First response: first aid and emergency care from the first day of school to the last

The Drawing Board

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HEALTH PAPER 09

First response: first aid and emergency care from the first day of school to the last

A paramedic reaches entry-level competence in a few years of full-time education. Children spend fourteen years in school.

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THE ASK

That the four nations fund a pilot of a continuous first-aid and emergency-care curriculum across representative primary, secondary and post-16 settings, with a named independent evaluator, carried in England through the next revision of the statutory health education guidance.

1. Executive summary

Every school-leaver in the UK should be able to recognise an emergency, protect themselves and others, summon the right help and give effective first aid until professional help arrives. No part of the school system currently produces that. This paper sets out a curriculum that would.

A paramedic reaches entry-level competence in a few years of full-time education. Children spend fourteen years in school.

The curriculum runs from Reception to Year 13 at roughly one hour a week. It starts with four-year-olds learning to spot danger, fetch an adult and call for help. It ends with eighteen-year-olds who can work through a structured assessment, control a major bleed, support a peer through a mental-health crisis, lead a small team at an incident and hand over to an arriving clinician.

The design is cumulative. Skills introduced at one age return every year with more realism, more independence and more complexity. Fourteen years of return visits turn taught behaviour into habit; a one-off qualification never does. The weekly rhythm does the work, because resuscitation skills decay within months of a single course (Section 8).

Health literacy carries equal weight. Pupils learn to triage what care a situation needs: which problems they can manage themselves, which need a community pharmacist, a general practitioner (GP) or NHS 111, and which need 999 and an ambulance. Across a whole population, that skill keeps the emergency system for emergencies.

The evidence that school-based training changes national outcomes is strong. Denmark made cardiopulmonary resuscitation (CPR) training mandatory in schools in Jan 2005 and for driving licences in Oct 2006; bystander CPR rose from 27% to 80% between 2005 and 2019, and 30-day survival from out-of-hospital cardiac arrest roughly tripled. [11] The international consensus position, the World Health Organization-endorsed Kids Save Lives statement, recommends two hours of CPR training a year from age 12. This proposal goes well past that floor, because the ambition here is broader than CPR. [12]

England has already started down this road. Statutory Health Education guidance requires primary pupils to learn basic first aid, and secondary pupils to learn CPR and the purpose of automated external defibrillators (AEDs), with revised statutory guidance in force from Sep 2026. [4] Resuscitation Council UK (RCUK) guidance published in 2025 goes further, recommending resuscitation education from ages 4 to 6 and annual resuscitation training in school curricula. [3] The government already runs a national preparedness campaign asking households to ready themselves for emergencies. [13] This proposal is the structural version of that objective. It builds resilience into every citizen through education instead of requesting it through advertising.

The ambition and its clinical boundary

The ambition sits at the ceiling of what is possible outside professional registration. The programme takes every school-leaver as close to paramedic entry-level capability as law, safety and the classroom allow.

That ceiling is real. A registered paramedic is a regulated healthcare professional who must meet the Health and Care Professions Council (HCPC) standards of proficiency, including autonomous clinical judgement, safe practice in unpredictable circumstances, patient assessment and management, communication and professional accountability. Entry to the register requires a bachelor's degree with honours, a threshold in force since Sep 2021. [5][6]

A school cannot replicate the regulated core: supervised placements with real patients, medicines and invasive interventions, and the accountable clinical judgement that registration certifies. One hour a week yields roughly 500 hours across the school journey. A paramedic degree delivers around seven times that, much of it in supervised clinical practice. [6]

Everything else is in scope. Whatever a layperson may lawfully and safely learn and do from the early foundations of paramedic education, a school-leaver should be able to do. The boundary is regulation, not the ceiling of knowledge or skill. That protects pupils, schools and the credibility of the programme.

The endpoint is advanced community first responder capability at the upper boundary of non-professional scope, with a strong foundation for a career in emergency care.

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2. Vision

A school-leaver at 18 can do the following.

1. Recognise an unsafe situation and protect themselves before intervening.
2. Recognise a life-threatening emergency quickly.
3. Call 999 (or 112 from a mobile) and communicate effectively with an emergency call handler.
4. Perform high-quality CPR and use an AED safely and confidently.
5. Manage choking, severe bleeding and other immediate life threats.
6. Perform a structured primary assessment and recognise deterioration.
7. Provide appropriate first aid for common injuries and medical emergencies.
8. Explain enough basic physiology to understand why first aid works.
9. Recognise the common symptoms of stroke, heart attack, asthma, anaphylaxis, hypoglycaemia and seizures.
10. Recognise a developing mental-health crisis, respond safely, and connect the person to appropriate support.
11. Use non-prescription first-aid equipment within their training, and name the limits of that training.
12. Work as part of a team during an emergency.
13. Manage multiple casualties at a basic community-incident level.
14. Apply safeguarding, consent, confidentiality, dignity and professional boundaries.
15. Triage the care a situation needs: self-care, NHS 111, a GP or community pharmacy, an urgent treatment centre, an emergency department or 999.
16. Leave school with durable lifesaving skills that can be refreshed throughout adulthood.

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3. Strategic objectives

3.1 Increase lifesaving capability

The programme exists to make recognition and treatment of time-critical emergencies faster. RCUK's 2025 guidelines support introducing resuscitation education in early childhood and reinforcing it throughout school. [3] Denmark shows what a national school mandate can do to bystander intervention rates over fifteen years. [11]

3.2 Improve health literacy and the triage of care

Students learn how to give first aid and when to hand the problem to a professional. Choosing the right level of care is itself a core skill of the curriculum, taught and assessed like any other. Pupils look at a situation and decide whether it needs self-care, community advice or an emergency response.

