MEDICAL STANDARDS

2023

RUGBY FOOTBALL LEAGUE

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i. SCOPE OF MEDICAL STANDARDS

The purpose of these Regulations is to protect the health and well-being of professional players. These Regulations are to be interpreted and applied by reference to and in a manner that advances this purpose and when an issue arises that is not expressly provided for in these Regulations the interpretation and application shall be consistent with the purpose of these Regulations.

The Medical Standards is a RFL Policy which is binding on all Persons Subject to the Operational Rules (as set out in Section A1 and C2 of the RFL Operational Rules).

All Club Medical Staff are bound by these Medical Standards and are expected to be fully conversant with the contents. Failure to comply with Mandatory elements of this Policy constitutes Misconduct under section D1 of the Operational Rules.

The medical information contained is a minimum standard. It is not a substitute for medical and clinical Best Practice. The RFL does not warrant that information provided will meet the health or medical requirements of each individual case. Medical practitioners should use their knowledge and experience to ensure that they fulfil their duty of care to a player

The listed areas of these medical standards set out are for guidance purposes, they are not a substitute for the Operational Rules.

ii. NOTE ON TERMINOLOGY

In these Medical Standards where the following terminology is used next to each sub heading e.g. A1, B2 it applies to the whole of that sub heading e.g. A1.1, A1.a etc.

MANDATORY - required under the RFL Operational Rules and failure to comply constitutes Misconduct.

BEST PRACTICE - recommended for all clubs subject to resources available.

FOR INFORMATION ONLY - no action required.

FULL TIME CLUB – for the purposes of these Medical Standards a Full Time Club is one which is not playing in Super League but has budgeted to spend (or is spending) £750,000 or more on players' contracts for the applicable season.

SECTION A

MEDICAL PERSONNEL

A1 MEDICAL STAFF REGISTRATION WITH THE RFL - MANDATORY

All Medical Staff working (or volunteering) at Clubs (including those providing locum cover at short notice) who are, or may be, involved in giving treatment or advice to Players within a professional Club environment (training and/or match days) must be registered with the RFL (on a Clubs GameDay account with qualifications and contact details to be included).

Clubs must ensure that:

- Ensure that the club has a team of correctly qualified and registered medical staff present at all home and away fixtures
- Ensure that correctly qualified and registered medical staff are available for all fixtures
- Ensure that the first aid provision at training sessions meets the Medical Standards

A2 DEFINITIONS OF MEDICAL STAFF TERMS USED IN THESE STANDARDS

DEFINITIONS

Doctor	**A Doctor must:** • hold a current license to practice with no restrictions and be fully registered with the GMC be in current practice • not be under any investigation or period of suspension with the GMC • possess the appropriate professional indemnity insurance for working in sport • hold a current IMMOFP qualification or *alternative qualification recognised by the RFL *It is Best Practice to hold a Diploma in Sports Medicine or equivalent/ higher.*
Physiotherapist	**A physiotherapist must:** (i) hold a degree in physiotherapy (and is not under investigation or suspension period) with CSP and HCPC registration (ii) hold a current IMMOFP qualification or *alternative qualification recognised by the RFL.
Advanced Nurse Practitioner (ANP)	Clubs or medical service providers **must apply for permission** (**applications will be considered by the Chief Medical Officer and IMMOFP Course lead whose decision is final**) on an individual basis to use an ANP who may only be used as set out below: **An ANP must:** i) be fully registered with the NMC and meet revalidation requirements ii) not be under investigation or suspension period iii) have evidential proof of an Advanced Practice MSc have evidence of twelve months' relevant experience in an acute setting, preferably A&E or minor injuries

	iv) have appropriate professional indemnity insurance for working in sport **v)** hold a current IMMOFP qualification. *vi) It is Best Practice to hold a current Advanced Life Support or Advanced Trauma Life Support certification*
Paramedic	Clubs or medical service providers **must apply for permission** (**applications will be considered by the Chief Medical Officer and IMMOFP Course lead whose decision is final**) on an individual basis to use a Paramedic who may only be used as set out below. **A Paramedic must**: • hold an BSc or HND/Foundation degree in Paramedic Science • registered with the HCPC • not be under investigation or suspension period • have evidence of 12 months or more experience in an acute setting • have appropriate professional indemnity insurance for working in sport • hold a current IMMOFP qualification.
Sports Therapist	**A graduate Sports Therapist must:** • hold a BSc in Sports Therapy • Be registered as a member with a professional body such as Society of Sports Therapists *or* Sports Therapy Association *or* Sports Therapy Organisation *or* Federation of Holistic Therapists • have appropriate professional indemnity insurance for work in sport • hold a current IMMOFP qualification. **NB: A Sports Therapist who is applying for IMMOFP for the first time and holds no existing or recently expired equivalent qualification (within 12 months) must:** **- hold a qualification of ITMMiF L4 (Football Association Qualification) or PHICIS L2 (Rugby Football Union Qualification) and** **- must be supervised by a Physiotherapist for one year's full time (or two part time) experience in a professional or lottery funded environment.** **Holding only ITMMiF L4 or PHICIS L2 qualification does not permit a Sports Therapist to provide on field medical game cover. IMMOFP or equivalent qualification must be held.** **Evidence of the above should be submitted to the RFL for consideration by the Chief Medical Officer and IMMOFP Course lead.**
Sports Rehabilitator	**A graduate Sports Rehabilitator must:** • hold a BSc Sports Rehabilitation • be a member of BASRAT • have appropriate professional indemnity insurance for work in sport • hold a current IMMOFP qualification. **NB: A Sports Rehabilitator who is applying for IMMOFP for the first time and holds no existing or recently expired equivalent qualification (within 12 months) must:** **- hold a qualification of ITMMiF L4 (Football Association Qualification) or PHICIS L2 (Rugby Football Union Qualification) and** **- must be supervised by a Physiotherapist for one year's full time (or two part time) experience in a professional or lottery funded environment.**

	Holding only ITMMiF L4 or PHICIS L2 qualification does not permit a Sports Rehabilitator to provide on field medical game cover. IMMOFP or equivalent qualification must be held. **Evidence of the above should be submitted to the RFL for consideration by the Chief Medical Officer and IMMOFP Course lead.**
Qualified First Aider	**A Qualified First Aider must**: • have a current Emergency First Aid in Rugby League qualification (or a RFL recognised alternative which must be a L3 qualification).

*** RECOGNITION OF ALTERNATIVE QUALIFICATIONS/COURSES**

IMMOFP is a RCSEd faculty of prehospital care endorsed course and part of the Cross Recognition of Emergency Care Courses in Sport Agreement. Only endorsed courses listed as advertised by the joint statement released by the FSEM, FPHC and BASEM will be accepted as equivalent.

Any Doctor or Physiotherapist who has successfully completed equivalent approved courses as above will on receipt of evidence of relevant documentation, be entitled to receive a dispensation by the RFL CMO to provide cover at matches and training until the expiry of the relevant alternative course qualification after which they must complete IMMOFP (or renew the other relevant alternative course).

NB:

- **In these Medical Standards the phrase "Doctor or Equivalent" is used for Doctors, Advanced Nurse Practitioners and Paramedics in a context which applies to all three roles. Where the context is role specific the individual role is identified**.

- **In these Medical Standards the phrase "Physiotherapist or Equivalent" is used to represent Physiotherapists, Sports Therapists and Sports Rehabilitators in a context which applies to all three roles. Where the context is role specific the individual role is identified.**

A3 IMMEDIATE MEDICAL MANAGEMENT ON THE FIELD OF PLAY

IMMEDIATE MEDICAL MANAGEMENT ON THE FIELD OF PLAY (IMMOFP©) - MANDATORY

Save as otherwise provided in these Medical Standards it is mandatory for those medical personnel entering the field of play to hold a current IMMOFP qualification. These persons must be qualified as a Doctor or Equivalent or Physiotherapist or Equivalent as set out in the table at A2. (See Appendix 1 for more details on IMMOFP).

A3a NON-COMPLIANCE OF IMMOFP REGULATIONS

Clubs will be reported to the RFL Compliance Department should medical staff without the appropriate qualification enter the field of play

A4 MEDICAL STAFF ATTENDANCE AT MATCHES & TRAINING - MANDATORY

MATCHES - MANDATORY

For matches, at all levels, the Doctor or Equivalent must be present in the dressing room area for at least one hour prior to kick off and must remain for at least 30 minutes following the end of the match. Where the away team does not have a doctor or Equivalent present, the Home club's Doctor or Equivalent must check with the away team Physio or Equivalent to confirm that their services are not required before leaving the dressing room area and venue

The responsibility to ensure the requirements above are communicated to the Doctor or equivalent (including any locum Doctors) lies with the club.

A4a The table below lists the Mandatory Medical Staff Requirements for each competition playing home and away games, and on training days.

