in transitional period</strong></td>
<td>...</td>
<td>555</td>
<td>35</td>
</tr>
<tr>
<td><strong>Total places required as in (i) (ii) and (iii) above</strong></td>
<td>...</td>
<td>360</td>
<td>25</td>
</tr>
<tr>
<td><strong>Residual places</strong></td>
<td>...</td>
<td>195</td>
<td>10</td>
</tr>
</tbody>
</table>
61. From these figures we estimate that during the transitional period (i.e. in each of the three years) from 500 to 600 training places will be required including 30 to 40 places for the Scottish Ambulance Service. During each year after the completion of the transitional period more than 250 places will continue to be required for new entrants, and a small number for the full four week advanced certificate course for potential officers and instructors giving a total of some 280 places. Since we would expect refresher courses to be held at training schools, a further 100 places will be required, i.e. a total of some 380 places. Some of the remaining spare capacity could be used for refresher civil defence training (for which one week in three years will, we understand, be required—some 100 places). The balance could be put at the disposal of ambulance driver-attendants who are sponsored by their employing authority to take Parts A or B of the Ambulance Services Advanced Proficiency Certificate.

62. Control Staff. We estimate that some 700 control staff would require to attend training school courses (see paragraph 16). During the transitional period a third of these should be sent each year on the week’s course we recommend in paragraph 43—say 240. For staff with some experience we would consider classes of 12 students sufficiently small and 20 classes would be required in a year. After the transitional period training will be required to replace wastage. If this is assumed to be some 5%, some 35 control staff would need training each year. For trainees with little experience of control work we would consider that classes should be smaller than those appropriate for the transitional period, say 6 to 7 students in a class.

63. Instructors. We recognise that some officers already have experience of training ambulance staff and at the commencement of the scheme a cadre of instructors would have to be created from amongst these officers although some ad hoc training would have to be arranged for them. For many, including those already trained for civil defence purposes, it may however be found that less than the 3 week course recommended in paragraph 45 is necessary. Initially 60 instructors for staffing the schools would have to be trained, and another 30 as reserves; these include 6 for the Scottish Ambulance Service. In addition, each local health authority should have at least one officer trained as an instructor to provide local training. For this we estimate 160, i.e. 250 in all. This would mean 20 courses of 12 or 13 students each. After the transitional period training would be required to replace wastage. If this is assumed to be some 10% some 25 instructors would need training every year, i.e. two courses per year would be required.

Training schools

64. We considered the size of school which should provide the training courses we envisage. In doing so we had in mind the following aims:

(a) Schools should be residential. This would have a number of advantages. Personnel from different services would have additional opportunities to exchange ideas. A sense of “belonging to the ambulance service” would be developed. Some of the practical training could
take place at night thus giving students experience of the difficulties which they may have to encounter when going to an accident case at night. Moreover students would not be distracted by watching the clock or tired by long hours of travel.

(b) The school should be open for most of the year in order to provide continuity and keep a team of instructors together and it should be large enough to have at least one class of 20 students. In England and Wales, with a population of 47 million, 555 places are necessary during the transitional period. Thus for a school to provide one class of 20 it would have to serve an area of nearly 2 million people and there would be a maximum number of 28 schools in England and Wales on this basis.

(c) But only a small number of schools should be established as

(i) this would make it easier for the Central Ambulance Services Council to ensure uniformly high standards in a newly organised system of training,

(ii) available resources could be more effectively and economically used to staff and equip schools when concentrated on a few points,

(iii) lectures by consultants and other experts not on the training staff could be more easily arranged, as classes could be grouped to provide a bigger audience, and thus fewer lecturers would be required to cover the year’s intake of students.

65. We considered the following three possibilities:

(a) schools of 20 pupils each, i.e. 28 schools for England and Wales and 2 for Scotland;

(b) a single national school;

(c) schools of intermediate size serving areas related to those covered by the Regional Hospital Boards.

66. Schools for 20 pupils. For the following reasons we consider that these schools are unlikely to provide the best standard of training.

(a) They would make more difficult the task of creating a uniformly high standard throughout the service.

(b) They would be less likely to provide sufficient stimulus for instructors.

(c) Resources might be inadequate to provide the variety of equipment desirable for training purposes.

(d) They would serve a relatively small area and it would be difficult for them to insist on residence, to which we attach importance.

(e) They would suffer from lack of flexibility: equipment and other facilities would remain idle when the single class was not using it.

(f) The best use would not be made of the services of outside lecturers.
(g) They would tend to be uneconomic as they would need a higher ratio of instructors.

(h) Difficulties from uneven intake would be greater where numbers are small and there is a restricted catchment area.

We came to the conclusion that whatever advantages they might have in providing training in local problems and in the shorter distances which recruits would have to travel to spend weekends with their families, schools of 20 pupils would not provide a suitable basis for training.

67. A single national school. This would clearly be able to provide the best service according to the criteria outlined in paragraph 64. Its resources would be great and it would be best able to deploy those resources, including the use of instructors. It would command respect as the upholder of a uniform standard of training. We realise, however, that there would be difficulties in bringing such a national institution into being. It would require a large building; it would have to be financed from Exchequer funds, and the considerable investment it would entail would have to be made before there could be any relevant experience of what such a training establishment should provide. It would have the disadvantage of requiring students to travel long distances and they would find difficulty in getting home at weekends; this might discourage recruitment.