The effect on accident and emergency (A&E) departments is compositional. The more confidently minor illness and injury are managed at home and in the community, and the more accurately people pick the right service, the more emergency departments can concentrate on the cases that need them. That concentration is also what allows A&E to deepen the specialist care it offers. First-aid education alone will not produce that shift; it also depends on access to primary and community care, on wider public behaviour, and on the clinical mix of attendances. A better-trained population changes demand in both directions, because people who recognise a stroke or a cardiac event call 999 more readily. What follows is better-targeted demand, with more appropriate emergency calls for time-critical conditions and more confident self-care for minor ones.

3.3 Build confidence and willingness to act

Plenty of people know the emergency number and have seen CPR on television, then freeze in front of a real casualty. The programme puts its weight on repeated simulation, communication and psychological preparedness, not written examinations. Willingness to act is also the most durable outcome long-run training buys: technical precision fades between refreshers, but the disposition to step forward, call and do something useful persists.

3.4 Make first aid a lifelong skill

First aid decays without practice. The programme's answer is structural. A protected weekly hour is a low-dose, high-frequency design applied across fourteen years (Section 8). Beyond school, the Danish model points to the adult maintenance pathway: first aid as a condition of a driving licence, workplace refreshers, and free public self-instruction tools. [11]

3.5 Build a national culture of safety and resilience

Every child learns the same emergency language and the same first actions from age four. A population-level expectation follows. Ordinary people can help, within safe limits. Over a generation that produces households and communities able to look after themselves and each other through the first minutes of an emergency, and through the ordinary run of minor illness and injury. The government already asks for exactly this through its national preparedness campaign. [13]

3.6 Reach the communities that voluntary training never reaches

Bystander CPR rates and cardiac arrest survival are markedly worse in deprived communities. In North East England, bystander CPR was recorded at 14.5% in the most deprived areas against 23.3% in the least deprived; in Scotland, people in the most deprived communities are nearly twice as likely to suffer an out-of-hospital cardiac arrest and less likely to survive one, and public defibrillator coverage is itself skewed away from the areas that need it most. [14] Voluntary and workplace training reaches the already-advantaged. School is the only institution that reaches every community at scale. Universal school-based training is therefore a health-equity measure as well as a safety one.

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4. Time commitment

The baseline assumption is one hour per week across the school journey. With a statutory pupil year of 190 days (38 weeks), this represents roughly 500 curriculum hours in total.

The hour is an entitlement, not a timetable instruction, and schools distribute it as suits them:

A weekly lesson, whole or split.

Assembly-format delivery for cohort-wide content such as recognition, service navigation and campaign-style refreshers.

Practical workshops in smaller groups for skills that need hands on equipment.

Occasional half-day simulation sessions replacing several ordinary sessions.

The mixed format matters for cost as well as flexibility: content that can be taught to a year group at once is taught to a year group at once, and small-group time is reserved for the skills that genuinely need it.

The proposal lands in a curriculum that the Curriculum and Assessment Review has just examined for overload. [15] Three answers apply. First, part of this is already statutory and already timetabled; the proposal organises and extends it rather than starting from zero. Second, the weekly hour is the evidence-based design. Spaced practice makes the skills stick, and the same hours delivered as annual blocks would buy less. [10] Third, the entitlement model leaves schools the flexibility the Review sought to protect: the commitment is annual learning time and assessed competence, not a fixed slot on every week's timetable.

Suggested annual pattern

60% practical skills and simulation.

25% knowledge, explanation and health literacy.

15% assessment, reflection and scenario review.

As students become older, the proportion of practical and scenario-based learning increases.

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5. Curriculum architecture

The programme is organised around five longitudinal strands that run through every year.

Strand A — Safety and scene management

Strand A covers personal safety, hazard recognition, personal protective equipment (PPE), infection control, scene assessment, safeguarding and safe decision-making.

Strand B — Immediate lifesaving skills

Strand B covers calling for help, CPR, AED use, choking, severe bleeding, the recovery position and management of immediately life-threatening problems.

Strand C — Injury and illness first aid

Strand C covers wounds, burns, fractures, sprains, head injury, poisoning, bites and stings, environmental emergencies and common medical emergencies.

Strand D — Assessment and clinical reasoning

Strand D progresses from simple recognition to structured assessment, symptom recognition, prioritisation, ABCDE thinking (airway, breathing, circulation, disability, exposure) and recognition of deterioration. The 2025 RCUK First Aid Guidelines recommend a structured ABCDE approach as the assessment framework for first aid, alongside early calling for help. [2]

Strand E — Health-system and human skills

Strand E covers communication, consent, dignity, teamwork, safeguarding, mental-health first aid and responder wellbeing, appropriate NHS access, documentation and reflection. Mental-health first aid develops through the strand from noticing that a friend is struggling in the early years to recognised crisis-response training in the senior years.

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6. Fourteen-year progression framework

Stages are given in England and Wales year groups; Scotland (P1 to S6) and Northern Ireland (Years 1 to 14) map their equivalents.

Reception — Ages 4–5

Theme: "Be safe and get help."

Objective: Create a positive, simple introduction to helping someone who is hurt without expecting children to perform complex treatment.

Topics

What first aid means.

Recognising danger: fire, traffic, electricity, hot objects, sharp objects and water.

Do not approach a dangerous situation.

Finding a trusted adult.

Recognising that someone may need help.

Calling 999 with an adult present and learning what an emergency is.

Learning their name and basic identifying information.

Simple hygiene and handwashing.

Basic understanding of pain, injury and illness.

Introduction to the idea that an unconscious person needs urgent help.

Very simple CPR awareness through songs, games and manikin familiarisation.

Practical proficiency by the end of the year

Can identify obvious hazards.

Can shout for help.

Can tell an adult what has happened.

Can recognise that an unresponsive person is an emergency.

Can copy the rhythm of chest compressions on a training manikin.