Competition	Match Day Home Games – Mandatory	Match Day Away Games - Mandatory	Training Days
Super League	- Doctor - Physiotherapist - Second Doctor or Equivalent - Second Physiotherapist or Equivalent (best practice) - NB Match Officials must be treated by the home team medical team if required. This should be provided without waiting for request in emergency situations.	- Doctor - Physiotherapist - Second Doctor or Equivalent (best practice) - Second Physiotherapist or Equivalent (best practice) - Physiotherapist or Equivalent (or Doctor or Equivalent) must travel with the players on the return journey in case of delayed concussion or other injuries/medical emergencies. - Where players travel independently this must be managed with the Club Medical Staff.	- IMMOFP Qualified Physiotherapist(s) – Best Practice or - IMMOFP Qualified Sports Therapist or Sports Rehabilitator – Mandatory with a current IMMOFP qualification.
Full Time Championship & League 1 Clubs	- Doctor - Physiotherapist - NB Match Officials must be treated by the home team medical team if required. This should be provided without waiting for request in emergency situations.	- Doctor or Equivalent - Physiotherapist or Equivalent - Physiotherapist or Equivalent (or Doctor or Equivalent) must travel with the players on the return journey in case of delayed concussion or other injuries/medical emergencies. - Where players travel independently this must be managed with the Club Medical Staff.	- IMMOFP Qualified Physiotherapist(s) – Best Practice or - IMMOFP Qualified Sports Therapist or Sports Rehabilitator – Mandatory with a current IMMOFP qualification.
Championship Clubs (other than full time Clubs)	- Doctor or Equivalent - Physiotherapist - NB Match Officials must be treated by the home team medical team if	- Physiotherapist or Equivalent - Physiotherapist or Equivalent (or Doctor or Equivalent) must travel with the players on the return journey in case of	- IMMOFP Qualified Physiotherapist or Equivalent - Best Practice - Qualified First Aider – Mandatory with a minimum Level 3 qualification.

Competition	Match Day Home Games – Mandatory	Match Day Away Games - Mandatory	Training Days
	required. This should be provided without waiting for request in emergency situations.	delayed concussion or other injuries/medical emergencies. - Where players travel independently this must be managed with the Club Medical Staff.	NB: The qualified First Aider must be registered with the RFL on GameDay.
League 1 Clubs (other than full time clubs)	- Doctor or Equivalent - Physiotherapist or Equivalent - NB Match Officials must be treated by the home team medical team if required. This should be provided without waiting for request in emergency situations.	- Physiotherapist or Equivalent - Physiotherapist or Equivalent (or Doctor or Equivalent must travel with the players on the return journey in case of delayed concussion or other injuries/medical emergencies. - Where players travel independently this must be managed with the Club Medical Staff.	- IMMOFP Qualified Physiotherapist or Sports Therapist or Sports Rehabilitator – Best Practice with a current IMMOFP qualification or - Qualified First Aider – Mandatory with a minimum Level 3 qualification. NB: The qualified First Aider must be registered with the RFL on GameDay.
Under 18s, Reserves and Scholarship Requirements	- Doctor or Equivalent - Physiotherapist or Equivalent - NB Match Officials must be treated by the home team medical team if required. This should be provided without waiting for request in emergency situations.	- Physiotherapist or Equivalent - Physiotherapist or Equivalent (or Doctor or Equivalent) must travel with the players on the return journey in case of delayed concussion or other injuries/medical emergencies. - Where players travel independently this must be managed with the Club Medical Staff.	- IMMOFP Qualified Physiotherapist or Equivalent Best Practice or - Qualified First Aider – Mandatory with a minimum Level 3 qualification. NB: The qualified First Aider must be registered with the RFL on GameDay.

A5 EMERGENCY MEDICAL STAFFING SITUATIONS AT MATCHES – FOR INFORMATION ONLY

In the event a club has a difficulty due to unavailability of a Doctor or Equivalent or Physiotherapist or Equivalent to cover one of its games, and have exhausted all possible options, Clubs may contact Lynn Green, lynn.green@rfl.co.uk no sooner than two weeks in advance of the match. An email will be sent to all IMMOFP qualified personnel requesting assistance (locum cover) on behalf of a club. When requesting cover clubs must ensure they provide the following information: Cover required (Doctor or Physio); date & level of fixture, i.e. First Team, Under 18s etc.; venue; kick off time; and to whom the IMMOFP personnel should contact at the club. It is the responsibility of the Club to liaise directly with locum medical staff and agree and pay fees and expenses direct.

For the avoidance of doubt, it is the responsibility of the club to source and provide appropriate medical cover as set out in these Standards.

In the event that an appropriately qualified Doctor or Equivalent or Physiotherapist or Equivalent replacement cannot be found by a Club to cover a Match, a Doctor or Physiotherapist who has not successfully completed any of the courses listed in the table at A2 can be used subject to the following conditions. NB The following does not apply to Paramedics, Advanced Nurse Practitioners, Sports Therapists or Sports Rehabilitators as per A2:

- Completing a IMMOFP course registration providing evidential proof to the RFL of relevant qualification and medical indemnity insurance cover for working in sport (all to be supplied in advance of the match in question);

- reading these Medical Standards and signing to confirm that they have read, fully understand the role they are undertaking and will apply these Medical Standards with particular emphasis on the concussion protocols.

- Medical Staff appointed in Emergency situations must hold a current IMMOFP or equivalent qualification unless dispensation is applied by the CMO.

- Doctors and Physiotherapists have a three-month grace period to obtain or be booked onto the next available course to gain an IMMOFP (or equivalent) qualification.

Dispensation requests will cease to be considered 24 hours in advance of the kick off (unless in exceptional circumstances as determined by the RFL CMO).

A6 MATCH DAY RULES & RESPONSIBILITIES RELATING TO MEDICAL STAFF - MANDATORY

Doctors or Equivalents and Physiotherapists or Equivalents must wear the distinctive coloured tops as set out in the RFL Operational Rules and abide by the procedures set out below. Doctor or Equivalents and Physiotherapists or Equivalents must adhere to their professional standards and only enter the field of play when required to do so to

assess or treat a player and not to pass messages or otherwise become involved in coaching tactics.

A6a PHYSIOTHERAPIST(S), SPORTS THERAPISTS & SPORTS REHABILITATORS

- Must wear an orange top.
- Check all mandatory medical equipment is in good working order and in date
- Is allowed unlimited access to the playing field to assess or treat injured players.
- Must go directly to the player concerned and in instances of severe injury may indicate to the referee that the game should be stopped.
- Is not allowed to pass on messages at any time.
- Must enter and leave the field as quickly as possible (i.e. running).
- Is not allowed to be involved in the on-field interchange process save that when he/she goes onto treat a player he/she can bring that player off i.e. escort him to the touch line - he/she cannot have any further involvement in the interchange process.
- May track play on the touch-line closer to the benches and where there are two physios one may track on the far side of the pitch

A6b DOCTOR(S), ADVANCED NURSE PRACTITIONERS & PARAMEDICS

- Must wear a red top.
- Check all mandatory medical equipment is in good working order and in date
- Enter the field of play when they are medically required to do so using their clinical judgement.
- Match Officials will call 'Time Off' upon sight of the Doctor or Equivalent entering the field of play.

A6c GENERAL

- The Doctor or Equivalent(s) and Physiotherapist or Equivalent(s) shall enter the pitch only from the designated technical area or bench or track the far touchline position (if applicable) and shall return to that area after coming from the pitch. They shall always be subject to the control of the Match Commissioner (where appointed) and Match Officials.
- The Doctor or Equivalent(s) and Physiotherapist or Equivalent(s) shall ensure that they refrain from involving themselves in any conflict between players and shall ensure that they refrain from making comments to opposition players.
- Persons entering the field of play must not make comments to match officials about their performance or decisions.
- Medical staff should arrive at the game no later than one hour prior to kick-off.
- Doctor or Equivalents need to be aware of their Duty of Care to players with regards to allowing a potentially seriously injured player to travel home unaccompanied following any match.
- All members of the Medical team must read the medical Emergency Action Plan (EAP)

A6d TREATMENT ON THE PITCH, TOUCH-LINE OR BENCH

Medical staff should be aware that, other than in an emergency situation, medical procedures should not be carried out in public (see Section F1a about stitching).

In addition, if it is necessary to administer supplements or other alternative treatments during a match then a dual chamber container or other suitable container should be used. It is not acceptable to use a syringe.

A6e POSITION OF MEDICAL STAFF DURING GAME

Doctor or Equivalents and Physiotherapist or Equivalents must be located within the bench area other than when carrying out their official duties save as set out above. NB touch judges, ball crew and camera operatives all have right of way, and it is the responsibility of the medical staff to ensure that there is not a collision. In the event a Team has a second physiotherapist or equivalent, they may track the far touchline on the opposite side of the field to the bench staff. Their movement must be compliant with Matchday Operations Manual C9.4.

A6f COMMUNICATIONS EQUIPMENT FOR MEDICAL STAFF – BEST PRACTICE

It is considered Best Practice for Doctors or Equivalents and Physiotherapists or Equivalents to communicate by electronic communications equipment subject to the conditions set out below. Any breach of such conditions shall be Misconduct.