68. Regional schools. If the establishment of a single national school is impracticable, we would recommend as an alternative a few regional schools based on combinations of Regional Hospital Board areas. Such schools would go a long way to meeting the criteria outlined in paragraph 64 above and have the additional advantage of relating the training of ambulance staff more closely to the hospital organisation with which they would be working and interesting that organisation in the training of ambulance services. A list of Regional Boards is given at Appendix VII which shows the number of training places required in each Board area on the basis of the national average. Appendix VIII shows the Board areas.

69. Selected schools might run courses for control staff and one or more of them might act as a school for instructors. We also consider that there would be advantage in having an establishment which could act as a forum for the discussion of problems of training and equipment, and other matters of interest to the ambulance service, and we would hope, therefore, that one of the schools would be able to provide facilities of this kind.

Manual

70. We have considered closely the need for a special manual of training for the ambulance service. We are aware of the existence of a large number of manuals and other text books on first aid and para-medical subjects, and in particular we were informed that the voluntary organisations were in the process of revising their first aid manual. We do not think it necessary at this stage for us to add to the handbooks already available, but because none of the existing books have been written with the particular needs of the ambulance service in mind, we believe that it will ultimately be necessary to prepare a comprehensive manual bringing together in a handy form information on all aspects of the ambulance service. We recognise that this would be a major undertaking. It would however
be of great value for the instruction and development of the training we propose if a series of Instructors’ Notes, on similar lines to those used for civil defence training, covering not only first aid and para-medical matters but also the general aspects of the service, were available at an early stage. We consider that the ambulance service needs a comprehensive manual and in our opinion this should evolve under the auspices of the Council from the experience of the training we propose and the use of Instructors’ Notes.

**Effect on Establishment**

71. We appreciate that at least for some years our proposals are likely to involve authorities in extra expenditure. We estimate that, on average, the training we propose will mean that some 4% of staff will not be available for normal duties for 40 weeks of each year, i.e. 3% over the whole year. This would require some additional staff provision by most authorities. Nevertheless, we consider that training of this kind is essential to enable ambulance staff to carry out their duties with uniformly high standards of efficiency. But we are confident that, in the long run, the higher standards to which our training proposals will contribute will produce an economical service by ensuring the best use of staff and vehicles, and by promoting a greater awareness of the need to confine the use of such a highly trained service to cases of real need.

**Addendum by Professor Pask and Dr. Stoker**

We consider that much could be done to improve the efficiency of training of ambulance attendants by local activity without necessarily establishing a full organisation of schools as set out in this Report.

E. A. Pask

A. D. Stoker
APPENDIX I

AMBULANCE SERVICE—LOCAL TRAINING

The subjects set out below give a general idea of the local training which new entrants should receive in accordance with paragraphs 30 and 36 of the Report. Additional subjects may have to be included because of particular local problems.

(1) Introduction to own service and conditions of service
   General description of local service
   Pay; holidays; sickness; rota
   Uniform, entitlement and care of.
   Vaccination and immunisation.
   Public and patient relationships.
   Local orders and regulations.
   Welfare.

(2) Operational and administrative systems (own service)
   Detailed organisation; chain of command; documentation; operational control; local communications procedures.

(3) Other local services
   Hospital services including accident and emergency units: location, lay-out and procedures.
   General medical services; police; fire; coroners’ courts.
   Local authority services.

(4) Vehicles
   Local arrangements for care and maintenance of vehicles.

(5) Local equipment
   Local arrangements for care and maintenance of equipment.
   Disinfection and disinfestation.

(6) Special local risks
   Airfields, factories, docks, radio-active substances, etc.
APPENDIX II

THE AMBULANCE SERVICES PROFICIENCY CERTIFICATE

OUTLINE OF COURSE

GENERAL

1. The general arrangements for the course, and the actual instruction, should be designed to give students technical competence in all aspects of their work, and also a spirit of pride and loyalty to the service in its role of helping sick, injured and distressed people. This should include training in the observance of a code of personal conduct to patients and their relatives, and to medical and nursing personnel.

2. Whilst theory should not be neglected, the main emphasis should be on practical training; this should be designed to simulate the conditions and situations which occur in the work of a statutory ambulance service and should include visits to hospitals and night work. To achieve realism the ambulance vehicle and its equipment should be the main setting, or the essential background, to all practical training and students should be trained to act in pairs as ambulance crews. The maximum use should be made of simulated casualties and realistic "props" such as wrecked cars.

3. Although the subjects to be covered in first aid, para-medical and non-medical training are given in separate lists below, they should be intermingled in practical training to give students a balanced picture of the work and problems of the service.

4. First Aid. The subjects listed below are similar to those given in most text books of first aid.

   Introduction
   (1) Outline of first aid.
   (2) Anatomy and physiology.

   Respiration
   (3) Breathing.
   (4) Suffocation.
   (5) Asphyxia.
   (6) Carbon monoxide poisoning.
   (7) Drowning.
   (8) Electric shock.

   Circulation
   (9) Circulation of the blood.
   (10) Wounds and bleeding.
   (11) Bleeding from special regions.
   (12) External cardiac compression.
   (13) Transfusion.
Injuries.
(14) Injuries to muscles, ligaments, bones and joints.
(15) Other injuries including head injuries.
(16) Burns and scalds.
(17) Effects of poisons and other chemicals and gases.