Assessment: Observation, games, role play and demonstration.

Year 1 – Ages 5–6

Theme: "Get help and help safely."

Objective: Establish the first reliable behavioural sequence: stay safe → get help → explain what happened → help within your ability.

Topics

999 and emergency situations.

What information an emergency call handler needs.

Small cuts and grazes.

Simple bruises and bumps.

Hand hygiene.

Covering a wound.

Simple cold-pack use with adult supervision.

Recognising when an injury is too serious for simple first aid.

Introduction to burns and why cooling is important.

Basic CPR recognition.

Practical proficiency

Can identify a simple injury and seek appropriate help.

Can apply a basic plaster or dressing under supervision.

Can explain the difference between a minor injury and a serious emergency.

Can demonstrate correct handwashing and infection-control behaviour.

Year 2 — Ages 6–7

Theme: "Stop bleeding and recognise unresponsiveness."

Objective: Introduce direct lifesaving action for common emergencies.

Topics

Bleeding and direct pressure.

Simple dressings and bandages.

Nosebleeds.

Recognition of an unresponsive person.

Calling 999.

Introduction to the recovery position.

CPR concept: recognising absent or abnormal breathing and why chest compressions matter.

Safe positioning while waiting for help.

Practical proficiency

Can apply direct pressure to a bleeding simulated wound.

Can assist with or demonstrate recovery-position steps appropriate to their physical ability.

Can give a clear emergency message to an adult or call handler.

Can demonstrate compressions on a manikin with appropriate instruction.

Year 3 — Ages 7–8

Theme: "Recognise and respond."

Objective: Move from isolated skills to short, structured emergency responses.

Topics

Burns and scalds.

Recovery position.

Fainting.

Head injury awareness.

Choking recognition.

Helping someone who is having difficulty breathing.

Basic allergy and anaphylaxis awareness.

Emergency communication.

Noticing when a friend is struggling, and telling a trusted adult.

Practical proficiency

Can demonstrate basic burn first aid.

Can select the recovery position for an unresponsive person who is breathing normally, with guidance.

Can recognise choking as an emergency.

Can call for help and communicate the problem clearly.

Year 4 — Ages 8–9

Theme: "First aider for common emergencies."

Objective: Build independence with common childhood injuries and introduce choking first aid.

Topics

Choking: encourage coughing when appropriate; back blows and abdominal or chest thrusts according to current age-appropriate guidance.

Bleeding and dressings.

Sprains and strains.

Simple fractures.

Burns.

Nosebleeds.

Foreign bodies in eyes.

Recognition of breathing difficulty.

Basic asthma awareness.

Repeated CPR practice.

Practical proficiency

Can manage a simulated minor injury independently.

Can demonstrate the age-appropriate response to choking on training equipment.

Can recognise when an injury may be a fracture and support the person without unnecessary movement.

Can perform a basic emergency sequence without prompting in simple scenarios.

Year 5 — Ages 9–10

Theme: "Manage the person, not just the injury."

Objective: Introduce the concepts of shock, prioritisation and looking at the whole patient rather than concentrating only on a visible injury.

Topics

Severe bleeding versus minor bleeding.

Shock and deterioration.

Fractures and limb injuries.

Head injury and concussion awareness.

Burns.

Choking.

Asthma.

Allergic reactions.

Seizure first aid.

Safe transport and positioning.

Introduction to emergency-scene awareness.

Practical proficiency

Can identify potentially serious deterioration.

Can prioritise bleeding control and emergency activation.

Can provide appropriate first aid for a simulated seizure.

Can manage a combined scenario involving more than one problem.

Year 6 — Ages 10–11

Theme: "Young lifesaver."

Objective: Establish confident hands-on CPR and basic understanding of first-aid equipment.

Topics

Adult CPR.

Child CPR awareness and differences.

AED introduction.

Bleeding control.

Dressings and bandages.

Burns.

Choking.

Recovery position.

Suspected spinal injury and when not to move someone.

First-aid kit contents and appropriate use.

Emergency communication.

Practical proficiency

Can perform CPR on a training manikin to the RCUK-aligned standard adopted by the programme.

Can use a training AED with guidance and follow its prompts safely.

Can complete a simple emergency sequence from recognition through handover.

Can assemble an appropriate first-aid kit for a basic scenario.

Milestone: This is the first point at which every pupil has received meaningful hands-on CPR and AED exposure.

Year 7 — Ages 11–12

Theme: "Emergency responder."

Objective: Transition into secondary-school level emergency care, with greater independence and realistic scenarios.

Topics

High-quality CPR.

AED use.

Recognition of cardiac arrest.

Recovery position.

Head injury and concussion.

Major bleeding.

Fractures, sprains and dislocations.

Asthma.

Anaphylaxis awareness and emergency medication concepts.

Seizures.

Heat and cold injuries.

Basic poisoning awareness.

Mental-health awareness: stress, panic and where help lives.

Practical proficiency

Performs the CPR and AED sequence with minimal prompting.

Correctly identifies major bleeding and initiates immediate control.

Can recognise several common medical emergencies from symptoms alone.

Can manage short scenario-based assessments in the correct sequence.

Year 8 — Ages 12–13

Theme: "Structured emergency assessment."

Objective: Introduce a simplified structured patient assessment and increase clinical reasoning.

Topics

Primary survey and structured approach to emergencies.

Introduction to ABCDE thinking.

Airway problems.

Breathing difficulty.

Circulation problems and severe bleeding.

Disability: altered consciousness and neurological problems.

Exposure and environmental hazards.

CPR and AED refreshers.

Asthma attacks.

Anaphylaxis.

Hypoglycaemia awareness.

Stroke recognition.

Heart-attack awareness.

Communication and handover.

Practical proficiency

Can work through a structured assessment with a scenario actor or manikin.