(i) The medical staff must use a different set of radios to the coaching staff and operate on a wavelength to which the coaching staff do not have access. This is to ensure that: (i) the medical radios are not used to communicate messages from the coaching staff or perceived to be used for that purpose; and (ii) the wavelength is not blocked as this could lead to vital medical communications failing.

(ii) No member of coaching staff shall use medical staff communications equipment in any circumstances.

(iii) The medical staff equipment must be clearly marked either by using green handsets (where possible) or by using green tape to identify the equipment.

(iv) Match Commissioners or where no Match Commissioner is appointed to a game, the Referee, shall be entitled to check both the medical staff and coaching staff communications equipment before and/or after matches

(v) Clubs are under no obligations to use medical staff communications equipment and when using it are responsible for ensuring a manual back up system if the equipment fails or the signal at the ground is insufficient for reliable communication (which should be checked before every game).

A7 SUPER LEAGUE CLUB DOCTOR/HEAD OF MEDICAL DUTIES - MANDATORY

Super League Clubs have a responsibility to deliver the following by having a Doctor and/or as applicable, the Clubs appointed Head of Medical who has agreed to provide duties outside match day requirements.

The Super League Club Doctors/Head of Medical have mandatory roles outside those on match days which are set out below:

- Ensure that there is a Medical Emergency Action Plan in place which must be shared with the away team
- Ensure that there is sufficient mandatory medical equipment to cover all home and away Super League games and all home Reserve, Women's Super League, Academy and Scholarship games.
- Ensure that there is a Pre-Match Briefing for all team medical staff on duty at a match, which should take place as soon as practicably possible after arrival of the away team
- Be responsible for ensuring that all Mandatory Medical Equipment is stocked, in date and in good working order
- Be available to players, and medical staff for medical advice at times outside of match days, and attend at least one training session per week to provide medical advice and/or treatment to players
- Keep electronic contemporaneous records of treatments given and interventions made during matches and at training sessions.
- Ensure that the RFL's concussion reporting requirements are met. Monitor players and evaluate their readiness to Return to Play under the Concussion Protocols in consultation with the club physio(s);. Ensure all Return to Play documentation is submitted to be received by the RFL prior to a player Returning to Play post-concussion
- =Provide players with medications required to treat common illnesses and injuries (whilst avoiding where clinically viable the use of addictive prescription medication and ensuring compliance with the Therapeutic Use Exemption process if treatment with a Prohibited Substance is necessary)
- Provide with the club, the opportunity for all First Team, Reserves, Academies and Scholarship players with the opportunity to attend annual pre-season medical screening as set out in the Screening section of these Standards
- Ensure, in conjunction with the head physiotherapist, that coaching staff are appropriately trained to assist with emergency scenarios such as spinal boarding
- Ensure other club medical staff and club coaching staff are aware of RFL (and other relevant) medical policies and understand the importance of compliance
- Co-operate with the RFL Head of Medical regarding reporting of serious injuries and concussions
- Facilitate referrals for players to secondary/tertiary care where appropriate including mental health providers
- Keep up to date with knowledge and skills required for working with elite athletes, including attendance at RFL CPD events when possible
- Comply with these Medical Standards and ensure good ethical governance.

A8 TRAVEL TO FRANCE – FOR INFORMATION ONLY

A8a MANDATORY MEDICAL EQUIPMENT

Please see section C1.

A8b MEDICAL TREATMENT IN FRANCE

For matches in France all eligible players should obtain a European Health Insurance Card or Global Health Insurance Card (EHIC/GHIC) before travel.

The RFL has an insurance policy in place to provide emergency medical treatment for players injured whilst playing away matches abroad. Full details are circulated by the Professional Game Delivery Team on an annual basis and medical staff should ensure they are aware of the Policy details and contact numbers before travel. In addition, the RFL's travel agents will, on request, make emergency travel arrangements required due to an injury. Medical staff should make sure that they have the travel agents' emergency contact details.

A8c LEGAL ISSUES

The GMC advises that all Club Medical Staff Doctor or Equivalents should consult their own Medical Professional Bodies to advise them of the legal implications of travelling to France with a Rugby League team and any obligations under French law.

However please be advised, for example, of the GMC's Good Medical practice guidance booklet which states:

Paragraph 9 "In an emergency, wherever it may arise, you must offer anyone at risk the assistance you could reasonably be expected to provide"; and

Paragraph 33 "You must have adequate insurance or professional indemnity to cover all aspects of your practice that is not covered by an employer's scheme."

The GMC would expect should a medical emergency arise, with a member of your own team, the French team, a Match Official or a spectator, that a Doctor or Equivalent would provide appropriate medical care. The nature and extent of the care will depend on the circumstances and the level of professional competence.

SECTION B

ETHICS, GOVERNANCE, PLANNING, INFORMATION & DATA

B1 ETHICS

Medical staff must apply the same ethical standards to their work in Rugby League as they are required to under their professional standards.

B2 GOVERNANCE

Medical staff are required to operate good clinical governance systems.

B3 RECORDING INJURIES - MANDATORY

Medical staff should make a note of any Player who has been injured in the match in any way whatsoever and retain such notes in line with their Professional Body (E.g., GMC for Doctors) recommendations. Medical staff leaving a club are responsible for ensuring that a copy of the relevant notes are provided to colleagues on departure and kept for the statutory period of time. For the avoidance of doubt, the notes shall remain subject to the rules of medical confidentiality save as set out in the standard Player Contract or as required by the RFL Operational Rules or the Injury Audit or as required by the Concussion Regulations contained in these Medical Standards or in the cases of Blood Borne Diseases as set out in sections F1 and F2. Medical Staff are expected to follow their professional obligations with respect to medical record keeping. Clear, contemporaneous record keeping underpins the Club's clinical governance arrangements and such records should usually be electronic.

B4 SHARING INFORMATION - MANDATORY

In the case of matches where the Away Team Doctor or Equivalent is not attending (relevant Championship Clubs, League 1, Reserves, Academy, or Scholarship) it is the responsibility of the Player's Club Doctor or Equivalent or Physiotherapist or Equivalent to provide the Home Team Doctor or Equivalent with the details in advance any special medical requirements of any of their players, the SCAT5 baselines and to provide the Home Team Doctor or Equivalent with any special medication/equipment on game day as part of the Pre-Match Briefing. This does not apply to Super League and Full Time Clubs where Doctors are required to travel to away matches.

B5 SHARING INFORMATION - DUAL REGISTERED /LOAN PLAYERS - MANDATORY

Club medical staff at both Clubs must liaise and share information as appropriate and in line with medical professional standards and any protocols published by the RFL from time to time to ensure the best care for the player see F14.

B6 RFL INJURY AUDITS & OFFICIAL RESEARCH - MANDATORY

It is compulsory for all Super League Clubs to complete the RFL Injury Audit run in conjunction with the Leeds Beckett University and other official research projects as

notified from time to time. This will apply to First, Reserve and Academy as directed. Clubs are responsible for ensuring a suitably qualified member of the medical staff completes the audit accurately and in a timely manner.

B7 REPORTING DEATH OR SERIOUS INJURY - MANDATORY

When a player has died or suffers a life threatening or catastrophic injury the RFL should be notified immediately using the emergency numbers provided below: -

The information does not necessarily need to be provided by a Doctor or Equivalent and the information required does not breach any medical confidentiality.

RFL CONTACTS

- Laura Fairbank - 07595 520184
- Robert Hicks – 07710 009244
- Kelly Barrett - 07739 819750 (for Community Game only)

Please make sure the RFL is provided with the name of the player, where possible contact details for the player's family and any initial prognosis.

The RFL will:

1) Inform the Benevolent Fund who may provide emotional and financial support to the player and their family.
2) Provide emotional support for those involved where required.
3) Handle any enquiries from the media in conjunction with the club, family and other relevant parties as appropriate
4) Inform the RFL's insurance brokers where relevant.

B8 MEDICAL EMERGENCY ACTION PLAN

All clubs must ensure a written Medical Emergency Action Plan for both matches and training, which includes all potential clinical scenarios is in place and must be shared with all medical staff and as a minimum but not limited to and must include the following. It is best practice to pre-agree this with your local ambulance authority.

- Effective means of communication with emergency services.
- Sound knowledge of additional medical persons at ground.
- Detailed knowledge of treatment room facilities.
- Correct postcode for the venue to ensure that emergency services come to the correct entrance to gain admission to the dressing rooms/pitch as appropriate
- Details of local Emergency departments including relevant specialist departments
- Arrangements for transporting injured players both at matches, post-match, and at training including ensuring that concussed players do not drive home
- Arrangements for notifying next of kin
- Arrangements for all grounds and training facilities used by the club.

Each club must share its Medical Emergency Action Plan with the opposition team's medical staff, preferably in advance or immediately on arrival at the ground, importantly it should form part of the Pre-Match Briefing lead by the Home Doctor or Equivalent.