General
(18) Shock.
(19) Unconsciousness and its consequences.
(20) Priorities where several conditions are present simultaneously.

Procedures.
(21) Observation of the patient (pulse, respiration, and colour, etc.).
(22) Posture.
(23) Control of pain.
(24) Emergency resuscitation, including artificial respiration and aspiration.
(25) Dressings and bandages.
(26) Contour splinting (plaster of Paris).
(27) Toilet, bedpans and urinals.

Apparatus
(28) Administration of oxygen.
(29) Resuscitation apparatus.
(30) Aspiration apparatus.
(31) The Thomas Splint (lower limb).

Maternity
(33) Use of incubators for premature babies.
(34) Emergency childbirth including abortions and miscarriages.

Para-Medical Training
5. Para-medical training must cover all subjects and procedures of a medical or nursing nature, knowledge of which is essential to ambulance personnel in addition to their knowledge of first aid. It should include the following, which should be given mainly by medical and nursing personnel:
   (1) Medical nomenclature.
   (2) Care of seriously ill patients, surgical and medical.
   (3) Precautions in handling infectious diseases patients.*
   (4) Care of patients under drug treatment.
   (5) Care of mentally ill patients.
   (6) Care of out-patients.

*Routine service procedure for these items is dealt with under non-medical training.
(7) Ambulance work when under medical instruction or direct supervision, e.g.
(a) At the scene of an emergency incident.
(b) Making reports and conveying information to accident and emergency officers.
(c) When ambulances are called by general practitioners.
(d) Inter-hospital transfer of patients.
(e) When assisting in accident and emergency reception centres.

(8) Radiation hazards.

(9) General ambulance nursing and hygiene, with particular reference to long journeys, including journeys by rail.*

Non-Medical Training

6. As the scope of this training may not be apparent to those who are unfamiliar with the detailed working of the ambulance service, and as no existing manual or text book gives all the details, explanatory notes are included with subject headings below. Training in driving should be carried out, if possible, with the co-operation of the police and should cover all aspects of advanced driving, including skid-pan experience.

(1) Information
The national health service, hospital, local authority and general medical services; the ambulance service, inception and origins, typical ambulance service organisation (accident and general), ports and airfields; welfare and community services; fire and police services; voluntary organisations; the press.

(2) Communications
G.P.O. Telephones, switchboards, '999' Circuits, Telex, Teleprinters, etc.
All aspects of Radio Telecommunications.

(3) Equipment
Use and care of all types of equipment.

(4) The patient
Professional conduct and relationship with patients and relatives; securing the co-operation of patients of various temperaments; care on arrival home; custody of patients' effects and clothing.

(5) The hospital
Practice and procedure within hospital, including out-patient departments.

(6) Liaison
With hospital transport officers and general practitioners.

(7) Lifting and carrying
Use of stretchers, carrying sheets, poles, canvas and chairs; restraint and securing; special lifts; use of blankets and pins; back rests; lifting and handling patients in various conditions; use of various items of equipment.

(8) Light rescue
Including co-operation with other services.

*Routine service procedure for these items is dealt with under non-medical training.
(9) **Major accidents**
Definition and characteristics; co-ordination of plans.

(10) **Special types of accidents**
Railways; aircraft.

(11) **Accidents and sudden illness**

   (a) **General**
   Proceeding to accidents; speeds; procedure on arrival; safety precautions at incidents; assessment of situation; collection of information; decision on action to be taken; co-operation with police and fire services; attitude to onlookers; proceeding to hospital; advance warning of arrival and patient’s condition; co-operation with staffs of accident and emergency units; completion of records; recovery of equipment; cleaning of ambulance.

   (b) **Sudden illness and accidents in the home**
   Correct approach and attitude in private properties; allowance for anxiety; collection of information regarding history of illness or accident; liaison with family doctor; notification to police where necessary.

   (c) **Assaults, suicides and deaths in suspicious circumstances**
   Action to be taken in varying circumstances; notification of suspicious circumstances.

(12) **Infectious diseases**
General principles of personal protection; protective clothing; disinfection and disinfestation; handling infected patients; disposal of infected equipment; vaccination and immunisation; special arrangements for smallpox.

(13) **Railway journeys**
Facilities; tickets and warrants; trolleys and station lifts etc.; escorts; types of cases; co-operation between ambulance authorities; special equipment.

(14) **Other forms of transport**
Including transport by air and water.

(15) **Removal of the dead**
Procedure; certification; protection of effects; moving of the apparently dead.

(16) **Legal information**
Breaking in; property rights; Larceny Act; forcible removals; Mental Health Act; intoxication; violence; searching personal effects for information as to identity; dangerous drugs.

(17) **Care and maintenance of vehicles**
Elements of design; simple faults and emergency repairs; routine inspection and maintenance; accidents to vehicles; vehicle hygiene and methods of cleaning.

(18) **Ambulance driving**
Principles of ambulance driving; use of warning devices; vehicle regulations; motorway regulations; the law relating to accidents; map reading; safe driving.
APPENDIX III
THE AMBULANCE SERVICES
ADVANCED PROFICIENCY CERTIFICATE
OUTLINE OF COURSE

GENERAL

1. The course is sub-divided into Part A (first aid and para-medical) and Part B (non-medical) (Paragraph 41 of the Report).

