Luca Safe Concussion Framework - Clubs (LSCF-C)

Version 1.0.1 | August 2026 | Published by **Luca Health**

What is the Luca Safe Concussion Framework for Clubs

Head injuries in community sport are under more scrutiny than ever, and the regulatory expectations placed on clubs have risen sharply. Unlike schools, most clubs are volunteer-run, operate across multiple sites and age groups, and share their players with schools, colleges, universities and representative squads. This makes consistent concussion management harder — and more important.

LSCF-C offers a comprehensive, evidence-based structure for managing concussion within a community sports club. It is designed for club committees, RugbySafe Leads, safeguarding officers, first aiders, coaches and team managers, and establishes clear, actionable standards across every stage of concussion prevention, recognition, management and recovery.

The framework is aligned with:

- RFU Regulation 9 (Player Safety) and the RugbySafe programme
- The RFU HEADCASE programme and the Graduated Return to Activity and Sport (GRAS) protocol
- The UK Concussion Guidelines for Grassroots Sport
- The RFU Pitch Side Care Standards (PSCS)

Where a club's national governing body sets a higher standard than this framework, the NGB standard takes precedence.

The framework is organised into eight key domains:

- Governance and Regulatory Compliance — Committee-approved policy, named accountable roles, and demonstrable compliance with NGB player safety regulations.
- Education and Training — Role-based, refreshed annually, with completion tracked.
- Pitch-Side Provision and Emergency Preparedness — First aid cover, equipment, AED, and a tested emergency action plan.
- Reporting and Communication — Timely, structured, GDPR-compliant recording and escalation.

- Clinical Management — Recognise-and-remove, healthcare professional review, and a governed graduated return.
- Return-to-Learn, Work and Education Liaison — Coordination with schools, employers and families during recovery.
- Cross-Organisation Duty of Care — Managing players who represent multiple organisations.
- Technology, Quality Assurance and Futureproofing — Digital systems, audit, feedback and benchmarking.

By adopting this framework, clubs meet their regulatory and duty-of-care obligations while demonstrating a proactive commitment to player welfare, volunteer confidence and the long-term health of their membership.

Intended Audience

- Club Chairs, Committees and Boards
- Club RugbySafe Leads (or equivalent player welfare lead)
- Club Safeguarding Officers
- Emergency First Aiders and Immediate Care Practitioners
- Head Coaches, Coaches and Team Managers
- Club Medical and Physiotherapy Staff
- Match Officials
- Parents, Guardians and Adult Players
- Constituent Body / County / League Player Welfare Officers

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1. Governance and Regulatory Compliance

1.1 Club Concussion Policy

- Every club should have a written, committee-approved concussion policy, publicly accessible via the club website and shared with all members at registration.
- The policy should be reviewed annually and updated in line with the latest NGB and UK-wide guidance.
- The policy must define roles and responsibilities across all tiers: committee, welfare lead, coaches, team managers, first aiders, medical staff, parents and players.
- Explicit guidance should be provided for training sessions, match days, away fixtures, tours, festivals and tournaments, and social or non-contact formats.

1.2 Named Accountability

- The club should appoint a **Club RugbySafe Lead** (or equivalent player welfare lead) with delegated responsibility for concussion policy, first aid provision and injury reporting. Clubs should identify a Club RugbySafe Lead to ensure the club meets its responsibilities for the welfare of players and is compliant with Regulation 9. England Rugby
- Contact details for this role should be kept current on the club's Game Management System (GMS) profile or NGB equivalent.
- The welfare lead should report to the club committee at least termly, with concussion incidents and compliance status as a standing agenda item.

1.3 Regulatory Compliance and Risk Assessment

- The club must complete an **annual first-aid-focused risk assessment**. This must be undertaken each season between the beginning of July and the end of September, and the club's RugbySafe and Player Welfare GMS profile must be kept up to date, especially the risk assessment completion date. England Rugby
- Additional risk assessments should be completed for multi-site training, tournaments and festivals with simultaneous games, and age-grade camps spanning multiple age groups.
- A **live risk assessment** must be completed if minimum provision standards cannot be met on the day, before any activity is allowed to proceed.
- Complete incident documentation must be maintained for audit, insurance and legal defensibility.

1.4 Insurance, Indemnity and Data

- The policy should confirm insurance and indemnity arrangements for first aiders, immediate care practitioners, contractors and visiting practitioners.
- Where a healthcare professional provides cover, the club should verify that their qualifications are relevant and current, that they are licensed and registered with the applicable regulatory body, and that appropriate insurance is in place; a written agreement setting out roles and responsibilities is recommended. England Rugby
- The policy must set out GDPR compliance for handling concussion-related health data, including lawful basis, consent for information sharing, retention periods and secure storage.