B9 PRE-MATCH BRIEFING – BY HOME CLUB MANDATORY

It is Mandatory for at least one member of a team's medical staff from both clubs to meet on match day at a suitable time prior to kick off for a pre-match briefing. Those who attend must ensure their wider medical team are briefed on the EAP before the match. The briefing must include, but not be limited to:

- The Medical Emergency Action Plan
- The location of the medical room
- Other relevant venue specific information, i.e. location of any Ambulances/Paramedics if on site
- Process for calling an ambulance
- The location of the Pitchside Replay system and if there is not a dedicated operator, basic operating instructions for the system including how and to whom to report a malfunction
- Any medical conditions or treatment requirements for individual players and SCAT5 baselines for the away team if the away team does not have a Doctor or Equivalent present. Where the away team does not have a Doctor or Equivalent present it is advisable to communicate any medical conditions or treatment requirements to the home club medical staff in advance, this is particularly relevant if the away team is travelling with locum medical staff
- Any other relevant information

SECTION C

MEDICAL EQUIPMENT & FACILITIES

C1 MANDATORY MEDICAL EQUIPMENT (MME) & MANDATORY DRUGS BOX

The RFL have produced a list of MME, including Mandatory Drugs, which must be present at all games. It is the responsibility of the Club Doctor or Head of Medical (as appointed) to check all MME with an expiry date e.g. defibrillator pads, drugs etc. and ensure replacements are ordered in a timely manner to be received in advance of the relevant item(s) reaching or passing their expiry date.

Home Clubs Requirements - Mandatory

The home Club is responsible for ensuring that all the Mandatory Medical Equipment (MME) is present in the dressing room area and available for use, at least one hour prior to kick-off or from arrival of teams, whichever is the earliest. NB: Clubs other than Super League and full time Clubs in Championship and League 1 are not required to travel to away matches with a full set of MME and must be provided with access to and use of the home club's equipment.

Away Club Requirements – Mandatory

Super League and Full Time Clubs in Championship and League One(Full Time as designated in Note on Terminology ii) must travel with a full set of MME. For all other teams it is Best Practice for away teams to travel with a full set of MME.

AWAY MATCHES V CATALANS AND TOULOUSE

When travelling to play Catalans Dragons or Toulouse Olympique a Club may use the equipment provided locally or may choose to take its own. If a Club intends to use the local set of equipment, it is responsible for liaising with the Catalans/Toulouse club at least 7 days prior to any planned travel to France to ensure that a full set of MME is available for use and that any equipment with an expiry date is in date and will be available for the match, in the timescale set out above, and for any training sessions taking place. If there is any doubt whatsoever it is strongly advised that the away Club make arrangements for transporting their own MME

NB: If a Club intends to travel with a defibrillator, oxygen and drugs, it may wish to check with its airline carrier in respect of CAA regulations in place for the transportation of such equipment.

The RFL strongly recommend that all medical staff also carry with them the items they deem necessary to fulfil their role and do not rely on the home team or someone else to provide. Please ensure that all locum cover staff are aware of what equipment will be present and what additional equipment they will require to cover a game' i.e. non-mandatory equipment.

Where a curtain-raiser is played on the same day clubs should ensure that there is a full set of MME available for each game (working on the assumption that equipment for the first game may not be available for the second).

Where an away team player requires the use of a piece of equipment which is then taken away (e.g. to hospital), it is the responsibility of the away team to retrieve or replace the item

.C2 DUPLICATE EQUIPMENT - MANDATORY

If a Club has more than one team playing at separate venues on the same day, duplicate equipment will be required. When scheduling fixtures, Clubs must consider the availability of medical personnel and equipment.

C2a FULL LIST OF MANDATORY MEDICAL EQUIPMENT AND BEST PRACTICE MEDICAL EQUIPMENT

Mandatory MME	Additional notes/requirements
Spinal Board and/or Scoop Stretcher and/ or Spinal Board (and trained stretcher barriers)	With full complement of: Head immobiliser blocks Head straps (or alternative) Body straps or spider straps and head straps with head Immobiliser Appropriately trained stretcher bearers (those trained by the club medical staff to adequately and safely, under the direction of the club medical staff, transfer a player onto the stretcher and remove him from the field of play). It is recommended (and mandatory for Super League Clubs) to provide both spinal board and scoop stretcher.
Cervical Stiff Neck Collar(s)	An assortment of collars, or adjustable collars, must be available to fit every player within the club (extrication collar). Soft neck collars are not suitable. Medical staff may wish to size players for collars pre-season to ensure they have collars sufficient to fit all players and all neck types.
Pelvic Binder	For use in the event of a pelvic injury. Binders should be checked in pre-season for sizing purposes, a range of sizes maybe required
Splints	For immobilisation of the limbs. Box splints, which are hygienic, stored flat and ready to use (these come in full and half sizes for upper and lower limb). SAM splints or vacuum splints can be used also.

Mandatory MME	Additional notes/requirements
Airways, Masks & Oxygen etc	Oropharyngeal airway [assorted sizes] Nasopharyngeal airway [assorted sizes] – Non-rebreather masks with oxygen tubing (x2) – Pocket Mask (1 way valve) - Nebuliser mask with chamber and tubing – Self-Inflating Bag - valve mask (with reservoir bag, face masks and oxygen tubing – Supraglotic airway device (such as iGel) in assorted sizes • Self-Inflating Valve mask • Airway Lubricant gel • Magills Forceps • Glucogel
AED	The AED should be present pitch side at all levels and be available solely for player use i.e. in addition to AEDs used for the benefit of spectators etc. The battery must be fully charged and in date, and the pads must not be out of date (past expiry date). An AED prep kit must also be carried. Please note if you carry an AED with a monitor, then you are required to carry, in addition to the above, the appropriate medication to deal with each potential outcome that might occur.
Portable Suction	Hand held or battery-powered - must be suitable for pitch side use.
Oxygen	Kits such as Life line pro kit, includes variable flow rate oxygen, bag valve mask capable of delivering 97% oxygen, non-re-breathing mask capable of delivering 80% oxygen, standard oxygen mask with attachable nebulizer chamber encased in a purpose made carrier with 10ml syringe and two OP airways. Minimum 2 litre oxygen cylinder
Foil Blankets and Ambulance Blanket	
Sharps Bin and Clinical Waste Bin	A sharp's bin and a yellow clinical waste bag should be present in the treatment room and on match days in the home and away dressing rooms. This is the responsibility of the Home Team to provide at all levels. See section C5 for further details on clinical waste disposal.
Penlight Torch	

Mandatory MME	Additional notes/requirements
Suture Kit/Wound Care	To include: dressing pack, normal saline irrigation sachets, forceps, suture holder, scissors, suture materials and local anaesthetic. Staple device, skin glue or other relevant equipment as required.
Bleach Solution, Disposable Gloves & Other Personal Protective Equipment	The recommended spray container with 15mls of standard washing-up liquid and 32mls of standard household bleach must be present on the touchline and in both dressing rooms for use on game days and present at during training for use by medical and kit-room staff. This is the responsibility of the Home Team to provide at all levels. This should be made fresh for every session. In addition, disposable gloves must be readily available for use with this solution and all clinical waste. Medical staff should also ensure that any Personal Protective Equipment deemed necessary for player medical care is available.
Penthrox	An alternative pain relief is Entonox. This may be used as alternative if Penthrox cannot be obtained, or in the event of allergy to Penthrox, or for under 18s, or where Penthrox is not licensed in UK. If using Entonox must ensure there are single-use microbiological filters
Magill Forceps	This equipment should be included within the oxygen kit.
Emergency Drug Box	Emergency drug box, to be utilised by both teams, where appropriate. It is the responsibility of Home Team Doctor/Head of Medical to update and maintain the drug box at the club. It is the responsibility of the Visiting Team to ensure that any medication or equipment required by their own players is brought with them to a game for a player with a known allergy, condition, or illness. Medical personnel should carry any additional medication considered necessary to cover all reasonable eventualities, together with any medication required for players with known allergies or medical conditions or illnesses. Regular checks of the contents of the drug box are essential as some items have relatively short shelf lives. All mandatory drugs must always be in-date and replaced as soon as is practicable after use. 6 vials x: Adrenaline 1:1000ml (or adrenaline autoinjector) 5 vials x: 10mls water for injection

Mandatory MME	Additional notes/requirements
	Amiodorone 300mg, 10ml minijet GTN Sublingual Spray 1 x 10mg Rectal diazepam 5 vials x Salbutamol UDV (Unit Dose Vial) 5mg per 2mls (to be nebulised using oxygen unit with mask and chamber Box of 300mg Aspirin - oral (antiplatelet effect for use in Myocardial Infarctions) 10% Glucose, 500mls IV fluids 500ml sodium chloride 0.9% IV giving set (ensure IV infusion set) Tourniquet x 2 Needles (3 of each size) – Green (21G), Blue (23G), Orange (25G) Syringes (2 of each size) – 10ml, 5ml, 3ml or 2.5ml, 1ml Cannulas (minimum of 4 in different sizes) – 14G, 16G, 18G, 20G, 22G