2. Officers and potential officers and instructors, nominated by their employing authorities will take both Part A and Part B (Paragraph 41 of the Report).

3. Part A may be taken by experienced ambulance personnel nominated by their employing authorities who are concerned in improving their performance as first aiders, but who are not aiming at immediate promotion. The same ground can be covered by private study, with visits to local hospitals and with the assistance of local classes if available (Paragraph 42 of the Report).

4. Personnel who have successfully passed Part A, as suggested in paragraph 3 above, will need to take Part B only if they are subsequently recommended for promotion.

Part A—First Aid and Para-Medical

5. The course is intended to increase the student's knowledge, skill and confidence. In addition to revision of the first aid and para-medical subjects covered in training for the Ambulance Services Proficiency Certificate, the course will include further experience and tuition in hospitals.

6. An outline of the course, including the associated hospital experience, follows:

(1) Physiology of respiration and its disorders
(a) Ventilation
   Recognition of normal respiratory movements and breathing sounds.
   Recognition of abnormal shape and movement of chest wall due to injury or disease.
   Recognition of defects of lung function due to airway obstruction, heart failure or pneumonia.
   The importance of postural drainage.
   Recognition of causes of airway obstruction in large air passages or small air passages (asthma).
   The use of suction apparatus.
   The use of artificial airways.
   The importance of cyanosis.

(b) The requirements of oxygen tents, masks and artificial ventilation machines.
(2) The heart and circulation

(a) Normal control of circulation and blood pressure:
   Cardiac output
   Venous return
   Elasticity of vessels and peripheral resistance
   Efficiency of myocardium.

(b) Common heart diseases.

(c) External cardiac compression.

(3) Surgical shock and bleeding
The nature, site and severity of injury should be considered in relation to shock. Burns, chest injuries, spinal injuries and acute heart disease should be mentioned as causes of shock.

(4) Other conditions which may lead to acute collapse should be mentioned, for example peritonitis, anaphylaxis, diabetic coma, etc.

(5) Nervous system
Particular attention should be paid to causes of unconsciousness and instruction should be given on the means of assessing degrees of unconsciousness and its consequences. Strokes; epilepsy; head injuries.

(6) There should be particular instruction in the use and misuse of certain special forms of treatment, for example pressure bandages, tourniquets, special splints (including the use of pneumatic splints and plaster of Paris) and aseptic dressings.

(7) In exceptional circumstances in this country a patient may be subjected to extremes of temperature. The most likely circumstance is an old person who lives in an unheated room. This may give rise to slowing of the respiration and heart rate. Exposure to very high temperatures may occur in certain industrial circumstances.

(8) Practical experience in hospital
This should include:

(a) instruction in lung ventilation apparatus in medical and thoracic surgical wards and in anaesthetic rooms,

(b) orthopaedic and general surgical wards and intensive therapy units,

(c) accident reception and recovery wards,

(d) operating theatres and post-mortem rooms where a case brought in by ambulance is being followed up.

The allocation of time should be laid down by the Council in view of the numbers involved and the facilities available but we should not expect this to be less than 20 hours in all.
Part B—Non-Medical

7. This covers training which is essential for officers and potential officers in connection with the supervision and planning of the service and includes:

(1) *Revision and amplification of proficiency certificate subjects.*

(2) *Administration and management of stations.*

   Documentation, accounting, statistical records and office procedures; complaints, investigation and report; preparation of rotas; inventories.

(3) *Staff Management.*

   Trade union relations; disciplinary codes; appeals; staff welfare schemes.

(4) *Fleet management*

   Administrative aspects of fleet management; inspections; running repairs and major maintenance; stores procedure; documentation; safety standards, vehicle design.

(5) *Operational control.*

(6) *Major accidents*

   With special emphasis on command and control by an ambulance officer at the scene of an incident.

(7) *Exercise and competition organisation and assistance to competition judges.*
APPENDIX IV

AMBULANCE SERVICES CONTROL COURSE

1. Whilst the list of subjects given below is intended to give a general idea of what a course for control staff should include, the comparatively small number of courses required per year may each have to be designed to suit the particular needs of the students who will be attending. Thus control courses for junior and potential control staffs would differ in emphasis from courses designed for experienced senior control officers; experience may also indicate that separate courses are desirable for county and county borough control needs.

2. While some theory will be necessary, the course should consist mainly of practical training, and should include the use of a fully equipped model control room with tape recorders to facilitate criticism of practice messages, and a visit to a G.P.O. telephone exchange having ‘999’ facilities.

3. Subjects to be covered are:

   (1) **Background Information**
   The national health service; the hospital service; the general medical services; the local health authority services; section 27 of the National Health Service Act, 1946, and other legislation; the voluntary organisations; the hospital car service; civil defence; Ministry of Health circulars; police and fire services; coroners; G.P.O.; the press.

   (2) **Equipment**
   
   (a) **Telephones.**
   Exchange and private lines; extensions; switchboards and exchanges; key and lamp units; alarm bells and lights; procedure.

   (b) **Radio.**
   Types of equipment; lay-out of schemes; limitations; faults; basic drill and procedure.

   (c) **Telephone tape recorders.**
   Uses and procedures.

