

Guide To Clinical Governance

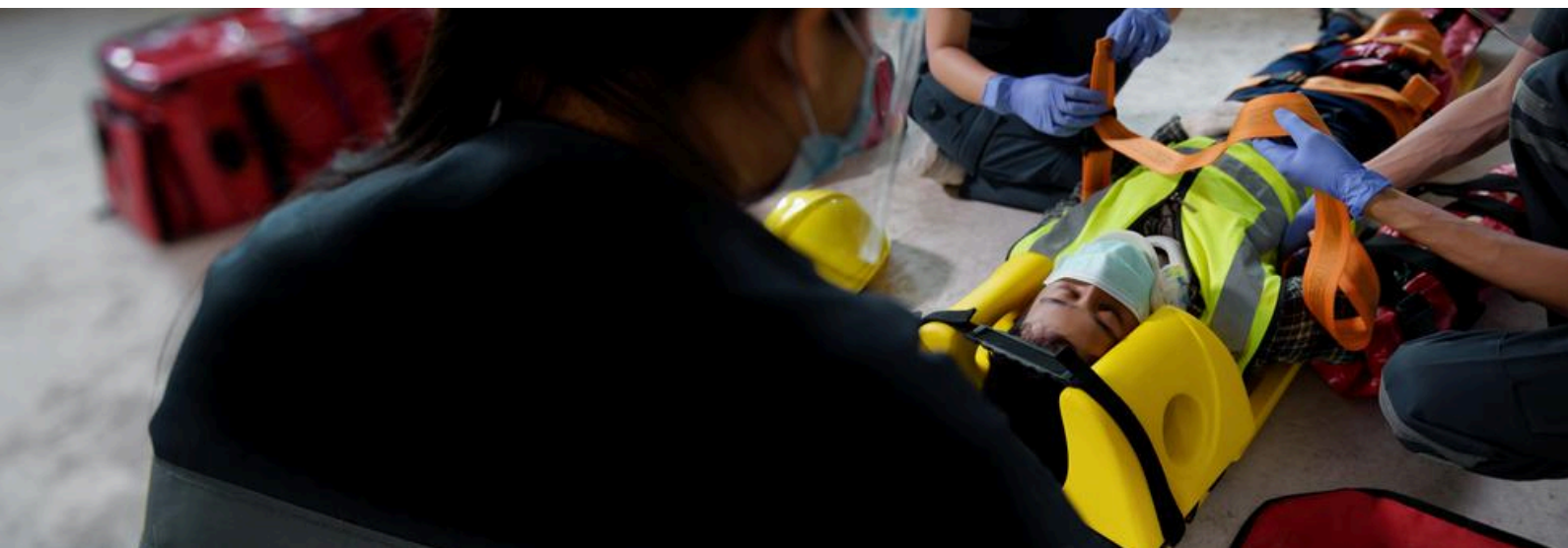
An Internal First Responder Model



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“The Royal College of Surgeons of Edinburgh, The Faculty of Pre-Hospital Care (RCSEd FPHC) support the endeavours of Kirklees College in improving patient safety through their Guide to Clinical Governance.”



Forward

Clinical governance is a systematic approach to maintaining and improving the quality of patient care within a healthcare framework. In a non-medical organisation, where an internal first responder model is employed to provide care beyond basic first aid, clinical governance ensures the delivery of safe, effective, and reliable care.

The Royal College of Surgeons of Edinburgh, The Faculty of Pre-Hospital Care (RCSEd FPHC) states that any training that goes beyond basic first aid should operate within a structured framework of governance and CPD. This ensures that individuals providing care work within a clearly defined scope of practice, are equipped with the latest knowledge and skills, and that their practice is continuously reviewed and improved.

Implementing clinical governance in a non-medical organisation with an internal first responder model is essential to ensuring the provision of high quality, safe, and effective care. By focusing on quality standards, risk management, clinical effectiveness, engagement, information management, and strong leadership, the organisation can foster a culture of continuous improvement and accountability, ultimately enhancing the health and well-being of those it serves.

This document, authored by Rob, serves as an excellent guide to what good governance should look like. It provides a comprehensive framework for implementing clinical governance in a non-medical organisation. By detailing key components, Rob has outlined a clear and practical approach to implementing clinical governance. This guide is invaluable for any organisation seeking to enhance the level of care it can provide.