Medical Equipment – Best Practice	Additional notes/requirements
Emergency Cricothyrotomy Device and/or needle Cricothyroidotomy equipment	Provides a quick method to provide an emergency airway with minimal bleeding in an extreme emergency in the presence of severe oro-facial injury when an airway cannot be maintained, and the patient is rapidly deteriorating.
Crutches	Adjustable with adequate ferrules
Other inc Resuscitation Equipment	Some of the resuscitation equipment below is only recommended for those medics who are competent in its use. It is up to each individual to act within their own clinical competence and professional training: • Laryngoscope • Stethoscope Various (Mandated) • ET tubes • Sphygmomanometer • Various needles, syringes – in addition to those in drug box • Adrenalin 1:10,000 plus additional 1:1000 or epipen (in addition to the adrenalin in the drug box) • Eye irrigation materials - Fluorescin Drops, saline irrigation, Chloramphericol ointment/drops, Eye pad & tape. • Anti-inflammatories (tablets/IM) • Painkillers (check WADA Prohibited List) [tablets & IM] • Anti-emetics • Anti-fungals • Antibiotics (various) • Medipreps • Gauze swabs • Scissors • Jelly Babies/Lucozade tablets for hypoglycaemic events

In addition to the MME and recommended as best Practice equipment, Doctors or Equivalents may carry any other equipment that they consider necessary to carry out their duties

C3 MATCH COMMISSIONER CHECKS

Match Commissioners, or where no Match Commissioner is appointed to a Match, the Referee or nominated Match Official will carry out spot checks on MME pre-match. An MME Form must be completed pre-match and signed by the doctor once the spot check has been completed.

Should any of the MME not be present, the Match Commissioner/Referee will order the kick-off to be delayed until the piece of equipment is present. Should it not be possible to locate a piece of essential equipment, the Match Commissioner /Referee has the power to postpone or abandon a game. This is a last resort and should be avoided by the appropriate planning, checking and management of medical kit.

C4 CLINICAL WASTE DISPOSAL - MANDATORY

Clinical waste disposal at clubs is a Health and Safety procedure and is a Club responsibility. The presence of the sharps bin and clinical waste bags is not sufficient: an adequate disposal system that meets H&S regulations is also required.

Sharp's Bins and Yellow Clinical Waste bags are part of the RFL Mandatory Medical Equipment to be present at every game. It is the home Club's responsibility to provide disposal facilities for both teams. Clubs should not have to travel home with their soiled clinical waste and sharps. A visiting team who finds that they have no clinical waste disposal facilities should inform the Match Commissioner immediately.

For those medical staff assisting their clubs with clinical waste disposal via their own practices and hospitals, please be aware of the guidance on traveling with clinical waste in cars which can be obtained from the Local Authority.

Under no circumstances should clinical waste be thrown into the general refuse bins.

C5 DISPOSAL OF DRESSINGS & STRAPPING - MANDATORY

Clubs have a duty of care to members of staff for example, ground staff and cleaning staff who may encounter blood-stained dressings and strapping post game/training.

These members of staff should be trained in procedures on how to handle such items, the risk of cross-contamination, infection control and must be provided with adequate bleach solution as per regulations, disposable gloves and other PPE

C6 FACILITY STANDARDS – TREATMENT ROOM - MANDATORY

Clubs must have a dedicated player and match official treatment room which is adjacent to both home and away dressing rooms. It may not be used to treat members of the public for whom a separate first aid room should be provided and equipped as set out in the Green Guide.

The treatment room must be equipped as follows:

- Adequate light
- Sink and hand washing and drying facilities
- Examination bed
- Suture trolley/table
- Bench for medical equipment
- Sharps container
- Designated contaminated waste disposal container

SECTION D

D1 ANTI-DOPING

CHANGES TO WADA CODE FOR 2023

All medical staff should make sure they are aware of the changes made to the Code and the Prohibited List. The main changes to the Prohibited List can be found here: The 2023 Prohibited List: Summary of Changes | UK Anti-Doping (ukad.org.uk)

The UKAD Introduction to Clean Sport course will make sure that you are aware of the changes.

If you have any questions regarding any aspect of anti-doping, please contact Laura Fairbank by email on laura.fairbank@rfl.uk.com.

D2 TESTING - BLOOD &/OR URINE – FOR INFORMATION ONLY

Under the provisions of the RFL anti-doping regulations, blood and/or urine samples can be collected. On some occasions, it may be one or the other, and in other cases it could be both. Blood tests will be conducted by a suitably qualified phlebotomist and 8ml will be taken, with appropriate rest periods before and after enforced. The only valid reason to refuse a blood test would be due to health reasons such as haemophilia, and appropriate medical evidence would obviously need to be provided to substantiate any refusal. If a refusal cannot be substantiated with the appropriate medical evidence then the player will be charged with an Anti-Doping Rule Violation for refusing a test.

In the 2023 season, Blood Spot testing may be introduced by UKAD. Education and information will be provided in advance of introduction.

D3 PROHIBITED SUBSTANCES - CHECKING MEDICATION - MANDATORY

For an immediate answer to an enquiry about the status of a substance for use in Rugby League log on to the Global Drug Reference Online (GlobalDRO) - www.globaldro.com. GlobalDRO allows you to search for the status of a licensed medication that can be purchased in the UK and also allows you to search for the status of generic ingredients that can be found in foreign products, which may contain different ingredients to similar brands in the UK.

If it does contain a Prohibited Substance a Therapeutic Use Exemption (TUE) will be necessary and this must be completed before taking the substance.

TUEs can take a number of days to process so early dialogue with UKAD is vital to ensure that the TUE can be granted before the medication is taken. Further information regarding TUEs can be found by visiting http://www.ukad.org.uk/medications-and-substances/tues/.

Please note supplements cannot be checked using the GlobalDRO system as they are not licensed medications.

The UKAD TUE Wizard is a useful tool in checking whether a Player requires a TUE TUE Decision Tree | UK Anti-Doping (ukad.org.uk)

The following link also provides information on glucocorticoids, ADHD medication, hay fever and asthma Special Topics | UK Anti-Doping (ukad.org.uk)

D4 ASTHMA

D4a BETA-2 AGONISTS - SALBUTAMOL, SALMETEROL FORMOTEROL AND VILANTEROL– FOR INFORMATION ONLY

Salbutamol, Salmeterol Formoterol and now Vilanterol do not require a Therapeutic Use Exemption (TUE) or a Declaration of Use.

Appropriate use of these inhalers with good administration technique is essential as there are specified levels of Salbutamol, Salmeterol Formoterol and Vilanterol a player can take above which an Adverse Analytical Finding will be declared.

The limit for Salbutamol is a maximum of:

- 1600 micrograms over 24 hours; and
- 800 micrograms over 12 hours.

Salbutamol inhalers commonly dispense either 100 or 200 micrograms per puff/inhalation, therefore this 800 microgram allowance equates to either 4 or 8 puffs per 12-hour period.

The limit for Formoterol is 54 micrograms over 24 hours.

Previously there has not been an explicit limit for Salmeterol, however the 2017 Prohibited List confirmed that maximum allowable amount permitted over 24 hours as 200 micrograms. If a player requires more than 200 micrograms per day, UKAD should be consulted as it may be necessary to apply for a TUE.

The limit for Vilanterol is 25 micrograms inhaled over a 24 hour period. **Inhaled dosage above this limit remains prohibited.**

The dose administered per puff/inhalation does vary between inhalers therefore it is vital that players are advised to check the information leaflet which accompanies the inhaler to establish the dose per puff/inhalation.

The presence in urine of these substances in excess of the respective limits is presumed not to be an intended therapeutic use of the substance and will be considered as an Adverse Analytical Finding unless the Athlete proves, through a controlled pharmacokinetic study, that the abnormal result was the consequence of the use of the therapeutic inhaled dose up to the maximum indicated above.

Poor administration technique or poorly controlled asthma are recognized as possible contributory factors to such abnormal urine findings. However, such a result will lead to an Anti-Doping Rule Violation hearing following which sanctions, including a suspension of up to two years, may be applied. It is therefore essential that all medical staff pay due diligence to ensuring optimal administration technique and optimum control of asthma in their playing staffs.

D4b BETA-2 AGONISTS - ALL OTHER BETA 2-AGONISTS OTHER THAN SALBUTAMOL, SALMETEROL AND FORMOTEROL – FOR INFORMATION ONLY

All other Beta-2 Agonists (e.g. Terbutaline) still require a TUE application and the supporting evidence.

TUE applications for Beta-2 Agonists (e.g. Terbutaline) require:

- Comprehensive Medical History
- Clinical Review
- Objective Spirometry assessment at rest and following a challenge
- Lung function test:
- Bronchodilator Challenge
- Bronchoprovocation Challenge

A clinical suspicion report should only be submitted if clinical suspicion persists and can be evidenced after Bronchodilator and Bronchoprovocation has delivered negative results.