Can identify immediate life threats in the correct order.

Can provide a concise handover to an adult or health professional.

Can distinguish a life-threatening emergency from a problem requiring non-emergency clinical advice.

Year 9 — Ages 13–14

Theme: "Trauma first responder."

Objective: Develop stronger trauma management capability while reinforcing lifesaving priorities.

Topics

Severe bleeding.

Tourniquet awareness and training where appropriate to current UK guidance and local policy.

Wound packing awareness and training within the competence framework adopted by the programme.

Crush injury awareness.

Amputation and avulsion first aid.

Serious head injury.

Spinal injury awareness.

Chest trauma awareness.

Shock.

Multiple injuries.

Seizures.

Drowning and near-drowning.

Safe scene management.

Practical proficiency

Can identify and prioritise life-threatening trauma.

Can demonstrate bleeding-control techniques taught by the programme.

Can maintain scene safety while coordinating assistance.

Can perform a short simulated trauma assessment.

Year 10 — Ages 14–15

Theme: "Advanced community first aid."

Objective: Consolidate emergency skills and introduce greater realism, uncertainty and independent decision-making.

Topics

Adult, child and infant CPR awareness and practice as appropriate.

AED use.

Cardiac arrest in different environments.

Severe bleeding.

Trauma.

Choking.

Drowning.

Anaphylaxis, including administration of another person's adrenaline auto-injector within lawful bystander scope.

Asthma, including helping with a casualty's own inhaler and spacer.

Stroke.

Heart attack.

Diabetic emergencies.

Seizures.

Poisoning and overdose awareness.

Environmental emergencies.

Psychological support after traumatic incidents.

Practical proficiency

Can manage a complete emergency scenario with little prompting.

Can identify several simultaneous priorities.

Can communicate effectively with ambulance call handlers and arriving clinicians.

Can maintain CPR and AED performance during realistic scenarios.

Can demonstrate use of a training adrenaline auto-injector.

Year 11 – Ages 15–16

Theme: "Helping when there are several casualties."

Objective: Add effective bystander coordination when professionals are on the way: prioritising help across more than one casualty, organising willing helpers, and handing over cleanly. Pupils are taught explicitly that arriving emergency services take charge, and that the bystander role is to help effectively until they do.

Topics

Dynamic risk assessment and personal safety with multiple casualties.

PPE.

Prioritising help using a taught framework.

Multiple-casualty situations.

Major trauma.

Catastrophic bleeding.

Crush injury.

Burns and blast injury awareness.

Organising willing bystanders into simple roles.

Communication with emergency services, and stepping back on their arrival.

Documentation and handover.

Safeguarding and vulnerable casualties.

Practical proficiency

Can organise a small group of first aiders in a simulated incident until services arrive.

Can apply a simple prioritisation framework across casualties.

Can identify the most immediately life-threatening casualty.

Can allocate tasks and provide a structured handover to arriving professionals.

Qualification opportunity: Schools can offer an externally accredited first-aid qualification at this stage, provided the course content and assessment align with current national standards. Mental Health First Aid training at a recognised youth standard belongs in this window. [16]

Year 12 — Ages 16–17

Theme: "Advanced emergency care."

Objective: Introduce near-adult community responder capability and deeper clinical understanding without implying professional paramedic competence. Delivered across every post-16 route: school sixth forms, further education colleges, and the off-the-job training component of apprenticeships.

Topics

Advanced structured assessment.

ABCDE assessment in greater depth.

Recognition of deterioration.

Chest pain and acute coronary syndrome recognition.

Stroke.

Severe asthma.

Anaphylaxis and adrenaline auto-injector administration.

Hypoglycaemia and hyperglycaemia awareness.

Seizures and altered consciousness.

Severe infection and sepsis awareness.

Poisoning and overdose emergencies.

Major trauma principles.

Bleeding control.

Airway positioning and simple airway-opening manoeuvres.

Mental-health first aid: crisis recognition, safe response, connecting to services.

Communication with healthcare professionals.

Legal and ethical boundaries of first aid.

Practical proficiency

Can perform a structured assessment on a simulated patient.

Can identify immediately life-threatening abnormalities.

Can initiate appropriate first aid while requesting professional help.

Can produce a concise, clinically useful handover.

Can respond safely to a simulated mental-health crisis and signpost support.

Understands clearly what falls outside student scope of practice.

Year 13 — Ages 17–18

Theme: "Community emergency responder."

Objective: Produce a confident, safe and mature school-leaver who can act effectively during emergencies while recognising the limits of non-professional practice. Delivered across every post-16 route.

Topics

Full emergency assessment.

ABCDE approach.

High-quality adult CPR and AED.

Paediatric CPR awareness.

Severe bleeding and major trauma.

Choking.

Anaphylaxis.

Asthma.

Stroke.

Cardiac emergencies.

Seizures.

Diabetic emergencies.

Poisoning and overdose.

Drowning.

Environmental emergencies.

Multiple-casualty response and prioritisation.

Team leadership.

Communication and handover.

Safeguarding, consent, dignity and professional boundaries.

Psychological first aid, mental-health first aid and responder wellbeing.

NHS navigation and appropriate service selection.

Practical proficiency

Can recognise a life-threatening emergency quickly.

Can make the area reasonably safe.

Can call 999 and communicate clinically relevant information.

Can perform CPR and operate an AED.

Can control major bleeding using the techniques taught.

Can manage choking.

Can recognise and respond appropriately to common medical emergencies, including a mental-health crisis.

Can perform a structured initial assessment.

Can prioritise casualties in a basic multiple-casualty scenario.

Can work within a team.

Can give a structured handover to an arriving clinician.

Can identify the limits of their competence and seek professional assistance appropriately.

Final assessment: A practical Objective Structured Emergency Assessment (OSEA) using several simulated scenarios, supported by knowledge testing and a reflective component.