Matt Tyldesley
Managing Director
Ambutech Pre-Hospital Care

Preface

Since the early 2000's the landscape in which many organisations and businesses operate within has been changing, we have seen changes in relation to an increase in crime, third party violence, terrorism, alongside a global pandemic in the year 2020 which brought fresh new challenges in terms of both physical and mental health.

Over the past ten years we have certainly seen a national increase in gang affiliation with an estimated 60,000 young people aged between 10 -17 either identifying as a gang member or knowing a gang member who is a relative. As a result of this we are seeing a national increase in knife crime, knife possession and gang affiliation and when coupled with the terror threat level within the UK and the recent findings of the Manchester Arena Inquiry there seems to be an increasing need to improve current knowledge and understanding with regards to first aid.

Covid has also increased the prevalence of mental ill health on a national level and unfortunately, we have seen a national increase in self-harm and suicide in children and young adults and this again drove the need to identify a model within my organisation that not only focused on traumatic injuries but also gave the team a wider skill set in managing a patient no matter the sickness or injury until specialist help arrived.

Further to this we are also experiencing an unprecedented demand on emergency services with ambulance response times severely impacted by both a reduction in physical resources within the ambulance services and also recent industrial action and I again sought a need to ensure that we were enabled to respond effectively until such help arrives.

In late 2022 we appointed a new trainer and clinical governance provider and working in partnership we developed a team of internal first responders who all completed a FREC 3 course. We then identified further courses to enhance knowledge and to give them a broader skill set and as such all first responders completed courses in Patient Report Form writing, clinical observations and administration of medical gases. To mitigate the risk of skill fade we then introduced a program of Continuous Professional Development and all first responders are now subject to continuous professional development as part of their role no less than four times per year.

Our new provider supported us with writing our clinical governance framework, our associated scope of practice and amended our medications policy and has since supported us in managing and monitoring our framework of which I am truly thankful to [Ambutech Pre-Hospital Care](#) for all their hard work and support.

This document aims to support you with your own journey towards clinical governance and the steps you will need to take to put in a higher standard of first aid within your organisation should you too feel the need to enhance your first aid provision.

Robert Harwood

Robert Harwood
CertIOSH
Head of Health and Safety
Kirklees College



Introduction

The beginning of the millennium saw an increased focus on the threat of international terrorism, heightened by the attack on the twin towers on 11 September 2001. In the year 2000 a new counter terrorism legislation had been passed in the UK and was designed to reform and extend state powers and indeed increase powers to both the home secretary and the police. Its focus of counter-terrorism was towards all forms of domestic terrorism and international terrorism, rather than just Northern Ireland related terrorism.



In 2003, the Government introduced its counter terrorism strategy CONTEST. Now in its fourth iteration CONTEST aims to reduce the risk of terrorism with four key objectives:

- **Pursue** – to stop terrorist attack
- **Prevent** – to stop people becoming terrorists or supporting terrorism
- **Protect** – to strengthen protection against a terror attack
- **Prepare** – to mitigate the impact of a terror attack

Between 1970 and 2019 there have been a total of 3,416 terrorism related deaths in the UK, with the majority of these deaths occurring between 1970 and the early 1990's. The general trend from the 1990's shows a decrease in the number of people killed due to terrorism however there are two notable exceptions, both in 2005 during the London bombings on the 7th July in which 52 deaths occurred and in 2017 which resulted in multiple deaths owing to three separate attacks:

- Westminster Bridge and Palace (5 Deaths)
- Manchester Arena (22 deaths)
- London Bridge (8 deaths)

This guidance document aims to support businesses in both the private and public sector with the implementation of its own first responder model and as such will ensure that businesses are better **PROTECTED** and **PREPARED** should such an incident occur.

With regards to criminality within the UK for the period March 2021 to March 2022 the police recorded crime data for 'violence against the person' offences indicated 2.1 million offences in the year ending March 2022. This showed an 18% increase compared with the 1.8 million offences recorded in the year ending March 2021.

In addition, the ONS also used police recorded crime data to report that there were:

- 710 homicides in the year ending March 2022
- 49,027 incidents involving knives or other sharps in the same period



With regards to knife crime, the ONS stated:

“Knife-enabled crime recorded by the police saw a 10% increase to 49,027 offences in the year ending March 2022, from 44,642 in the year ending March 2021. There were increases across all knife-enabled violent and sexual offences except for attempted murder, which saw a 9% decrease (to 441 offences). Levels of knife-enabled crime in the year ending March 2022 remained below levels recorded in the pre-coronavirus year ending March 2020 (55,078 offences). This is predominantly because the number of knife-enabled robbery offences (17,037 offences) was still 30% lower than in the year ending March 2020 (24,314 offences)”.