It is essential that the TUE Beta-2 Agonist Guidance document is consulted to obtain full details of these requirements so that the correct evidence is submitted with TUE applications.

Also, please note that there is a specific TUE application form for those Beta-2 Agonists which require TUEs. Applications on regular TUE forms will not be accepted. These documents can be downloaded from the RFL website or obtained by contacting the RFL Professional Game Delivery Team.

In order to control the number of players having to undertake lung function testing, the RFL, in conjunction with UKAD, have decided that only the first team squads from Super League clubs will have to complete proactive TUEs for those Beta-2 Agonists which require TUEs. (ALL Beta-2 agonists OTHER THAN Salbutamol, Salmeterol and Formoterol) Proactive TUEs means that these must be granted before these players take the medication.

All other players (non- first team squad Super League players, Championship, League One, Academys, Reserve & Scholarship players) must complete TUEs for Beta-2 Agonists (i.e. FOR ALL Beta 2 agonists OTHER THAN Salbutamol, Salmeterol and Formoterol) retroactively, i.e. once they are tested they have 10 days to submit the TUE application.

However, we would recommend that any player currently using ANY Beta-2 Agonist speaks to his Doctor to ascertain if he really needs to use it, as it may be the case that a player was given an inhaler as a preventative measure but does not actually have asthma.

If a player needs a TUE as outlined above but after testing cannot meet the criteria, the player needs to have a discussion with the Doctor to find out why they have been prescribed asthma medication. If clinical suspicion of asthma or any other respiratory problem is still present then this must be recorded in a Clinical Suspicion Report as this can be used to support a TUE application if the criteria are not met, although it is not a guarantee that the TUE will be granted. If an application for a TUE is rejected, there is a TUE Appeals Committee to whom an appeal can be made. If this appeal is rejected then the player may be charged with an Anti-Doping Rule Violation. Therefore, medical staff need to take all reasonable steps to ensure that players who require Beta-2 Agonists do meet the criteria for being granted a TUE.

D4c BETA-2 AGONISTS AND INHALED CORTICOSTEROIDS SUMMARY - MANDATORY

Players have a responsibility to ensure that they take appropriate action when prescribed any inhaled medication. The table below details the action to take:

Medication	Action Required
Salbutamol	None*
Salmeterol	None*
Formoterol	None*
Terebutaline	TUE
Corticosteroids	None
Vilanterol	None*

*Refer to D11a regarding the upper limits for Salbutamol, Salmeterol and Formoterol.

Objective medical evidence will have to be provided to obtain a TUE. UKAD have developed a TUE Wizard which assists in identifying whether a TUE is required. Details are on the TUE form and Club medical staff need to be fully

aware of this process. If specific advice is needed please contact the RFL or UKAD.

D4d ACUTE EXACERBATION OF ASTHMA

UK Anti-Doping (UKAD) consistently receives Therapeutic Use Exemption (TUE) applications for the use of oral prednisolone, following the exacerbation of an athlete's asthma. Many of these are not supported by the relevant information or sufficient medical documentation to allow approval.

This class of medication is only prohibited in-competition and therefore a TUE application is only necessary if the athlete will be competing within two weeks of the final dose of prednisolone.

UKAD accepts that, in many cases, it is essential the athlete begins this medication as a matter of urgency. In these circumstances an emergency TUE must be submitted immediately. Any applications made after the treatment is complete may not be considered. Typically, UKAD require proof of asthma diagnosis it is advised to check for a previous specialist diagnosis in the event a TUE is required.

There are other circumstances where oral prednisolone is considered a possible treatment option but is not an emergency. These TUE applications must be made in advance of commencing treatment.

All applications for the use of prednisolone in athletes suffering from an exacerbation of asthma are expected to be supported by the following information:

- Details of clinical examination findings, including symptoms, heart rate, and respiratory rate
- Medications tried before, and leading up to, prescribing oral prednisolone (including names, doses and frequency of use of each medication, and whether inhaler dosages were increased before considering prednisolone)
- The athlete's 'normal' peal flow measurements and the measurements at the time of clinical examination
- Relevant past medical history (i.e. an outline of how the diagnosis of asthma was originally made, and details of any previous exacerbations requiring hospitalisation or oral prednisolone)
- The date that treatment with oral prednisolone began

For further information please contact UKAD.

D5 HAY FEVER - MANDATORY

UK Anti-Doping receives Therapeutic Use Exemption requests for the one-off use of intramuscular corticosteroid injections to treat hay fever. Applications must be submitted in advance of treatment and be supported by medical evidence to justify therapeutic use.

Required supporting evidence:

1. Description of symptoms to confirm diagnosis

Provide details of when the hay fever started; the symptoms experienced; the severity of these symptoms; the effect on performance; and symptoms suffered in previous years.

2. Medical history documented

Provide details of any known allergens or allergic history. Submit results of immunological investigations such as skin prick tests or specific IgE to confirm these details.

3. Confirmation that reasonable therapeutic alternatives have been trialled

Provide details of the permitted oral, nasal and/or ophthalmic medications that have been trialled for at least 2 weeks including names, doses, dates, duration and the effect of the treatment.

4. Specialist referral

A specialist opinion (i.e. ENT, immunologist or respiratory) is required to support the proposed treatment request. The specialist will need to give a reasoned opinion in view of the British Society for Allergy and Clinical Immunology (BSACI) guidelines and NHS Clinical Knowledge Summaries (CKS) on hay fever.

BSACI and CKS guidelines do not recommend the use of intramuscular corticosteroid injections to relieve hay fever symptoms. These guidelines consider the risk-benefit profile of intramuscular corticosteroid injections to be poor in comparison with other treatments available.

Please note that in severe uncontrolled cases where symptom control is critical (e.g. imminent competition), an emergency TUE application for a single short course of oral prednisolone will be considered without specialist opinion. Supporting evidence points 1, 2 and 3 above must be covered in such applications. Thereafter, applications will require specialist opinion to support any further proposed courses of oral prednisolone. Please contact tue@ukad.org.uk for further information.

D6 GENERAL - MANDATORY

All other Prohibited Substances will require a full TUE (completed proactively) if prescribed for a legitimate medical condition. TUE applications are reviewed by a panel of independent physicians known as UKAD's TUE Committee.

TUE applications should be sent direct to UKAD in an envelope marked

"Private & Confidential" to:

TUE, UKAD, Fleetbank House, 2-6 Salisbury Square, London, EC4Y 8AE

Or emailed to tue@ukad.org.uk

D7 INTRAVENOUS INFUSIONS - MANDATORY

Regardless of the ingredient or brand, intravenous infusions are prohibited at all times except in the management of surgical procedures, medical emergencies or clinical investigations.

This is to prohibit hemodilution and over hydration as well as the administration of Prohibited substances by means of intravenous infusion.

An intravenous infusion is defined as the delivery of fluids through a vein using a needle or similar device.

The following legitimate medical uses of intravenous infusions are not prohibited:

- Emergency intervention including resuscitation;
- Blood replacement as a consequence of blood loss;
- Surgical procedures;
- Administration of drugs and fluids when other routes of administration are not available (e.g. intractable vomiting) in accordance with good medical practice, exclusive of exercise induced dehydration.

Injections with a simple syringe are not prohibited as a method if the injected substance is not prohibited and if the volume does not exceed 100 ml within a 12 hour period.

E CONCUSSION & MANAGEMENT OF HEAD INJURIES REGULATIONS – MANDATORY

E1 PURPOSE, SCOPE & INTERPRETATION

The systems and protocols for managing head injuries are mandatory and have full force of the Operational Rules as set out in A1 and C2 of those Rules. However, all decisions and diagnoses will be based on the clinical opinion of the relevant Doctor while acting within these Regulations.

The RFL will monitor (such monitoring will include reviewing recordings of matches) incidents of apparent concussion during matches, concussion assessments, notifications of concussion, recurrent/subsequent concussions and Return to Play (RTP) and the actions taken. Where appropriate the RFL may refer any concerns for peer review. The results of such peer review will be provided to the RFL and may form the basis for Misconduct action by the RFL Compliance department.

The RFL Chief Medical Officer or the RFL Head of Medical or the RFL Compliance Department, are entitled to ask a Club and/or Medical team to justify and substantiate the clinical information and reasoning which underpinned the decision making in relation to Section E of these Regulations and in such circumstances the Clinician is required to respond promptly. It is therefore especially important that all Doctors, including any locum Doctors, ensure the clinical reasoning supporting their decision making is clearly documented in contemporaneous clinical notes. Where appropriate the RFL may refer such a response to panel of at least two Doctors for peer review. The results of such peer review will be provided to the RFL and may form the basis for Misconduct action by the RFL Compliance department. In addition, the RFL may ask Clinicians to carry out an internal self-reflective review of their procedures.

The protocols set out in these Regulations are only for use by qualified Doctors or Equivalent working in the professional game (all levels). All other personnel involved in concussion management should use the Community Game Regulations/Guidelines.