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2. Education and Training

2.1 Baseline Awareness for All

- All coaches, team managers, first aiders, match officials and committee members with player-facing responsibility should complete recognised concussion awareness training **annually**. The RFU recommends that first aiders and all relevant volunteers and individuals complete the HEADCASE concussion awareness module on an annual basis. England Rugby
- Training should cover: what concussion is, how it presents, red flags, immediate removal and management, prevention strategies, and the graduated return process.
- A digital record of completion should be held centrally and monitored by the welfare lead.

2.2 Role-Based Training

- Training should be tailored to role. HEADCASE eLearning is available in versions for coaches of adult players, adult players, coaches and teachers of age grade players, parents and guardians of age grade players, age grade players (U13–U18), and match officials. Keepyourbootson
- Clubs should set an internal expectation that no coach takes a session, and no first aider covers an activity, without current concussion training.

2.3 First Aider Qualification and Refresher

- The minimum qualification for an appointed first aider is a Level 3 or equivalent first aid qualification, such as Emergency First Aid at Work, delivered by a provider accredited with a recognised awarding body and recognised on the Regulated Qualifications Framework. England Rugby
- Level 3 first aid qualifications are valid for three years, with annual refresher training recommended in between; the England Rugby First Aid in Rugby Union (FARU) CPD series provides free online modules for this purpose. England Rugby
- Course content should as a minimum cover primary survey, CPR and AED, wounds and external bleeding, seizures, minor injuries and shock, and it is highly recommended that it also covers concussion and head injuries, suspected fractures and suspected spinal injuries. England Rugby
- Clubs should ask all appointed first aiders to self-certify their qualifications on their GMS profile so the club can monitor qualified numbers and renewal dates. England Rugby
- Note that the RFU no longer delivers face-to-face first aid training and clubs are expected to source training independently from local or national providers. Club policies referencing EFARU as a required course should be updated. Crfu

2.4 Player and Parent Education

- Concussion awareness should be built into pre-season briefings for every squad, adult and age grade.

- Parents and guardians of age grade players should receive concussion information at registration and be signposted to the relevant awareness module.
- Clubs should provide openly accessible information covering, at minimum: general concussion information, the graduated return to activity and sport protocol, return-to-learn and return-to-work guidance, and an overview of the club's own concussion provision.
- For any player with a suspected or confirmed concussion, the club should provide the player and, for age grade players, their parent or guardian with written guidance on symptoms, recovery expectations and warning signs to monitor.

2.5 Safeguarding Interface

- Volunteers working frequently or unsupervised with age grade players in a first aid capacity should hold a current DBS check, as required by NGB safeguarding policy.

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3. Pitch-Side Provision and Emergency Preparedness

3.1 Minimum First Aid Cover

- Clubs must meet the applicable **Pitch Side Care Standards** for every training session and match, unless the annual risk assessment justifies a different level. The PSCS set out the minimum first aid and immediate care provision required under Regulation 9 for the recognition, assessment and immediate management of potential life- and limb-threatening injuries during organised training and matches. England Rugby
- For training sessions, provision is based on a ratio of approximately one first aider to 40 players; where a first aider covers more than one group, proximity of the groups must be considered in the risk assessment, and larger groups may require additional first aiders. England Rugby
- Where the standard is one first aider per match, the home club is responsible for organising the cover, and both clubs should discuss a pitch-side first aid plan as part of pre-match communications. England Rugby
- One first aider per team, rather than per match, is recommended as best practice: it provides a safer experience and reduces stoppages. England Rugby
- At the higher levels of the community adult game, the standard includes a Level 2 Immediate Care Practitioner per team; for age grade representative rugby it includes a Level 2 ICP per match. Clubs should confirm the exact requirement for their level and season directly against the current RFU standards. England Rugby
- Ideally the appointed first aider should be a dedicated role — acting solely as first aider, not doubling as a coach. England Rugby

3.2 Medical Emergency Action Plan (MEAP)

- Every club should have a Medical Emergency Action Plan setting out a simple, safe and systematic approach for emergencies, including ensuring ambulance access is available and access points are kept free of parked vehicles and other obstructions. England Rugby
- The MEAP must be effectively communicated to all first aiders, coaches and anyone who would be involved in managing an incident. England Rugby
- The MEAP should be venue-specific, reviewed annually, and rehearsed at least once per season.

3.3 Equipment and Facilities

- Each first aider should be equipped with a personal first aid kit, with a central, fully stocked kit held at the venue; a match-day medical point should be designated and clearly marked, and a dedicated first aid room provided where practicable. England Rugby
- It is highly recommended that all clubs have an AED on site, easily accessible, correctly stored and regularly maintained. England Rugby
- Where additional equipment such as stretchers is used, appropriately trained individuals must be available. England Rugby
- Concussion recognition cards and pitch-side reference materials should be present in every first aid kit and displayed in changing rooms and on club noticeboards.