   (d) **Telex and teleprinters.**
   Lay-out of schemes; uses and procedures.

   (e) **Visual aids.**
   Date and time stamps; control desks and consoles; tally boards; quick reference equipment for street plans, maps, telephone lists, etc.

   (3) **Definitions, etc.**
   Service terms and abbreviations; medical terms.

   (4) **Types of work and their control characteristics.**
   
   (a) Emergencies and sudden illness; maternity; admissions and discharges; hospital transfers; infectious disease; mental illness; special cases; major emergencies.
(b) Outpatients; day hospitals and the like; advance bookings; repeat bookings; cancellations and alterations; planning and control of inward and outward journeys.

(c) Journeys by railway, air (including helicopters), and by sea.

(d) Escorts; vehicle breakdowns; enquiries and complaints; Emergency Bed Bureau; rotas for midwives, mental health officers, etc.; payment journeys under the National Health Service (Amendment) Act, 1957.

(5) **Principles of control.**

Priorities; emergency cover and response; single journey control; double journey (outpatient) control; accuracy and punctuality; queries and decisions required; 24 hour “Duty Officers”.

(6) **Control systems and lay-out.**

(a) Central control; sub-controls.

(b) Functions:

- emergency watch and cover; receipt of calls; eligibility; advance and repeat booking diaries and/or card indices; planning section; briefing and deployment; control of planned work.

(c) Lay-out of equipment.

(7) **Liaison with hospitals.**

The function and duties of “Hospital Transport Officers”; admissions and discharges; appointment systems; radio at hospitals.

(8) **Documentation.**

Lay-out and processing of essential forms; special reports; records; statistics.

(9) **Liaison with other ambulance services.**

Standing arrangements; mutual assistance between authorities; co-ordination schemes; reinforcements for major emergencies; rail journeys; Section 24 of the National Health Service (Amendment) Act, 1949.
NUMBERS OF STAFF—ENGLAND AND WALES
Summary of Information from Local Health Authorities

TABLE I—Estimated annual intake of recruits.

<table>
<thead>
<tr>
<th>Financial year</th>
<th>Number required to replace normal wastage (1)</th>
<th>Number required to extend service as for 10 year plan (2)</th>
<th>Total (3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) 1963/64*</td>
<td>912</td>
<td>298</td>
<td>1,210</td>
</tr>
<tr>
<td>(2) 1964/65</td>
<td>976</td>
<td>506</td>
<td>1,482</td>
</tr>
<tr>
<td>(3) 1965/66</td>
<td>945</td>
<td>587</td>
<td>1,532</td>
</tr>
<tr>
<td>(4) 1966/67</td>
<td>963</td>
<td>282</td>
<td>1,245</td>
</tr>
<tr>
<td>(5) 1967/68</td>
<td>999</td>
<td>255</td>
<td>1,254</td>
</tr>
<tr>
<td>(6) 1968/69</td>
<td>1,023</td>
<td>170</td>
<td>1,193</td>
</tr>
<tr>
<td>(7) 1969/70</td>
<td>1,042</td>
<td>178</td>
<td>1,220</td>
</tr>
<tr>
<td>(8) 1970/71</td>
<td>1,104</td>
<td>146</td>
<td>1,250</td>
</tr>
<tr>
<td>(9) 1971/72</td>
<td>1,049</td>
<td>157</td>
<td>1,206</td>
</tr>
<tr>
<td>(10) 1972/73</td>
<td>1,095</td>
<td>153</td>
<td>1,248</td>
</tr>
<tr>
<td>(11) Total</td>
<td>10,108</td>
<td>2,732</td>
<td>12,840</td>
</tr>
</tbody>
</table>

*Factual.
TABLE II.—Length of service of staff in post at 30th April, 1964.

<table>
<thead>
<tr>
<th>Length of service completed by 30th April, 1964</th>
<th>Number of Staff</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male (1)</td>
</tr>
<tr>
<td>(1) less than 1 year</td>
<td>1,224</td>
</tr>
<tr>
<td>(2) 1 year but less than 2</td>
<td>905</td>
</tr>
<tr>
<td>(3) 2 years but less than 3</td>
<td>1,022</td>
</tr>
<tr>
<td>(4) 3 years but less than 4</td>
<td>1,087</td>
</tr>
<tr>
<td>(5) 4 years but less than 5</td>
<td>706</td>
</tr>
<tr>
<td>(6) 5 years but less than 10</td>
<td>2,500</td>
</tr>
<tr>
<td>(7) 10 years or over</td>
<td>4,702</td>
</tr>
<tr>
<td>(8) Total</td>
<td>12,146</td>
</tr>
</tbody>
</table>

*The figures for England and Wales include personnel other than ambulance crews, while those for Scotland only ambulance crews are given. For this reason the total in Table II for England and Wales is greater than in Table III, but for Scotland the totals are the same.*

TABLE III.—General allocation of duties of ambulance crews.