What changes across Years 10 to 13

The senior years revisit a stable set of conditions. What advances is the demand placed on the student. The progression runs on six dimensions.

DIMENSION	YEAR 10	YEAR 11	YEAR 12	YEAR 13
Simulation fidelity	Single casualty, clear signs	Several casualties, competing needs	Evolving condition during the scenario	Full-fidelity OSEA scenarios
Learner autonomy	Prompted where needed	Leads peers with oversight	Works unprompted	Leads and is assessed unprompted
Stress and time pressure	Mild	Moderate, divided attention	Sustained, with distractions	Examination conditions
Information ambiguity	Complete picture given	Incomplete picture	Misleading or conflicting cues	Realistic uncertainty throughout
Casualty load	One	Two to several	One complex	Multiple, prioritised
Assessment standard	Skills checks	Scenario assessment	Structured assessment with handover	Final OSEA against the graduation standard

7. Progressive proficiency model

The programme defines proficiency in terms of what the student can actually do under pressure.

STAGE	APPROXIMATE SCHOOL YEARS	PROFICIENCY EXPECTATION
1. Awareness	Reception–Y2	Recognise danger, get help, communicate, perform simple safe actions.
2. Supported responder	Y3–Y5	Perform common first-aid tasks with supervision and recognise serious problems.
3. Independent lifesaver	Y6–Y8	Perform CPR and AED use and common emergency first aid with limited prompting.
4. Advanced responder	Y9–Y11	Assess, prioritise, manage trauma and medical emergencies, work in teams.
5. Community emergency responder	Y12–Y13	Conduct structured assessments, manage complex scenarios, coordinate a basic response and hand over safely.

Each year carries roughly 38 hours of curriculum time, with the annual focus set by the theme in Section 6. The central progression is:

Recognise → Call → Act → Assess → Prioritise → Coordinate → Handover → Reflect

8. The refresher principle

Spiral learning is the mechanism. Core skills recur every year, in short and frequent practice rather than single annual blocks, because that is what the skill-decay evidence supports. Basic life support skills measurably fade within three to twelve months of one-off training, and the European Resuscitation Council's education guidance warns that annual retraining may not be frequent enough. [10] The weekly hour exists precisely to beat that decay curve.

At minimum, every later year revisits:

Emergency call activation.

CPR;

AED use;

Choking.

Severe bleeding.

The recovery position.

Structured assessment.

Recognition of deterioration.

Medical emergencies.

Communication and handover.

The 2025 RCUK education guidance supports annual resuscitation training in school curricula as a floor; this design exceeds it. [3]

Beyond school, the programme needs an adult maintenance pathway, and Denmark supplies the template: first-aid training as a condition of a driving licence, workplace refreshers, and free public self-instruction tools, so that the capability built by the school years is topped up rather than left to fade. [11]

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9. Practical teaching methodology

9.1 Teach through simulation

The curriculum uses realistic but age-appropriate scenarios rather than lectures.

Examples include:

A child falling in the playground.

A family member collapsing at home.

Choking at a meal.

A sports injury.

A burn in the kitchen.

An allergic reaction.

A cyclist involved in a road collision.

An unconscious person in a public place.

A friend in a mental-health crisis.

A cardiac arrest.

A multiple-casualty incident.

9.2 Use deliberate practice

Students repeat key skills until they become automatic. Reliable performance under mild stress is the target, not perfection in one lesson.

9.3 Increase realism with age

Younger pupils use simple stories and games. Older pupils encounter:

Time pressure.

Incomplete information.

Distractions.

Emotional stress.

Multiple casualties.

Changing patient conditions.

Communication challenges.

9.4 Keep the programme psychologically safe

Some scenarios involve death, serious injury or distress. Schools use age-appropriate language and give students opportunities to debrief. Participation in realistic simulations must never become humiliating or frightening. Section 14 sets out the adaptation and opt-out framework for pupils for whom specific content is unsafe.

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10. Assessment framework

Assessment is predominantly practical.

Reception–Year 2

Teacher observation.

Games.

Demonstrations.

Verbal responses.

The emphasis is on recognition and safe behaviour rather than formal testing.

Years 3–6

Practical skills checks.

Short scenarios.

Simple written and visual quizzes.

Annual CPR and AED awareness assessments once developmentally appropriate.

Years 7–9

Practical skills stations.

Scenario-based assessments.

Short knowledge assessments.

CPR and AED performance checks;

Emergency communication exercises.

Years 10–13

Objective Structured Emergency Assessments;

Multi-stage scenarios.

Team exercises.

Prioritisation simulations.

Structured handovers.

Written clinical reasoning questions.

Final practical assessment.

Assessment principle

Competence means recognising the situation, choosing the right action, performing it safely and knowing when to escalate. Reciting a procedure demonstrates none of that.

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11. Teacher workforce and delivery model

Practical first aid is a skills discipline, and the delivery model is designed so that the existing education and health workforce carries it rather than a new specialist profession.

Ordinary teachers deliver most of the curriculum. Initial teacher training is updated to include first-aid teaching competence, so every new entrant to the profession arrives able to teach the early-years and primary content as naturally as they teach reading. Serving teachers pick the same competence up through continuing professional development, delivered within existing development time wherever possible. Teachers are never asked to teach outside their competence.

Assembly-format delivery covers cohort-wide content. Recognition, service navigation, campaign-style refreshers and much of the knowledge strand can be taught to a whole year group at once. Class-by-class time is reserved for hands-on skills.

School and community health professionals deliver the clinical modules. School nurses, community nurses, GPs and paramedic educators take the senior-year clinical content, the assessment of advanced competencies, and the annual quality assurance of school delivery, through structured local partnerships with:

Ambulance services.

NHS trusts and community health services;

Resuscitation training organisations.