It should therefore be noted that a first responder model is not only designed to support both private and public sector businesses in the face of a terror related incident, but it’s also suitable for any incident in which serious injuries or multiple deaths can occur, such as gang related violence and knife crime, or indeed where there is a presence of complex medical needs within your organisation, such as a school or a college with a presence of SEND and those with both profound and complex medical needs within the student and staff community.

Lessons Learnt from the Manchester Arena Inquiry

There were many lessons to be learnt following the Manchester Arena Inquiry, but with regards to lessons learnt around first aid:

- First aid training for many that responded was considered inadequate for the extent of injuries sustained to those that were critically injured and/or dying.
- Of those who had attended first aid at work courses, many felt unconfident and ill-equipped to deal with the situation in which they found themselves in.
- Equipment on site was inadequate, for example there were no tourniquets or stretchers available, nor were there adequate supplies of haemostatic gauze and/or dressings.
- Some casualties describe the casualty clearing station as being chaotic and that triage was ineffective with some categorised incorrectly. Triage plays an important role and an improved triage system ([Ten-Second-Triage](#)) has since been adopted.

In the event of a terror related incident, patient care can be significantly delayed until the ambulance service is cleared to enter the ‘hot zone’. Internal first responders are likely to be in the hot zone to provide immediate triage and treatment, subject to them feeling safe to proceed and dynamically risk assessing the situation.

Therefore, this model, when embedded and managed effectively, has the potential to save lives and give better clinical outcomes to those injured, catastrophically or otherwise, and those who are sick. Buying time for your patients, and these could be students, staff members, visitors, contractors, members of the public or indeed anyone who frequents your premise, can be achieved through prompt and effective identification and interventions during the initial triage and primary survey assessment stages.

Legislation

The Health and Safety (First-Aid) Regulation 1981

The Health and Safety (First-Aid) Regulations 1981 require employers to provide adequate and appropriate equipment, facilities and personnel to ensure their employees receive immediate attention if they are injured or taken ill at work. These Regulations apply to all workplaces, including those with less than five employees and to the self-employed.

Employers are also required to carry out an assessment of first-aid needs. This involves consideration of workplace hazards and risks, the size of the organisation and other relevant factors, to determine what first-aid equipment, facilities and personnel should be provided.



With there being an increased risk of terrorism within the UK it is recommended that organisations consider the risk of terrorism when assessing first aid needs. They should also consider the risk of gang related violence, knife crime and the presence of complex medical needs within their organisation and then decide the equipment that is required and at what level staff members need to be trained.

Health and Safety at Work Etc. Act 1974

General duties of employers to their employees.

- (1) It shall be the duty of every employer to ensure, so far as is reasonably practicable, the health, safety and welfare at work of all his employees.

The Management of Health and Safety at Work Regulations 1999

Employers need to:

- Make arrangements for implementing the health and safety measures identified as necessary by the risk assessment
- Appoint competent people (often themselves or company colleagues) to help them to implement the arrangements
- Set up emergency procedures
- Provide clear information and training to employees
- work together with other employers sharing the same workplace.

Health Act 1999

Under section 18 of the Health Act 1999 those providing health care or indeed rendering treatment to their patients outside of the scope of First Aid at Work have a duty at common law to provide reasonable care and skill in providing medical treatment and other services. Under this section those who consider implementing a first response model must ensure that they put into place arrangements for monitoring and improving the quality of health care that they provide. A fundamental component will be the implementation of clinical governance arrangements within your organisation.

Social Action, Responsibility And Heroism Act 2015 (Sarah Act)

The core aim of the Act is to provide reassurance to people who act in socially beneficial ways, behave in a generally responsible manner, or act selflessly to protect someone in danger by ensuring that the courts recognise their actions and always take context into account in the event that something goes wrong and they are sued.

The Act is made up of four short clauses setting out how the courts should consider 'context' in negligence and statutory duty of care claims. It requires that the courts consider the following factors:

- Was the person acting for the benefit of society?
- Has the person demonstrated a predominantly responsible approach towards protecting the safety of others?
- Was the person acting heroically by intervening in an emergency to assist a person in danger?