<table>
<thead>
<tr>
<th>Type of duty (A and E = accident and emergency)</th>
<th>Number of staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) Mainly or solely on A and E duties</td>
<td>1,232</td>
</tr>
<tr>
<td>(2) Partly on A and E duties (i.e. mixed with other duties)</td>
<td>9,830</td>
</tr>
<tr>
<td>(3) Never, or very rarely, on A and E duties</td>
<td></td>
</tr>
<tr>
<td>(a) Employed on transport of Section 27 patients</td>
<td>1,118</td>
</tr>
<tr>
<td>(b) Employed on transport of other persons</td>
<td>38</td>
</tr>
<tr>
<td>(c) Employed on mixture of (a) and (b)</td>
<td>208</td>
</tr>
<tr>
<td>(4) Total</td>
<td>12,426</td>
</tr>
</tbody>
</table>
NUMBERS OF STAFF—SCOTLAND

Summary of Information from the Scottish Ambulance Service

**TABLE I.—Estimated annual intake of recruits.**

<table>
<thead>
<tr>
<th>Financial year</th>
<th>Number required to replace normal wastage (1)</th>
<th>Number required to extend service as for 10 year plan (2)</th>
<th>Total (3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) 1963/64*</td>
<td>39</td>
<td>31</td>
<td>70</td>
</tr>
<tr>
<td>(2) 1964/65</td>
<td>44</td>
<td>44</td>
<td>88</td>
</tr>
<tr>
<td>(3) 1965/66</td>
<td>45</td>
<td>42</td>
<td>87</td>
</tr>
<tr>
<td>(4) 1966/67</td>
<td>47</td>
<td>41</td>
<td>88</td>
</tr>
<tr>
<td>(5) 1967/68</td>
<td>47</td>
<td>32</td>
<td>79</td>
</tr>
<tr>
<td>(6) 1968/69</td>
<td>43</td>
<td>30</td>
<td>73</td>
</tr>
<tr>
<td>(7) 1969/70</td>
<td>56</td>
<td>30</td>
<td>86</td>
</tr>
<tr>
<td>(8) 1970/71</td>
<td>45</td>
<td>30</td>
<td>75</td>
</tr>
<tr>
<td>(9) 1971/72</td>
<td>53</td>
<td>30</td>
<td>83</td>
</tr>
<tr>
<td>(10) 1972/73</td>
<td>61</td>
<td>30</td>
<td>91</td>
</tr>
<tr>
<td>(11) Total</td>
<td>480</td>
<td>340</td>
<td>820</td>
</tr>
</tbody>
</table>

*Factual.
**Table II.**—Length of service of staff in post at 30th April, 1964.

<table>
<thead>
<tr>
<th>Length of service completed by 30th April, 1964</th>
<th>Number of Staff</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male (1)</td>
</tr>
<tr>
<td>(1) less than one year</td>
<td>74</td>
</tr>
<tr>
<td>(2) 1 year but less than 2</td>
<td>82</td>
</tr>
<tr>
<td>(3) 2 years but less than 3</td>
<td>104</td>
</tr>
<tr>
<td>(4) 3 years but less than 4</td>
<td>73</td>
</tr>
<tr>
<td>(5) 4 years but less than 5</td>
<td>31</td>
</tr>
<tr>
<td>(6) 5 years but less than 10</td>
<td>174</td>
</tr>
<tr>
<td>(7) 10 years or over</td>
<td>202</td>
</tr>
<tr>
<td>(8) Total</td>
<td>740</td>
</tr>
</tbody>
</table>

*The figures for England and Wales include personnel other than ambulance crews, while in those for Scotland only ambulance crews are given. For this reason the total in Table II for England and Wales is greater than in Table III, but for Scotland the totals are the same.*

**Table III.**—General allocation of duties of ambulance crews.

<table>
<thead>
<tr>
<th>Type of duty (A and E = accident and emergency)</th>
<th>Number of staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) Mainly or solely on A and E duties</td>
<td>NIL</td>
</tr>
<tr>
<td>(2) Partly on A and E duties (i.e. mixed with other duties)</td>
<td>660</td>
</tr>
<tr>
<td>(3) Never, or very rarely, on A and E duties</td>
<td>(a) Employed on transport of Section 27 patients</td>
</tr>
<tr>
<td></td>
<td>(b) Employed on transport of other persons</td>
</tr>
<tr>
<td></td>
<td>(c) Employed on mixture of (a) and (b)</td>
</tr>
<tr>
<td>(4) Total</td>
<td>762</td>
</tr>
</tbody>
</table>
CALCULATION OF NUMBER OF PLACES, CLASSES AND INSTRUCTORS REQUIRED

General

1. The main purpose of this appendix is to show how the estimates of the number of staff requiring training and the number of places required given in Tables I and II of paragraph 60 have been calculated. For ease of reference the main assumptions made in paragraphs 53, 54, 55 and 60 are listed below:

(a) The figures are based on the numbers of staff shown in Appendix V.
(b) The base year is 1963/64, the most recent for which full information is available.
(c) There will be a transitional period of three years starting with 1963/64.
(d) The normal pattern of training will begin in 1966/67.
(e) New entrants and staff with less than two years' experience by 1st April, 1963 will require to take 8-week courses.
(f) Staff with more than two and less than five years' experience by 1st April, 1963 will require to take 4-week courses.
(g) 10% of staff with more than five years' experience by 1st April, 1963 will require to take 4-week courses.
(h) 1% of total staff will need the full 4-week advanced certificate course, from 1st April, 1966.