3.4 Immediate Care Practitioners

- Being a healthcare professional does not in itself qualify someone for the ICP role; HCPs can only provide ICP cover if they have attended specific immediate care training. England Rugby
- The RFU's Pre-Hospital Immediate Care in Sport (PHICIS) Level 2 is a three-day course aimed at HCPs working in the community game, with accreditation lasting two years; other courses are accepted if endorsed by the Faculty of Pre-Hospital Care and appropriate for sport. England Rugby
- Hospital-based ATLS or ALS courses do not meet this standard. England Rugby

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4. Reporting and Communication

4.1 Incident Notification

- Any suspected concussion should be logged at the point of removal from play, not retrospectively.
- A secure system should alert key stakeholders within **30 minutes** of a logged incident — including, as applicable, the player, parents or guardians of age grade players, the coach, the welfare lead, and any other organisation the player represents.

- A structured reporting template should capture time, location, mechanism of injury, observer account, signs and symptoms observed, and immediate action taken.

4.2 Full Incident Report

- A complete incident report should be filed digitally within **24 hours**, with all supporting documentation.
- Reports should be reviewed and countersigned by the club welfare lead or designated medical lead.
- Where a potential insurance or personal injury claim may arise, factual witness statements should be collected, signed and dated, and stored securely; statements must confine themselves to fact and not include opinion, hearsay, or apportion or infer blame. England Rugby

4.3 Regulatory Escalation

- Clubs must understand the distinction between internal injury recording and formal NGB reportable events. An RFU reportable event is defined as an injury resulting in the player being admitted to hospital, or a death occurring during or within six hours of a game finishing; it does not include attendance at A&E where the player is then allowed home. England Rugby
- For a reportable event, the club should provide immediate first aid and arrange ambulance transfer as needed, complete the online Reportable Injury Event Form, contact the RFU Injury Reporting Helpline (0800 298 0102) once the seriousness of the condition is confirmed and certainly within 48 hours, notify the insurance provider, and collect and securely store witness statements. England Rugby
- Clubs should check whether their Constituent Body or county imposes additional concussion reporting requirements and timescales.

4.4 Unified Record System

- The club should operate a single, secure platform for incident logging, recovery tracking and clearance, with role-specific access for the welfare lead, coaches, first aiders, medical staff, players and parents.
- The recording process must be GDPR compliant, with all records stored appropriately and securely, and every first aider must be aware of and have access to the process. England Rugby
- Every action, comment and update should generate an audit trail.
- The club welfare lead and any club medical staff should have secure access to the full incident record: mechanism of injury, assessment outcomes, clinician notes, current GRAS stage and scheduled follow-up.

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5. Clinical Management

5.1 Recognise and Remove

- Any player showing any sign or symptom of a suspected concussion must be **immediately and permanently removed** from play or training and must not return that day. This applies at every level of the community game, with no exceptions and regardless of the player's or parent's wishes.
- There is no formal in-match head injury assessment in the community game — the decision to remove is made on suspicion alone, by anyone present. England Rugby
- The Concussion Recognition Tool 6 (CRT6) can be used by anyone, including non-healthcare professionals, for the identification and immediate management of a suspected concussion; it is not designed to diagnose concussion. Staffs Rugby
- Red flag symptoms require urgent medical assessment, on site or at an emergency department, via emergency ambulance if necessary.

5.2 Healthcare Professional Review

- Anyone suspected of sustaining a concussion should be assessed by an appropriate healthcare professional, or call 111, within 24 hours of the injury. World Rugby
- Where symptoms persist beyond 28 days, the player should see an appropriate healthcare professional. World Rugby
- SCAT6 and SCAT6 Child are standardised assessment tools for use only by appropriately trained healthcare professionals — SCAT6 Child for ages 8 to 12 and SCAT6 for ages 13 and over. They should not be administered by coaches or first aiders. Staffs Rugby

5.3 Graduated Return to Activity and Sport (GRAS)

- Every confirmed or suspected concussion must be managed through a documented graduated return protocol. This is a minimum of 21 days for all community rugby players, across a phased approach of six stages. Keepyourbootson
- The stages progress from initial relative rest in the 24 to 48 hours after concussion; to return to daily activities and light physical activity; aerobic exercise and low-level body-weight resistance training; rugby-specific non-contact training drills and weight resistance training no earlier than Day 8; full contact practice no earlier than Day 15; and return to play no earlier than Day 21. Bridportrugby
- The earliest a player should return to competition is 21 days, and only if they have been symptom free for the preceding 14 days. World Rugby
- A player does not need to be symptom free to progress between the earlier stages, provided they have been at their current stage for a minimum of 24 hours and the current activity level is not making symptoms significantly worse. Richmondfc
- The club should hold a documented record of each stage completion, dated, with the name of the person confirming progression.