Those working as a first responder within their organisation are not likely to be covered by the Social Action, Responsibility And Heroism Act 2015, and will therefore need to be covered by robust clinical governance and professional indemnity insurance.

Pre-Hospital Emergency Medicine Competency Framework

The Pre-Hospital Emergency Medicine (PHEM) Competency Framework was developed by **The Royal College of Surgeons of Edinburgh, The Faculty of Pre-Hospital Care** (RCSEd FPHC) to provide structure for the training and practice of pre-hospital emergency medicine. This framework was designed to define competencies and standardise training across different organisations.

The PHEM Competency Framework is used by NHS trusts, private medical providers, voluntary aid societies and other organisations who provide pre-hospital care such as the Police, Coastguard, Fire Service and Military.

PHEM Competency Framework Descriptors

Level	Description
A	First Aider (management of an unconscious, bleeding or arrested patient). Certificated by a non-national organisation.
B	First Level responder, nationally certified and qualified to meet statutory requirements within the work place eg EFAW, FAW.
Levels C to H will be operating within a framework of governance and CPD	
C	Nationally certificated pre-hospital responder (use of airway adjuncts & oxygen) eg Community First Responder.
D	Nationally certificated non-health care professional pre-hospital provider caring for patients as a secondary role eg Police Officers in Specialist Roles, Fire Service IEC, equivalent UKSAR trained personnel, Enhanced Community First Responder.
E	Nationally certificated non-health care professional pre-hospital provider caring for patients as a primary role eg UKSAR, some military personnel and specialist certificated police officers and firefighters.
F	Non-registered health care professional e.g. Ambulance Technician, CMT1.
G	Registered pre-hospital care practitioner.
H	Advanced registered pre-hospital care practitioner.

The framework can be found here:

<https://fphc.rcsed.ac.uk/media/2911/phe-competency-descriptors-and-framework.pdf>

Clinical Governance

Clinical Governance is most commonly found within patient facing clinical settings, such as hospitals, dentists, doctors surgeries and nursing homes.

Although most private and public sector settings do not provide patient care, it is important to note that when implementing a first responder model you are operating above the scope of First Aid at Work. For example, within first aid at work you are not trained in the administration of oxygen, clinical observations like pulse oximetry, or the use of airway adjuncts such as oral/nasal pharyngeal airways.

This is not to say that there is a need to move away from First Aid at Work, but it is important to note that First Aid at Work has its own scope of practice, and from an assessment of needs and risks you need to identify the

level of training and equipment needed which is relevant for your organisation. For example, the risk to an organisation that is primarily a small office with no public interaction could be considered small, and therefore a First Aid at Work course may be considered suitable.

If you are a larger organisation, say a Further Education provider that has approximately 4000 staff and students on site at any given time, including a large foundation department with complex needs students, and evidence shows that you are at an increasing risk of third-party violence, then your needs assessment may indicate the need of a higher level of care and training.

If you decide to implement an advanced level of first aid and integrate a first responder model within your organisation, you will need to ensure you have a suitable and sufficient framework in place so that you can demonstrate you are safeguarding high standards of care, and that you are creating an environment in which excellence in care will flourish, by ensuring review and improvement by way of continual monitoring and audit.

The main components of clinical governance are:

- clear lines of responsibility and accountability for the overall quality of clinical care;
- a comprehensive programme of quality improvement systems (including clinical audit, supporting and applying evidence-based practice, implementing clinical standards and guidelines, workforce planning and development);
- clear policies aimed at managing risk; and procedures for all professional groups to identify and remedy poor performance.

The 7 Pillars of Clinical Governance

Traditionally, clinical governance has been described using 7 key pillars. Although it has been refined over the past few years, this approach remains the easiest to remember, the 7 pillars are as follows:

- Clinical effectiveness and Research
- Audit
- Risk Management
- Education and Training
- Patient and Public Involvement (PPI)
- Using Information and IT
- Staffing and Staff Management



Clinical Effectiveness and Research

Clinical effectiveness means ensuring that everything you do is designed to provide the best outcomes for patients i.e. that you do "the right thing to the right person at the right time in the right place".

Audit

The aim of the audit process is to ensure that clinical practice is continuously monitored and that deficiencies in relation to set standards of care are remedied.

Risk Management

Risk Management involves having robust systems in place to understand, monitor and minimise the risks to patients and staff and to learn from mistakes. When things go wrong in the delivery of care, staff should feel safe admitting it and be able to learn and share what they have learnt.