E2 CONCUSSION INTRODUCTION

The RFL takes player welfare very seriously and following available, appropriate research and a cautious approach in line with all sports when drawing up its concussion regulations.

E3 COGNIGRAM – DIGITAL CONGITIVE ASSESSMENT SYSTEM - MANDATORY

To effectively manage Concussion Assessments the RFL uses the Cognigram Digital Cognitive Assessment System as part of its Graduated Return to Play protocols.

Cognigram is a test prescribed by clinicians to measure cognitive function. It allows for regular and standardized testing to assist in the early detection of even subtle changes that could signify the need for further evaluation.

To effectively manage head injury assessments and graduated return to play it is essential that clubs have appropriate baselines and concussion records in place for all its registered players. See E3.2 and E3.2.2.

NB Cognigram costs are recharged to Clubs on an annual basis.

E3.1 Cognigram - Normative Database and Comparison Score

The normative sample represents data from a healthy population.

The Normative Comparison Score is intended to show the extent to which performance on the current assessment differs from that of healthy age-matched individuals. This is achieved by comparing the current assessment to normative data within that age range. For each of the outcomes, performance is standardized against a normative database and presented on a scale consisting of three categories: Normal, Borderline and Abnormal. The score is a standardized t-score with a mean of 100 and standard deviation (SD) of 10.

E3.2 Cognigram Baselines - Mandatory

It is mandatory for a club to ensure each of its registered players, across all levels, (First Team, Reserves, Academy & Scholarship, including trialists), establish a **valid** Cognigram baseline on an annual basis and prior to taking part in any training, either pre-season or in season, or play, including any warmup fixtures. **As concussions can be sustained outside of contact training/play i.e., slips/trips on and off field, during gym sessions, accidental collision with pitch furniture/team mates etc. players must not engage in any training session until they have established a valid Cognigram baseline. For clarity, the baseline re-set date will be no later than 1st November in each calendar year (accepting some teams/Clubs may operate at a slightly earlier date for pre-season requirements).**

A **Player is not eligible to participate in any training session or to play until a valid Cognigram baseline has been established.** . **Any Club allowing a Player to take part in any training session or play without first establishing a current baseline/valid baseline will be guilty of Misconduct.**

It is the responsibility each club, not the RFL, to review its own Cognigram account regularly to ensure all its players have established a baseline/valid baseline. Clubs are advised to have their own system in place for checking out of clinic Cognigram tests issued to players (both baseline and post injury) have been completed in full and a valid result recorded. **NB:** CogniGram is suitable to use for all players, including those of Scholarship age.

E3.2.1 Review of Baseline Results - Mandatory

It is the club's responsibility to ensure the Cognigram test report is reviewed for each registered player to determine if the baseline assessment provides a valid measure of baseline performance of a healthy individual. This is determined by the following criteria:

- **There must be no completion (red exclamation in a red circle) or performance (exclamation in a yellow triangle) flags on any of the outcomes on the first four modules**

- **The normative comparison scores on any of the first modules must not be in the abnormal range (a score of 79 or below)**

If either of the above were not met, a retest must be undertaken. If the retest still does not meet the criteria for a valid baseline (as defined above), evaluate if the results make sense in the context of the person's medical history, the testing conditions, etc. see E.3.2.2.

NB: It is Serious Misconduct to allow anyone other than the player to whom the record belongs to take a Cognigram test (baseline or Return to Play) on their behalf.

E3.2.2 Player Unable to Establish/Failure to Establish a Cognigram Baseline/Valid Baseline

If a player is repeatedly producing invalid Cognigram baseline results and otherwise shows no signs of a head injury (after clinical review by the club doctor) the RFL should be informed that the player is unable to record a baseline. In which case the club should arrange for an alternative baseline, for instance King Devick, to be established. The results of any alternative baseline must be submitted to the RFL.

SCAT5 CANNOT be Used as an Alternative Baseline. Please note that SCAT5 is not considered suitable as a standalone tool for ongoing management of concussion as its utility decreases significantly three to five days after injury.

E3.2.3 Dual Registered/Loan Players - Mandatory

It is the responsibility of a player's Parent club to ensure baseline testing on any Dual Registered or Loan Players is undertaken. it is also incumbent on the receiving club to check that the player in question has established a valid baseline before allowing him to take part in any training or play pre-season, in season, and on or off field.

Allowing a player, without a valid baseline, to train or play is Misconduct and clubs concerned will be referred to Compliance.

Loan/Dual Registered Players Cognigram Record

It is preferable for the Cognigram record of a loan/dual registered player to remain on the parent club account. If a player sustains a concussion playing for the receiving/non-parent club whilst on loan/dual registered both club's medical staff should liaise regarding GRTP management and post-injury testing. If necessary, a player's Cognigram record can be temporarily transferred between club accounts. However, note: a Clinician User at a player's parent club can launch an out of clinic post injury test (after notification of successful completion of stage 4 of the GRTP protocol) and provide the club a player is loaned/dual registered to with a copy of the test result report (pdf format) as required for onward transmission to the RFL along with all other RTP documentation.

E3.2.4 Cognigram Record – Players Changing Club Pre-Season or Mid-Season (Permanent Transfer)

- **One Player One Cognigram Record (Tracking Change in Performance Over Time)**

  It is preferable for a player to only have one Cognigram record throughout his career which provides the healthcare professional(s) at each relevant club a quick visual of change(s) in performance over time,

  If a player is permanently transferred pre-season or in-season etc. it is possible for their CogniGram record to be moved to their new club's Cognigram account. However, the record transfer can **only** take place if a written request to do so is made to the RFL. Upon receipt the RFL will check to ensure the player has a Cognigram record (and a current valid baseline as appropriate) and make a written request to CogState who will make the necessary arrangements for the transfer.

  NB: Cognigram is not linked to GameDay and a record transfer does not occur automatically when a player moves clubs.

  Transferring records between club accounts would ensure that a player does not have multiple Cognigram records on multiple club accounts.

  NB in-season player transfers: If a request to transfer a player's Cognigram record is not received it will remain in situ on his previous club's account and unavailable for their new to club to use for post-injury testing.

E3.2.5 It is mandatory for club to log and keep a record of all concussion HIA undertaken.

It is good practice for doctors to interview players to record a structured concussion history including specific questions on previous symptoms and length of recovery and including all head, face or cervical spine injuries, as well as non-sporting concussions.

E3.3 OTHER NEUROLOGICAL ASSESSMENTS

It is **mandatory** for all players in the first team squad of a Super League Club, and Best Practice for all first team squad players at other Clubs, to have a full neurological assessment baseline.

E3.4 SCAT5 BASELINES - MANDATORY

It is a Club's responsibility to ensure a SCAT5 baseline has been established for all its players - applicable to players at all levels. The SCAT5 should be provided in an easy format and must be available and used as part of the Head Injury Assessment process in training and on match days (both home and away). It is particularly important for SCAT5 baselines to be available in-season where the away team does not have a Doctor or Equivalent present. Clubs must share baselines with the RFL upon request.

- **SCAT5 baselines must be established before players take part in any training, contact training or play**

- **Head Injuries can be sustained in training (contact and non-contact) both on and off-field and a SCAT5 baseline must be established for every player before pre-season training commences**

Any variation from baseline in one or more sections is strongly in favour of a diagnosis of concussion. Doctors should also be wary of the possible "ceiling" effect with SCAT5 and where a player's baseline is high should place particular emphasis on clinical signs.

E4 MATCHES &/OR TRAINING

E4.1 Removal from Play (or Training) - Mandatory

All players who are diagnosed with concussion OR players who have any of the signs or symptoms set out below OR players whom medical staff suspect may have concussion MUST BE REMOVED from the field of play. A player must also be removed if a concussion/suspected concussion is sustained during a training session which takes place indoors, i.e. during a gym or wrestle session.

Where medical staff are unsure whether a player is concussed or concerned that a player may be concussed a Head Injury Assessment (HIA) MUST be carried out. For clarity, during a match or outdoor training session assessments must not be carried out on the field of play and Maddox questions should not be used to decide whether to carry out a Concussion Assessment. The Club Doctor or Equivalents, Physiotherapist or Equivalents, trainers and coaches) is responsible for ensuring that Players are removed from the field of play or other environment.

During any match (applicable at all levels) if a player is removed from the field of play more than once for a HIA they are not allowed to return to play that same match.