- Return-to-education or return-to-work should be complete before unrestricted return to sport is contemplated.

5.4 Baseline and Post-Injury Testing (optional)

- Baseline neurocognitive testing is not required at community club level and should not be treated as a substitute for the GRAS protocol.
- Clubs with the clinical capacity to do so may offer baseline and post-injury neurocognitive or vestibular-ocular motor screening as an additional input to clinical decision-making, provided it is administered and interpreted by appropriately qualified personnel.

5.5 Referral Network

- The club should hold a documented referral pathway with named local providers: GP practices, urgent care, and concussion-experienced clinicians.
- Clubs should be able to signpost players and families to appropriate specialist services when symptoms persist or recovery is atypical.
- Referral pathway contacts should be reviewed annually.

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6. Return-to-Learn, Work and Education Liaison

6.1 Recognising the Club's Position

- Clubs do not control a player's classroom or workplace, but they are frequently the first to know about a concussion. The club's obligation is to inform, coordinate and avoid undermining recovery elsewhere.

6.2 Age Grade Players

- Where an age grade player sustains a concussion at the club, the club should, with parental consent, notify the player's school or college so that return-to-learn adjustments can be put in place.
- Parents should be provided with written guidance they can pass directly to the school, including the injury date, current stage, and expected timeline.
- Coaches must not clear a player to return to contact training before the player has fully returned to normal educational activity.

6.3 Adult Players

- Adult players should be given return-to-work guidance and signposted to occupational health where relevant, particularly for safety-critical occupations such as driving, construction, and emergency services.

6.4 Symptom Monitoring

- Players should complete a structured symptom self-report at least weekly throughout recovery, and daily during the first week where practicable.
- Persistent mood change, anxiety or low mood during recovery should trigger a signpost to appropriate mental health support. Clubs should hold contact details for local and national services.

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7. Cross-Organisation Duty of Care

7.1 The Multi-Team Player

- Clubs must assume that many of their players — particularly age grade players and students — also play for a school, college, university or representative squad. The 21-day protocol applies to the **player**, not to any single organisation.

7.2 Registration Disclosure

- At registration, players and parents should be asked to declare all other teams or organisations the player represents, with contact details.
- Registration should include consent to share concussion-related information with those organisations for player safety purposes.

7.3 Notification Obligations

- On any suspected concussion, the club should notify every other organisation the player represents within 24 hours, subject to consent.
- On receiving notification of a concussion sustained elsewhere, the club must log it, stand the player down, and track the GRAS protocol as if the injury had occurred at the club.
- Where a player, parent or another organisation disputes the stand-down, the club's decision to hold the player out prevails. No player returns to contact at the club before the club is satisfied the protocol has been completed.

7.4 Match Day Verification

- Coaches and team managers should confirm before every fixture that no selected player is within an active return protocol.
- Match officials should be supported in removing any player they suspect of concussion, and the club should never contest such a decision on the day.

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8. Technology, Quality Assurance and Futureproofing

8.1 Digital Management Platform

- Clubs should move away from paper-based first aid books and WhatsApp threads to a centralised, secure digital system covering incident logging, recovery tracking, notification and analytics.
- The system should include automated stage reminders, escalation flows, and prompts for healthcare professional review at key points.
- Records must be retained in line with the club's GDPR retention schedule and remain accessible for audit and insurance purposes.

8.2 Training and Compliance Tracking

- The club should be able to produce, at any time, a current register of qualified first aiders with expiry dates, concussion training completion by role, the date of the last first aid risk assessment, and the status of all open concussion cases.

8.3 Wearable Safety Technology (optional)

- Clubs may pilot the use of impact sensors, instrumented mouthguards or headgear in higher-risk squads.
- Any such technology should be positioned as supplementary. It does not diagnose concussion and must never override recognise-and-remove.

8.4 Predictive Risk Analytics (optional)

- Anonymised incident data may be used for trend analysis and prevention planning, with key indicators including activity type, session type, age group, time of day and pitch location.

8.5 Annual Audit

- The club should conduct an annual internal or third-party audit of concussion policy compliance and incident trends, including case sampling, policy alignment against current NGB guidance, and stakeholder interviews.
- Audit findings should be reported to the club committee with a dated action plan.

8.6 Feedback and Improvement

- Anonymous feedback should be sought from players and parents following any concussion case.
- Findings should be consolidated into an annual player welfare report presented to the committee and made available to members.

8.7 Benchmarking

- Clubs are encouraged to participate in county, regional or national benchmarking initiatives and to contribute de-identified data to research collaborations.