Table I of paragraph 60

2. The average number of new entrants given in Table I is based on the following figures derived from items (1) (2) and (3) in Table I of Appendix V:

<table>
<thead>
<tr>
<th></th>
<th>England and</th>
<th>Scotland</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Wales</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1963/64</td>
<td>1,210</td>
<td>70</td>
<td>1,280</td>
</tr>
<tr>
<td>1964/65</td>
<td>1,482</td>
<td>88</td>
<td>1,570</td>
</tr>
<tr>
<td>1965/66</td>
<td>1,532</td>
<td>87</td>
<td>1,619</td>
</tr>
<tr>
<td></td>
<td>4,224</td>
<td>245</td>
<td>4,469</td>
</tr>
</tbody>
</table>

Average for each year
(Divide by 3) 1,408 82 1,490

3. The average number of staff with less than two years' experience at April, 1963 is derived from column (3) of items (1) and (2) in Table II of Appendix V:

<table>
<thead>
<tr>
<th></th>
<th>England and</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Wales</td>
<td>Scotland</td>
<td>Total</td>
</tr>
<tr>
<td>Less than 1 year</td>
<td>1,293</td>
<td>76</td>
<td>1,369</td>
</tr>
<tr>
<td>1 year but less than 2</td>
<td>959</td>
<td>87</td>
<td>1,046</td>
</tr>
<tr>
<td></td>
<td>2,252</td>
<td>163</td>
<td>2,415</td>
</tr>
</tbody>
</table>

Average for each year
(Divide by 3) 751 54 805
4. The number of places for 8-week courses as required by staff in paragraphs 2 and 3 above has been calculated on the assumption that there would be five such courses in a 40 week year, i.e. by dividing by 5.

5. The average number of staff with more than two but less than five years' experience is based on the following figures derived from column (3) of items (3) (4) and (5) of Table II of Appendix V.

<table>
<thead>
<tr>
<th>England and Wales</th>
<th>Scotland</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 years but less than 3</td>
<td>1,074</td>
<td>109</td>
</tr>
<tr>
<td>3 years but less than 4</td>
<td>1,138</td>
<td>76</td>
</tr>
<tr>
<td>4 years but less than 5</td>
<td>736</td>
<td>32</td>
</tr>
<tr>
<td><strong>Average for each year (Divide by 3)</strong></td>
<td><strong>983</strong></td>
<td><strong>72</strong></td>
</tr>
</tbody>
</table>

6. The average number of staff with more than five years' experience is given in column (3) of items (6) and (7) in Table II of Appendix V.

<table>
<thead>
<tr>
<th>England and Wales</th>
<th>Scotland</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>5 years but less than 10</td>
<td>2,614</td>
<td>175</td>
</tr>
<tr>
<td>10 years or over</td>
<td>4,880</td>
<td>207</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>7,494</strong></td>
<td><strong>382</strong></td>
</tr>
</tbody>
</table>

While the number of these staff who will not receive the certificate cannot be estimated with any degree of certainty it has been assumed that 10% will not do so because they have not had adequate experience i.e. 749 in England and Wales and 38 in Scotland, total 787.

<table>
<thead>
<tr>
<th>England and Wales</th>
<th>Scotland</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average for each year (Divide by 3)</td>
<td>249</td>
<td>13</td>
</tr>
</tbody>
</table>

7. The number of places for 4-week courses has been calculated on the basis of ten 4-week courses in a 40 week year, i.e. by dividing by 10.

Table II of paragraph 60

8. The number of new entrants derives from column (3) of item (4) in Table I of Appendix V and the number of places has been calculated on the assumption that there would be five 8-week courses in a 40 week year, i.e. by dividing by 5.

9. Number of 4-week courses for the advanced certificate. No way has been found of making a reliable estimate of the number of potential officers and instructors who are likely to come forward for these courses. A guess has been hazarded at 1% of the total staff. The total staff for 1966/67 has been calculated
by adding the increases envisaged in 10 year plans for 1963/64, 1964/65, 1965/66 and 1966/67 given in column (2) of Table I of Appendix V to the total given in column 3 of item (8) in Table II of Appendix V, i.e.

<table>
<thead>
<tr>
<th></th>
<th>Wales</th>
<th>Scotland</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1%</td>
<td>14,367</td>
<td>920</td>
<td>15,287</td>
</tr>
<tr>
<td>1%</td>
<td>144</td>
<td>9</td>
<td>153</td>
</tr>
</tbody>
</table>

10. **Number of places for 4 week advanced certificate courses** has been calculated on the assumption that there would be ten 4-week courses in a 40 week year, i.e. by dividing by 10.

11. **The number of staff requiring refresher courses** has been calculated on the assumption that all the staff in post in 1966/67 will require refresher courses in the following three years except the intakes of new entrants in 1965/66 and 1966/67. (Column 3 of items (3) and (4) in Table I of Appendix V.)

<table>
<thead>
<tr>
<th></th>
<th>Wales</th>
<th>Scotland</th>
</tr>
</thead>
<tbody>
<tr>
<td>1965/66 intake</td>
<td>1,532</td>
<td>87</td>
</tr>
<tr>
<td>1966/67 intake</td>
<td>1,245</td>
<td>88</td>
</tr>
<tr>
<td></td>
<td>2,777</td>
<td>175</td>
</tr>
</tbody>
</table>

12. The staff requiring refresher courses over three years commencing 1966/67 would thus be

- **In England and Wales**: \(14,367 - 2,777 = 11,590\)
- **In Scotland**: \(920 - 175 = 745\)

The average number in each of the three years will thus be one third of 11,590 and 745, i.e. 3,863 and 248. Total 4,111.