Education and Training

This entails providing appropriate support available to enable staff to be competent in doing their jobs and to develop their skills so that they are up to date. Professional development needs to continue through lifelong learning.

Patient and Public Involvement

(PPI) PPI is about ensuring that the services provided suit patients, that patient and public feedback is used to improve services into day-to-day practice to ensure an increased level of quality and suitability, and that patients and the public are involved in the development of services and the monitoring of treatment outcomes.

Using Information and IT

This aspect of clinical governance is about ensuring that

- Patient data is accurate and up-to-date
- Confidentiality of patient data is respected
- Full and appropriate use of the data is made to measure quality of outcomes (e.g. through audits) and to develop services tailored to local needs.

Staffing and Management

This relates to need for appropriate recruitment and management of staff, ensuring that underperformance is identified and addressed, by encouraging staff retention by motivating and developing staff and by providing good working conditions

Governance Structure

Governance Structures should have both an internal and external steering group, a Clinical Governance Board monitors and manages your clinical governance framework.

It should be noted that you are not expected to create and manage your own clinical governance framework, but you will need to identify a provider who can create your clinical governance and scope of practice framework for you, and support you in the management and continual review and improvement of the framework.

It is important to identify a provider that possesses the knowledge and expertise in supporting you with the above requirement, don't be afraid to seek assurance as to this.

The reason governance is so important is that treatment rendered at this level has the potential for negatively impacting a patient's health if administered incorrectly, and by having a strong clinical governance and competency framework in place will ensure that you safeguard not only your patients health, but will in turn ensure you remain legally compliant and protected against any potential civil liabilities and/or negligence.

The First Responder Model

The implementation of a first responder model is relatively straightforward, but care and consideration need to be taken with regards to the key elements:

- Identifying a clinical governance and training provider
- Accountability for the clinical governance framework
- Identifying those to be trained as first responders
- Training Requirements and CPD
- Kit & Equipment
- Clinical Protocols
- Clinical Governance Committee
- Audits and Continual Review



It should be made clear that first responders **are not** paramedics, they are simply providing a higher level of care to a sick or critically injured patient until specialists arrive. The role of a first responder is to try to prevent worsening and stabilise the patient, and to take clinical observations in readiness to hand the patient over to the ambulance service.

Essentially, your first responders will become masters of time, every critically injured or sick patient has a “death clock” above their heads and each person's clock will tick differently depending on the extent of their injury and/or illness. The first responder should be able to identify those who are critically ill and/or injured and treat them in priority order in readiness for specialists to take over.

Identifying a Clinical Governance and Training Provider

There are many training providers that are able to deliver First Response Emergency Care (FREC) courses, however, not many are able to provide both the training and the clinical governance framework needed to effectively support and manage your first responder model.

There are a number of training providers that are also Care Quality Commission (CQC) registered ambulance services, providing event medical cover and supporting NHS Trusts. These organisations should have in place their own clinical governance framework for the activities they are undertaking, and as such may be willing to support you in creating and managing your own.

This is by far the most challenging of the steps needed to implement an effective first responder model, and it does take time; however, it is the most important and as such it needs great care and attention as your patient's safety has to be your number one priority.

I would recommend that you meet with a number of providers, discuss the training and the services that they offer and enquire whether they can provide both the training, the governance, scopes of practice and continual review and audit. Our chosen provider is [Ambutech Pre-Hospital Care](#).

Past experience has shown that there will usually be a cost to set up your Governance Framework but your provider should be able to write your Clinical Governance Policy and Scope of Practice as part of the initial set up. It's important to note that these should be bespoke to your organisation.

There will be an ongoing cost dependant on the size of your organisation, these ongoing costs could include:

- Ongoing support for your organisation.
- Debriefs with first responders when they have attended any serious illness or critical injury, for example if a first responder performs CPR on a patient, has been involved in an incident where a patient has died, or has attended a major incident just to name but a few. This is to ensure both parties can review the incident whilst it is still fresh in the minds of those who responded and to document further recommendations if necessary, its aim should also give support and reassurance to those who have attended and to answer any questions that they may have.
- Continuous Professional Development (CPD) – your provider should provide a number of CPD days throughout the year to your first responders. Depending on the nature of your business, your first responders may attend very few incidents, therefore there is a risk of memory fade which can present a risk to patient safety.
- Continual Audits of your Patient Report Forms and continual feedback.
- On site Audits.
- Governance Committee Meetings, the frequency will be determined by the nature of your business.