First-aid organisations.

Universities and paramedic education programmes.

Community first responder organisations.

Each school has a designated First Aid Curriculum Lead. The lead coordinates the programme, manages equipment, owns quality assurance and assessment, and liaises with external providers.

Northern Ireland already demonstrates the train-the-trainer route at CPR scale through its ambulance-service-supported schools programme; this model extends the same architecture across the wider curriculum. [9] Denmark supplies the warning. A mandate without machinery to deliver it under-delivers; fewer than a third of Danish classes had been trained years after the school requirement arrived. [11] The workforce model, the curriculum lead and the governance in Section 18 exist to avoid repeating that.

12. Cost and return

The figures below are planning estimates built on the delivery model in Section 11. The assumptions are given so a pilot can correct them.

What the model does not cost

Delivery time comes from the existing teaching workforce and the weekly entitlement, so the programme creates no new standing teaching profession. Assembly-format delivery further reduces the class-hours required. The largest cost line in a naive model, thousands of new specialist teachers, is designed out.

What it does cost

A one-off national curriculum design, assessment framework and materials programme, shared across all four nations.

An initial teacher training module and a serving-teacher CPD module, with periodic refreshers; the marginal cost is course development and trainer time, since the audience is already in training or development.

Equipment for every school: manikins, AED trainers, bleed-control and choking trainers, consumables and replacement cycles, on a national specification (Section 13). This is the main capital line, in the low hundreds of millions across roughly 32,000 UK schools, followed by a recurrent consumables share.

Clinical educator time for senior-year modules and quality assurance, bought by the session from local health partners.

A curriculum lead allowance in each school.

The return side

Lives: earlier CPR and defibrillation are the difference between Denmark's 4.5% and 14.4% cardiac arrest survival. [11] Government appraisal values a prevented fatality at roughly £2.4 million (Department for Transport appraisal values, 2023 prices; the Health and Safety Executive's equivalent is £2.2 million at 2024 prices), with the caveats that the figure is road-calibrated and that a survival gained is not always a fatality prevented. [17]

Avoided demand: confident self-care and accurate triage of care remove some share of minor-injury and minor-illness contacts from GPs and A&E. Each avoided contact has a published unit cost, in the Unit Costs of Health and Social Care manual for general practice and the National Cost Collection for A&E, and even small percentage shifts across tens of millions of annual contacts are material. [18] At the margin an avoided contact releases capacity rather than cash (Section 3.2).

Resilience: a population able to manage the first minutes of any emergency, which is what the government's preparedness campaign asks for. [13]

Workforce: a talent pipeline into nursing, paramedicine, medicine and allied health at a time when every one of those professions is short.

Equity: the health-equity return in Section 3.6, which no voluntary model delivers.

The pilot in Section 22 prices all of this properly.

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13. Equipment requirements

A national specification ensures pupils receive consistent practical exposure.

Primary level

First-aid kits.

Disposable gloves.

Dressings and bandages.

Triangular bandages.

Practice cold packs.

Simple CPR manikins.

Child-friendly training materials.

Secondary level

Additional resources include:

Adult and child CPR manikins.

AED trainers;

Choking trainers.

Simulated bleeding equipment.

Trauma dressings.

Tourniquet trainers where included in the approved curriculum.

Scenario cards.

Casualty simulation materials.

PPE;

Training adrenaline auto-injectors.

Training inhalers and spacers where appropriate.

Monitoring and simulation equipment for advanced scenarios.

Prescription medication and invasive equipment stay out of the classroom unless governance, supervision, training and safeguarding arrangements are in place.

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14. Safeguarding, inclusion and ethics

Safeguarding and adaptation

A universal curriculum that simulates death, serious injury and crisis needs a designed adaptation framework:

Design is trauma-informed throughout. Recently bereaved pupils, pupils who have witnessed violence, care-experienced pupils and pupils with trauma histories are identified through existing pastoral systems, and content is adapted or deferred for them without penalty.

Pupils who live with a condition being simulated (epilepsy, anaphylaxis, diabetes, asthma) are consulted about how that content is taught in their class, and never made the involuntary subject of it.

Parents and carers receive advance notification of high-fidelity content, with a structured opt-out and alternative provision for specific scenarios.

Debriefing is built into every realistic simulation, per Section 9.4.

Special educational needs and disabilities (SEND)

Every pupil is entitled to the curriculum, and the assessment framework adapts to the pupil. A pupil who cannot physically perform chest compressions demonstrates competence through direction: recognising the arrest, summoning help, directing another person's compressions, operating the AED. Alternative demonstrations of competence run through every certification tier, so that no pupil is structurally excluded from Bronze, Silver or Gold. The national specification includes the SEND pathway from the start rather than retrofitting it.

Consent, ethics and law

Older students learn that first aid is never simply a technical activity:

Consent before helping where the person is conscious and able to consent.

Implied consent in life-threatening emergencies.

Privacy and dignity.

Safeguarding concerns, children and vulnerable adults.

When a person refuses assistance.

Confidentiality.

Appropriate boundaries.

Respect for cultural and communication differences.

Accurate handover and recording.

A short legal annex accompanies the programme. Neither the Social Action, Responsibility and Heroism Act 2015 nor section 1 of the Compensation Act 2006 gives a first aider immunity; both direct or permit a court to weigh the social value of helping when it sets the standard of care, and both apply in England and Wales only, with Scotland and Northern Ireland governed by their own law. The stronger protection is the common law itself, which judges a trained bystander as a reasonable person with that training rather than as a clinician. Certification under this programme records training; it creates no duty of care by itself.

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15. Responder wellbeing

A mature programme teaches students what happens after an emergency.

Later years cover:

Normal emotional reactions after witnessing trauma.

When to talk to a trusted adult.

Peer support.