13. **The number of places required for a refresher course of one week** has been calculated on the assumption of 40 courses in a 40 week year, i.e. divide by 40.

14. **The number of classes** is calculated by dividing the total number of places by the average number in a class—20, i.e. during the transitional period 28 classes will be required for England and Wales and 2 for Scotland, 30 in total.

15. **The number of instructors** is calculated by multiplying the number of classes by three, i.e. during the transitional period 84 instructors will be required for England and Wales and 6 for Scotland, 90 in total.
APPENDIX VII

ESTIMATE OF THE NUMBER OF PLACES REQUIRED IN EACH HOSPITAL BOARD AREA (PARAGRAPH 68)

England and Wales
1. The total of 555 places required for England and Wales (paragraph 60, Table 1) for the total population of 47,401,000 is the equivalent of just under 12 places per million of population.

2. On this basis, the places required per hospital board area are shown in the following Table:

<table>
<thead>
<tr>
<th>Region or Board</th>
<th>Population* (1,000s)</th>
<th>Approximate number of places required</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Newcastle</td>
<td>3,059</td>
<td>36</td>
</tr>
<tr>
<td>2 Leeds</td>
<td>3,160</td>
<td>36</td>
</tr>
<tr>
<td>3 Sheffield</td>
<td>4,500</td>
<td>53</td>
</tr>
<tr>
<td>4 East Anglian</td>
<td>1,605</td>
<td>19</td>
</tr>
<tr>
<td>5 N.W. Metropolitan</td>
<td>4,223</td>
<td>50</td>
</tr>
<tr>
<td>6 N.E.</td>
<td>3,296</td>
<td>38</td>
</tr>
<tr>
<td>7 S.W.</td>
<td>3,235</td>
<td>38</td>
</tr>
<tr>
<td>8 S.E.</td>
<td>3,427</td>
<td>40</td>
</tr>
<tr>
<td>9 Oxford</td>
<td>1,751</td>
<td>20</td>
</tr>
<tr>
<td>10 South Western</td>
<td>2,977</td>
<td>35</td>
</tr>
<tr>
<td>11 Welsh</td>
<td>2,676</td>
<td>31</td>
</tr>
<tr>
<td>12 Birmingham</td>
<td>4,926</td>
<td>59</td>
</tr>
<tr>
<td>13 Manchester</td>
<td>4,499</td>
<td>53</td>
</tr>
<tr>
<td>14 Liverpool</td>
<td>2,216</td>
<td>26</td>
</tr>
<tr>
<td>15 Wessex</td>
<td>1,851</td>
<td>21</td>
</tr>
<tr>
<td></td>
<td>47,401</td>
<td>555</td>
</tr>
</tbody>
</table>

3. A map showing Board areas is at Appendix VIII.

Scotland
4. It is assumed that the Scottish Ambulance Service would require one school to provide the 35 places estimated in paragraph 60, Table 1.

APPENDIX IX

List of bodies and persons submitting written evidence

Association of Anaesthetists of Great Britain and Ireland
Association of Hospital Management Committees
Association of Industrial Medical Officers
Association of Municipal Corporations
Association of Police Surgeons of Great Britain
Birmingham Regional Hospital Board
British Association of Oral Surgeons
British Association of Plastic Surgeons
British Medical Association
British Medical Association (Scottish Office)
College of General Practitioners
Confederation of Health Service Employees
County Councils Association
Eastern Regional Hospital Board, Scotland
Institute of Certified Ambulance Personnel
Leeds Regional Hospital Board
Liverpool Regional Hospital Board
Manchester Regional Hospital Board
National Ambulance Services Association
National Association of Ambulance Officers
National Union of General and Municipal Workers
National Union of Public Employees
Newcastle Regional Hospital Board
North Eastern Regional Hospital Board, Scotland
North East Metropolitan Regional Hospital Board
Northern Regional Hospital Board, Scotland
North West Metropolitan Regional Hospital Board
Oxford Regional Hospital Board
Royal College of Nursing, Scottish Board
Royal College of Physicians
Royal College of Physicians, Edinburgh
Royal College of Physicians and Surgeons of Glasgow
Royal College of Surgeons of England
Royal College of Surgeons, Edinburgh
Royal Medico-Psychological Association
Scottish Association of Executive Councils
Scottish Council of the College of General Practitioners
Sheffield Regional Hospital Board
Society of British Neurological Surgeons
South Eastern Regional Hospital Board, Scotland
South East Metropolitan Regional Hospital Board
South Western Regional Hospital Board
Transport and General Workers Union
Transport and General Workers Union, Scotland
Welsh Hospital Board
Wessex Regional Hospital Board
Western Regional Hospital Board, Scotland
Dr. M. H. Hall, Senior Casualty Officer, Royal Infirmary, Preston
J. E. Hill, Esq., Normanton, Yorkshire
A. Naylor, Esq., The Royal Infirmary, Bradford
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Numbers refer to paragraphs
(I) — Paragraphs in Introduction
(S) — Paragraphs in Summary
(R) — Paragraphs in List of
    Recommendations
Otherwise numbers refer to paragraphs
in Report on Training

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