Accountability for the Clinical Governance Framework

Once you have identified an external provider for your governance and training, you must ensure that someone is given responsibility for managing your first responders and framework internally.

Depending on the size of your organisation, and the frequency of incidents attended, the time needed to manage your internal governance framework could range from a couple of hours each week to needing to have someone manage it full time.

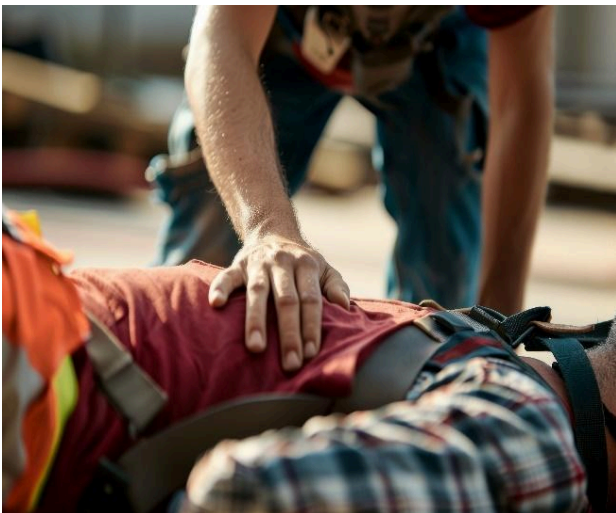
Your clinical governance provider should undertake continual audits of your Patient Report Forms (PRF's) and should give feedback to you on a regular basis. As such, the nominated person will need to ensure they upload redacted PRF's to whatever platform your provider uses in a timely manner so that your provider can monitor, review, audit and feedback as required.

These audits should be risk rated as low, medium, or high risk of patient safety being compromised, and as such corrective action may need to be taken so that lessons are learnt and that there is a prevention of future recurrence.

By nominating a responsible person internally, it will ensure accountability and that lessons learnt are properly disseminated within the team, and feedback is then given to those involved. This should also be documented as an action plan so that both you and your clinical governance team (internally and externally) are able to see what action has been taken.

Those responsible for managing clinical governance internally should also be trained in first response emergency care themselves as they will have detailed knowledge and understanding of the role and the expectations in line with the training and the Governance and Scope of Practice. You can also ask your provider for additional training for those who have been given responsibility for managing the framework internally which will then give further reassurance to your organisation and to those supporting you externally, this could be for example a FREC 4 course.

Identifying Those to be Trained as First Responders



Those wishing to be First Responders within your organisation should ideally already have a first aid at work qualification, and should possess a strong knowledge of first aid.

Most importantly is that those who you appoint must want to do it, forcing people into a role that they don't want to do could lead to an unwillingness to attend when needed. They ideally should feel passionate about first aid, are willing and eager to help, and show kindness and compassion towards those that they encounter and treat.

The Quallsafe Level 3 Award in First Response Emergency Care (FREC 3) course is designed for those seeking a career in the event medical and security sector or those who work in high risk workplaces, it covers the full range of skills required by the HSE for first aid, and is an informative, hands-on 5-day course which fulfils the competencies set out in the PHEM competency framework at descriptor level D, providing the knowledge and practical skills needed to deal with a range of prehospital emergency care situations.

There are a number of practical elements to the course but also a number of exams and as such candidates can fail, therefore care and consideration should be taken towards appointing first responders, again your provider may help with the vetting process.

First responders will need to be given time to fulfil their role, so consideration also needs to be taken towards whether you are able to commit to being able to give them the much-needed time each year for CPD and initial training, as some roles within an organisation are easier to give that time as opposed to others.

Training Requirements

The exact training requirements of your first responders will depend on your organisation, its risks and the skills you wish your first responders to have.

Our First Responders complete the following training:

- [Qualsafe Level 3 Award in First Response Emergency Care \(FREC 3\)](#) – 5 days and to be refreshed every 3 years.
- [Qualsafe Level 3 Award in Administering Emergency Medical Gases](#) – typically half a day and to be refreshed annually, can be added as a bolt-on to the FREC 3.
- Clinical Observations for First Responders, a CPD accredited course to include Blood Pressure and Blood Glucose which aren't included in FREC 3 – typically half a day.
- Patient Report Form (PRF) Writing, a CPD accredited course to ensure the first responders document any patient contact thoroughly and accurately – typically half a day.