Responder stress.

Recognising when an experience has become overwhelming.

The importance of debriefing.

The principle that a first aider is not responsible for the final outcome.

This strand and the mental-health first aid content in Strand E reinforce each other: pupils learn to look after casualties, each other and themselves.

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16. Relationship to paramedic education

The programme is pre-professional. Within that boundary, the curriculum tracks the early foundations of paramedic education as far as non-professional scope allows, stopping only where regulated practice begins:

Structured assessment.

Clinical reasoning.

Anatomy and physiology.

Communication.

Emergency decision-making.

Trauma care.

Resuscitation.

Teamwork.

Professional boundaries.

Reflective practice.

The programme is therefore a significant talent pipeline into nursing, paramedicine, medicine, emergency care, physiotherapy, occupational therapy and allied health professions, while remaining appropriate for pupils who never enter healthcare.

The HCPC states that paramedics must be able to practise safely within their scope, identify their limits, manage unpredictable situations and exercise professional judgement. Those are useful design principles for the school programme, even though pupils remain firmly within a non-professional scope. [5]

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17. UK-wide implementation and the post-16 routes

The educational framework is nationally consistent and locally adaptable, because education is devolved and school structures differ.

England

The proposal fits naturally within statutory Health Education, whose revised guidance takes effect from Sep 2026 and already expects primary pupils to learn basic first aid and secondary pupils further first aid including CPR and defibrillator awareness. [4] Participation in education or training is required to age 18 in England, so the senior tier reaches every young person through whichever route they take: school sixth forms, further education colleges, and the off-the-job training component of apprenticeships. The statutory guidance is also the one instrument that reaches academies, which sit outside the national curriculum.

Wales

The Curriculum for Wales Health and Well-being Area states that learning should include lifesaving skills and first aid, and gives schools the design freedom this framework is built for. [7] Delivery is specified as an entitlement rather than a timetabled hour, consistent with the Welsh curriculum's design principles.

Scotland

The programme sits within Health and Wellbeing across Curriculum for Excellence, mapped to P1 through S6, with post-16 delivery through schools and colleges. [8]

Northern Ireland

Northern Ireland has the strongest existing precedent: CPR at Key Stage 3 and the ambulance-service-supported Community of Lifesavers programme with train-the-trainer delivery. [9] The framework maps to Years 1 through 14.

The proposal is a UK framework with devolved implementation routes, not a single statutory lesson plan imposed on four different systems.

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18. Quality assurance and governance

A national programme has a standing clinical governance group including representatives from:

Resuscitation Council UK;

Ambulance services.

Emergency medicine.

Paediatrics.

Nursing.

Paramedicine.

Mental-health practice.

Education.

Safeguarding.

First-aid training organisations.

Young people and parent and carer representatives.

The curriculum is reviewed whenever national clinical guidelines change; the 2025 RCUK guidelines are the current foundation. [1]

A national standard defines:

Minimum content.

Minimum annual hours.

Mandatory skills.

Assessment standards.

Teacher competencies.

Equipment specifications.

Governance requirements.

Refresh intervals.

Safeguarding, SEND and adaptation requirements.

Denmark shows why. A mandate without delivery assurance can sit undelivered for years. [11]

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19. Measuring success

The programme is evaluated as a public-health intervention, with an evaluation design fixed before rollout: a phased pilot across representative areas of all four nations, a pre-registered protocol with a named independent evaluator, bystander CPR rate in the trained cohort's age band as the primary outcome linked to cardiac arrest registry data, and skill retention at six and twelve months plus service-selection accuracy as secondary outcomes.

Short-term measures

Proportion of pupils passing practical assessments.

CPR and AED confidence;

Knowledge of 999 and 112.

Knowledge of NHS service pathways.

Willingness to intervene.

Retention of skills after six and twelve months.

Teacher confidence.

Medium-term measures

Proportion of young people undertaking recognised first-aid and mental-health first-aid qualifications.

Bystander CPR rates among young adults.

AED use by members of the public;

Correct recognition of major bleeding and stroke.

Appropriate use of emergency services.

Confidence in managing common minor injuries.

Long-term measures

Bystander intervention rates.

Out-of-hospital cardiac arrest outcomes, including by deprivation quintile.

Major bleeding survival.

Health-literacy measures.

Appropriate use of NHS services.

Emergency-department attendance patterns for selected minor conditions.

Recruitment into healthcare careers.

The intended system effect is that emergency departments are reserved for the cases that need them, which in turn allows A&E to deepen its specialist care (Section 3.2).

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20. Proposed graduation standard at age 18

The proposed graduation standard is:

Level 5 — Community Emergency Responder

A student achieving the standard can do the following.

Recognise

Identify immediately life-threatening emergencies.

Recognise major trauma and serious deterioration.

Recognise common time-critical medical conditions and a mental-health crisis.

Respond

Make the scene as safe as reasonably possible.

Summon 999 or 112.

Perform effective CPR.

Use an AED.

Manage choking.

Control major bleeding.

Provide appropriate first aid for common injuries and medical emergencies.

Assess

Conduct a structured initial assessment.

Identify immediate priorities.

Monitor for deterioration.

Reassess after interventions.

Coordinate

Communicate clearly with bystanders and emergency services.

Allocate basic team roles.

Conduct basic casualty prioritisation.

Give an organised clinical handover.

Practise safely

Understand consent and safeguarding.

Work within competence.

Avoid unsafe interventions.

Seek professional help appropriately.

Recognise when they do not know what to do.

This is an ambitious but realistic target for a highly trained school-leaver. It is a record of training at the upper boundary of non-professional scope, not a professional registration or a duty of care.

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21. Suggested national certification structure

A three-tier certification system makes achievement visible without turning every year into a qualification process. Every tier carries the SEND-adapted routes in Section 14.