Total: 6-7 days

If you decide to hold medications such as Adrenaline, Aspirin, Naloxone and Salbutamol, there will be a requirement for additional training in their use, your provider should be able to advise you on what further training your first responders may require, in all cases where medication is held, you need to have a framework of clinical governance in place.

Be cautious if providers try to include some additional elements within your FREC 3 course as there is a risk that other units could be compromised, and you could be liable if you did something your qualification doesn't cover, for example taking a blood pressure or blood glucose measurement does form part of the FREC 3 syllabus.

There should be a programme of Continuous Professional Development then made available to your First Responder team to run throughout the year, typically you want all First Responders to attend no less than 4 days per year and each day can focus on different elements of the above, or it could be used to focus on lessons learnt from a previous incident. Remember that one of your annual CPD days will be spent completing the Level 2 Award in Basic Life Support (BLS) for Adults and Children and refreshing the Level 3 Award in Administering Emergency Medical Gases.

Some providers may also try and advocate that some of your team complete the [Level 4 Certificate in First Response Emergency Care \(FREC 4\)](#) once they have completed their FREC 3, as there is then no need to refresh a FREC 4 every 3 years, nor is there a need to refresh the Level 3 Award in Administering Emergency Medical Gases once a FREC 4 qualification has been achieved. A word of caution though, FREC 4 is a significant jump from FREC 3, you must have good knowledge and understanding of FREC 3 skills before even considering it. You are also required to complete 118 hours of CPD following your FREC 3 prior to being allowed to complete FREC 4. It's also worth noting that those who are trained at FREC 4 level must complete an annual [Level 4 Award in Out of Hospital Adult Immediate Life Support \(ILS\)](#) course, and maintain a suitable CPD portfolio for their qualification to remain valid.



Continuous Professional Development (CPD)

First responders are unlikely to be exposed to instances of ill health, medical emergencies, injuries and major trauma on a day to day basis, and therefore there is a significant risk of skill fade for first responders working outside of the pre-hospital care sector.



There are a number of benefits with regards to maintaining CPD for all first responders:

- Skill Enhancement - CPD allows first responders to continually update and expand their skills, ensuring they are well-equipped to handle the latest challenges that they may face. Importantly, lessons learnt from your internal audits may form part of your programme of CPD and this will ensure lessons are learnt and that you maintain the highest level of patient care.
- Improved Safety - Regular training and development will help first responders stay informed about the latest safety protocols and best practices, reducing the risk of injury and enhancing overall patient safety.
- Increased Confidence - Continuous learning boosts confidence, enabling first responders to perform their duties more effectively and with greater assurance which will again have an impact on overall patient safety within your organisation.
- Enhanced Public Trust - Well-trained first responders who engage in CPD are often seen as more competent and trustworthy, which is crucial for maintaining support and cooperation.
- Compliance with Regulations - Many first responder roles require ongoing education to comply with regulatory standards, ensuring that first responders meet necessary certification and insurance requirements.
- Adaptability - CPD helps first responders adapt to new roles, responsibilities, and changes in practice, making them more flexible and capable of handling diverse situations.
- Job Satisfaction - Engaging in CPD can lead to greater job satisfaction by providing a sense of accomplishment and recognition for personal and professional development efforts.

Equipment

The equipment you carry should be reflective of the training your first responders have undertaken and their scope of practice. You should consult your provider prior to purchasing any equipment to avoid spending money unnecessarily on kit that cannot be used.

Response bags should ideally be laid out in a format that maintains standardisation across the organisation, this is especially important if you have more than one, again a needs assessment should help you determine the amount and type of equipment needed.



As a guide, Kirklees College holds the following equipment:

Airway & Breathing
Oxygen Cylinder
Bag Valve Mask (BVM)
Adult and Paediatric Oxygen Masks
Oropharyngeal Airways (OPAs)
Nasopharyngeal Airways (NPAs)
Lubricating Jelly
Manual Suction

Trauma
Celox Z Fold Gauze
Trauma Dressings
Tourniquets
Non-Occlusive Chest Seals
Compressed Gauze
Pelvic Splint
Tuff Cut Shears

Observation
Pulse Oximeter
Blood Pressure Monitor
Blood Glucose Monitor
Tympanic Thermometer
Spare Batteries
Sharps Box

Wound Care
Burns Dressings
Cling Film
Triangular Bandages
Dressings & Bandages
Plasters
Saline Wipes
Sterile Gauze Swabs
Saline Eye/Wound Wash
Micropore Tape

Medication
Adrenaline Auto-Injector (Epi-Pen)
Aspirin
Glucose Oral Gel
Naloxone Nasal Spray
Salbutamol Inhaler

Entonox / Nitronox
Nitronox Cylinder
Nitronox Giving Set & Demand Valve
Nitronox Mouth Pieces with Filter

Clinical Protocols

All first responders who operate within your organisation need to follow a set of clinical protocols. You can write these yourself, but most pre-hospital care organisations and NHS trusts follow the Joint Royal Colleges Ambulance Liaison Committee (JRCALC) guidelines.

JRCALC develops and maintains clinical guidelines for UK NHS ambulance service paramedics on behalf of the Association of Ambulance Chief Executives (AACE).

JRCALC guidelines are available as a pocket book or as an app for Apple and Android devices. The pocket book is published once every three years and during that time there are a number of updates, as such the book is rarely up to date and we find the app is a much better solution. All first responders have access to the app on their phone and use it to take reference from when responding to any incident. You will need to purchase a subscription for each device through Class Publishing.

The AACE JRCALC iCPG app is designed for paramedics, and may be overwhelming to those not familiar with the world of pre-hospital care. Class Publishing has developed a similar app called Responder Plus which is primarily written for first responders. Which app you choose will depend on the level of training and scope of practice of your first responders. Your provider will be able to help you with this.

Further information with regards to annual subscriptions for your first responder team can be sought by emailing Class Publishing: class@classpub.co.uk

Clinical Governance Committee

The purpose of the Clinical Governance Committee within your organisation is to monitor and review the clinical governance activity being delivered, and to provide assurance to stakeholders that the mechanisms are acceptable. The Committee oversees activities in relation to the development and delivery of the Clinical Governance Framework.

The Clinical Governance Committee should be made up of senior members from both your and your clinical governance providers organisations, this could be structured as follows:

- Head of Health and Safety from your organisation
- Designated Safeguarding Lead from your organisation
- Director of Human Resources from your organisation

- Managing Director of the clinical governance provider
- Education Lead from the clinical governance provider
- Designated Safeguarding Lead from the clinical governance provider
- Clinical Governance Lead from the clinical governance provider (this should be a registered health care professional with relevant industry knowledge and experience)



The frequency of committee meetings may vary, but will be relevant to the level of risk and activity within your organisation. As a guide, some committees will seek to meet on a monthly basis and some may feel that quarterly is suitable and sufficient.

Audits and Continual Review

As described within the Principles for Best Practice in Clinical Audit (2002, NICE/CHI):

“Clinical audit is a quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria...Where indicated, changes are implemented...and further monitoring is used to confirm improvement in healthcare delivery.”

When first responders attend an incident, they will perform a clinical assessment within their defined scope of practice, they take clinical observations such as blood pressure, blood glucose, pulse oximetry, pulse rate and respiratory rate, and as such these will be recorded on a Patient Report Form (PRF). They will then need to decide on the best course of action, provide care within their scope of practice and then signpost to the appropriate care, for example the patient may be conveyed directly to hospital via ambulance, they may be advised to visit their GP, or they may indeed be sent home with advice given to the patient so that they are able to identify any signs of worsening. In all instances the observations, treatment and disposal need to be recorded within a Patient Report Form. These reports should be redacted and uploaded to your provider's platform of choice, and then audited. Action plans should be created where required, and actions taken documented which need to be continually reviewed by both the internal and external clinical governance team.

In addition to PRF audits, your provider should conduct a site visit, usually annually, to ensure the systems created within the governance framework are being adhered to and are fit for purpose.

Remember your provider is there to support you to deliver the best possible patient care, not to try and catch you out.

Conclusion

Implementing an internal first responder model is the gold standard for organisations with increased risk. Ensuring that first responders are supported by a structured framework of clinical governance enhances the safety, effectiveness, and reliability of the care they provide. This structured approach is essential not only for meeting legal and professional standards but also for fostering a culture of continuous improvement and accountability.

While the implementation of clinical governance is relatively straightforward, the most challenging aspect lies in identifying a reliable and trustworthy provider. This provider will be instrumental in setting up and maintaining the governance framework, ensuring the highest standards of training and practice. Once a good provider is found, their expertise and support will transform the organisation's emergency response capabilities, making it one of the best decisions an organisation can make.