Bronze — Junior Lifesaver

Pupils take this award around Year 6. Core competencies:

Emergency recognition.

Basic wound care.

Recovery position.

CPR;

AED awareness and use;

Choking.

Emergency communication.

Silver — Young First Responder

Pupils take this award around Year 9 or Year 10. It adds:

Structured assessment.

Major bleeding.

Trauma.

Medical emergencies.

More independent scenario management.

Team response.

Gold – Community Emergency Responder

Pupils take this award at the end of the senior tier, through whichever post-16 route they follow. It adds:

Advanced scenario management.

ABCDE assessment;

Major trauma response.

Multiple-casualty prioritisation.

Leadership.

Mental-health first aid.

Clinical handover.

Formal practical assessment.

External accreditation can be incorporated where appropriate, with the national educational standard as the central framework.

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22. Implementation roadmap and the ask

Phase 1 – Design

A national clinical and educational working group finalises curriculum content, progression standards, the assessment framework, teacher competencies, equipment specifications and the safeguarding, SEND and adaptation requirements.

Phase 2 – Pilot (the first ask)

The ask is a funded pilot across representative primary, secondary and post-16 settings in all four nations, with a named independent evaluator and the pre-registered protocol of Section 19, reporting within two academic years on feasibility, workload, engagement, retention, competence, cost and curriculum fit. A pilot is a decision a minister can take at modest cost, and its evaluation settles arguments that cannot be settled on paper.

The vehicle in England is the statutory Relationships, Sex and Health Education guidance, whose next revision can carry the entitlement, alongside the implementation of the Curriculum and Assessment Review; the devolved routes run through the Curriculum for Wales, Curriculum for Excellence, and Northern Ireland's existing Community of Lifesavers architecture. The natural coalition is Resuscitation Council UK, the British Heart Foundation, St John Ambulance, the British Red Cross, the Royal College of Emergency Medicine, the Association of Ambulance Chief Executives and the College of Paramedics. School leadership bodies belong inside the design from the start, because their members carry the workload question.

Phase 3 — Teacher development

The initial teacher training module and the serving-teacher CPD pathway roll out, building internal capacity while clinical partners retain oversight of the senior tier.

Phase 4 — National rollout

The curriculum rolls out progressively, beginning with early years and core CPR and defibrillator content and expanding through the full age range and all post-16 routes.

Phase 5 — Evaluation and continuous improvement

Outcomes are reviewed annually, clinical content is revised whenever national guidance changes, and the cost model is re-based on pilot actuals.

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23. Why the curriculum repeats itself

In first aid, repetition is a safety feature.

A person experiencing a real emergency may have no warning, very little time, strong emotional stress, incomplete information, people shouting around them, and no certainty about what has happened. The programme therefore aims to make the first actions automatic. For the most important emergencies, pupils repeatedly practise the same basic sequence:

Safety → Responsiveness → Breathing → Call for help → Immediate intervention → AED/first aid → Reassess → Handover

The exact clinical details always follow current RCUK guidance and the approved national teaching standard.

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24. Expected wider benefits

The programme's central purpose is emergency preparedness, and its side effects are considerable.

Health literacy

Children learn how the body works, how common illnesses present and how the NHS is organised.

Confidence

Students learn that they can contribute meaningfully during emergencies.

Responsibility

The curriculum reinforces looking after other people, teamwork and community responsibility.

Careers

Repeated exposure to first aid, anatomy, physiology, mental-health practice and emergency care builds interest in healthcare and emergency-service careers.

Community resilience

Every graduating cohort adds another group of adults capable of responding to emergencies in homes, workplaces, public spaces and communities. [13]

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25. Core principles for policy adoption

The national specification is built on eight principles.

1. Every child learns first aid, and every certification tier has an adapted route.
2. Lifesaving skills begin early and recur every year, in short and frequent practice.
3. Practical competence outranks memorisation, and personal safety comes before helping others.
4. The curriculum is age-appropriate, trauma-informed, and clinically current.
5. Students understand their limits, and calling for professional help early is a core skill.
6. First-aid education is integrated with health literacy, mental-health first aid and the triage of care.
7. Teachers are trained and supported through initial teacher training and continuing development, and never teach outside their competence.
8. The framework is nationally consistent and adaptable to the four UK education systems and every post-16 route.

26. Conclusion

A fourteen-year first-aid curriculum is a major investment in public safety, health literacy and community resilience. The case for it is straightforward.

Every adult should leave school knowing what to do when someone collapses, bleeds heavily, chokes, stops breathing, suffers a serious injury or reaches a mental-health crisis. Most do not. Fourteen years of cumulative practice can take a school-leaver to the ceiling of what a layperson may lawfully and safely do, drawing on the early foundations of paramedic education rather than three years of professional training.

Starting at four makes the skills normal instead of novel. Continuing to eighteen, through every education and training route, lets each new layer sit on a secure foundation. Denmark shows the national result. Bystander intervention tripled, and cardiac arrest survival tripled with it, from a smaller programme than this one. [11]

UK guidance already points this way. England requires basic first aid within Health Education and further first aid including CPR and defibrillator awareness in secondary schools. [4] RCUK's 2025 guidance recommends resuscitation education in early childhood with reinforcement through school. [3] The Welsh curriculum names lifesaving skills and first aid as expected learning, and Northern Ireland runs a structured school CPR programme backed by its ambulance service. [7][9] The government asks households to prepare for emergencies through a national campaign. [13]

What is missing is coherence. The move is from fragmented first-aid exposure to a single national progression from age 4 to 18, producing young adults who are calm around emergencies, know how to summon help, can give effective lifesaving first aid, can support someone in crisis, can spot deterioration, can choose the right part of the health service, and know the limits of their own competence. That is a substantial public-health asset, and the first step costs only a pilot.

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