E4.2 Signs and Symptoms of Concussion (Mandatory)

- **CATEGORY/CRITERIA ONE SYMPTOMS/FEATURES**

- **Where Medical Staff observe, become aware of or are reliably informed that a player has presented one or more Category One symptoms/features they must be removed from the field of play/other environment outside the field of play, may not return and must be diagnosed as concussed.**

- **Where the Medical Staff have removed a player for a Concussion Assessment but subsequently become aware that they have, or has had one or more Category / Criteria One symptoms/features they cannot return to the field of play/other environment outside the field of play and must be diagnosed as concussed.**

  - Confirmed loss of consciousness
  - No protective action in fall to ground
  - Impact seizures (including tonic posturing, tonic/clonic jerks)
  - Traumatic convulsion
  - Loss of body tone (floppy)
  - Ataxia / balance disturbance– unsteady on feet
  - Disorientated
  - Definite confusion
  - Dazed, ie blank or vacant stare or not their normal self
  - Memory impairment
  - Definite behavioural change atypical of the player
  - Oculomotor signs
  - Player reports significant concussion symptoms
  - Clinical features including abnormal neurological signs of a serious or structural head and/or neck injury requiring emergency management and hospital transfer

- **CATEGORY/CRITERIA TWO SYMPTOMS/FEATURES**

  Where Medical Staff observe, become aware of, or are reliably informed that a player has presented with one or more

Category Two symptoms/features or otherwise suspect that a player may have concussion he must be removed from the field of play/other environment outside the field of play, for a HIA. There must be a rest period of five minutes before the HIA takes place.

- Possible loss of consciousness
- Possible loss of responsiveness (player motionless until medical staff arrive)
- Possible impact seizure including (possible tonic posturing, tonic/clonic jerks
- Possible balance disturbance specifically slow to stand following contact with a delay greater than 10-15 secs
- Suspected facial injury, facial fracture or injury event witnessed with potential to result in a concussive injury
- Possible confusion
- Possible behavioural change
- Head injury where diagnosis is not immediately apparent
- Any other sign or reported symptom that may indicate concussion
- Any clinical impression or uncertainty from the team's medical staff that the player is not quite right following trauma

E4.3 Players Refusing to Leave the Field of Play During a Match – Match Officials - Mandatory

Where a player refuses to follow the instructions of the medical staff to leave the field of play the medical staff may ask the match referee to instruct the player to leave the field. In which case the clock shall be stopped until the player departs.

If a Match Official has concerns that a player may have suffered a concussion, they may stop play, call the medical team onto the field of play to express their concerns and request the player is examined.

E4.4 Pitch Side Replay - Mandatory

Each Super League, Championship and League One Club must have a Pitch Side Replay facility installed and which is operational at all its home first team fixtures, failure to do so is misconduct.

On match-days the Pitch Side Replay facility must be made available to medical staff of both competing teams. It is Best Practice, for speed of access, to have a dedicated Pitch side Replay operator who can operate the system for the medical staff.

On arrival a visiting club must be shown the location of the Pitch Side Replay facility, how to use it and how and to whom any malfunctions should be reported. The system must be in full working ahead of kick off.

E4.4.1 The Pitch Side Replay facility can be used to assist the Doctor or Equivalent in their clinical decision making and should be used to determine the mechanism of a suspected concussion and/or to assist with identifying category One or Two symptoms/features.

E5 HEAD INJURY ASSESSMENT (HIA) PROCESS - MANDATORY

a) Following the removal of a player the Doctor or Equivalent must wait five minutes before beginning a HIA during which time they should view a playback of the incident on the pitch side replay facility (the player must not be left alone whilst this takes place). If at this stage, they become aware that the player had one or more Category/Criteria One symptoms/features the player cannot return to play and must be diagnosed as concussed.

b) The HIA must not take place on the pitch-side but in the medical or dressing room or other suitable facility

c) SCAT5 **must** be used as part of the HIA, as an aid to clinical judgement. The Doctor or Equivalent's clinical assessment MAY NOT overrule an adverse SCAT5 or evidence of one or more Category/Criteria One features –Similarly, a "normal" SCAT5 does not mean the doctor cannot diagnose the player as concussed. The Club Doctor or Equivalent may also elect to use additional assessment tools such as King Devick as part of their evaluation.

d) Where a Doctor or Equivalent is aware, or becomes aware, that a Player has at one or more Category One symptoms/features, the Doctor or Equivalent **must diagnose them as being concussed for the purposes of these rules** and may **NOT** use clinical judgement or the results of SCAT5 (or any other assessment tool) to return the Player to the field. Alternative concurrent causes for the displayed signs and symptoms must always be considered as structural brain injuries can mimic concussion in the initial stages.

e) Where the Player has not had any Category/Criteria One symptoms/features and has returned a SCAT5 comparable to their pre-season SCAT5 baseline assessment then the Doctor or Equivalent may use their clinical judgement to determine whether the Player has suffered a concussion. In these circumstances where the Doctor or Equivalent using his clinical judgement deems that the player is fit to RTP, the Player may do so at the end of the 15-minute concussion assessment, but not earlier than the end of the 15 minutes.

f) Where a Doctor or Equivalent does not know the player, they should err on the side of caution when applying clinical judgement.

g) Any player removed from the field of play more than once during the same match for a HIA is not allowed to return to play during that same match, no matter the outcome of the second HIA. The decision to diagnose the player

as concussed or not remains with the assessing doctor, but irrespective of the diagnosis, they may not return to the pitch during that match (E4.1).

For the avoidance of doubt, **it should be noted that SCAT5 SUPPORTS the Doctor or Equivalent to make a diagnosis and is not a stand-alone method to diagnose concussion, measure recovery or make decisions about a player's readiness to return to competition after concussion. A player may have a concussion even if their SCAT5 is "normal".**

Therefore, a Doctor or Equivalent using SCAT5 for a Concussion Assessment at matches may diagnose that a player is concussed despite a "normal" SCAT5, however, to re-iterate, a Doctor or Equivalent is **NOT** entitled to use clinical diagnosis to overrule a SCAT5 which is below the player's baseline or, where no baseline is available, has any significant fails.

Failure to comply with this Rule constitutes Misconduct, and the Club (and any relevant individual) may be subject to disciplinary action.

E5.1 Concussion Interchanges - **Informing the Match Commissioner and/or Interchange Officials**

When a Match Commissioner is appointed to the match they must be informed by the medical staff as the player leaves the pitch whether the player is leaving the field for a HIA; medical staff must also inform the Match Commissioner of any HIAs undertaken during the half time interval or post-match where appropriate. The Match Commissioner must be advised of the outcome of the HIA. Where a Match Commissioner is not appointed this process must be managed by identified personnel from each Club with the appointed Match Officials.

- If Medical staff have already diagnosed concussion on the field of play the player must not return to play, and an interchange (subject to availability) should be made immediately.

- Where Medical staff suspect concussion, the 15-minute HIA t period will begin as the Player leaves the field of play, for which there is a free interchange. (Full details of interchange process are detailed within the Match Day Operations Manual.)

- The player may not return to the field (if it is judged that he is not concussed until a minimum of fifteen minutes have elapsed (five minutes' rest and ten minutes to conduct the SCAT5 and make a decision around return to play).

- If the player is diagnosed as being concussed, or if the Concussion Assessment takes longer than 15 minutes the "free" interchange becomes permanent.

- If the HIA takes longer than 15 minutes, (e.g., other treatment, wound repair, toilet, *and* HIA being undertaken at the same time), with the caveat the player has passed the HIA the player can return to play (RTP), but this will count as a further player interchange against the team's quota.

- If the Player is deemed fit to Return To Play (RTP) at the end of the 15-minute assessment period, the process will be managed by the Match Commissioner and/or medical and bench staff (as set out in the Match Day Operations Manual)). In summary:

  - The Player must be (subject to the following paragraphs) with the Match Commissioner and ready to return to the field of play at the expiry of the 15-minute assessment period.
  - The Match Commissioner shall then release the Player to the Interchange Official.
  - The Interchange Official shall return the Player to the field of play as per the normal Interchange Process listed in the Match Day Operations Manual. For the avoidance of doubt the interchange may take place during general play, after any scoring has been completed or when play has been temporarily suspended by the Referee.
  - The latest time that a Player must return to the field is immediately his team is in possession at the commencement of a new set.. If the interchange is not made on or before this time, then the concussion interchange will convert to a normal interchange and the Club must hand the next interchange card to the Interchange Official.
  - Should a Doctor require additional time to conduct a HIA due to concurrent HIA's or other demands on their time, they may request a delay with the Match Commissioner or Reserve Official, whose decision shall be final and binding. Full details are contained within the MDOM.
  - Should 3 players fail HIA within the same, the team may use their 18th Player as concussion interchange.
  - Interchange should be done safely and not interfere with play.

E6 POST MATCH AND TRAINING

E6.1 Immediate After Care - Mandatory

Where a player is diagnosed with concussion:

- they should not be allowed to drive themselves home
- Assuming hospitalisation is not required be taken home by and left in the care of a responsible adult.
- The responsible adult should be given a head injury sheet (e.g. SCAT5 Concussion Injury Advice section) and advised to monitor the Player over at least the next four hours.

- The responsible adult should also be advised of the warning signs and symptoms of deteriorating head injury, which may indicate cerebral bleed, and advised in this event to contact emergency services.
- The Player should be advised to avoid alcohol and non-steroidal anti-inflammatory medication, sleeping tablets and other sedating medication and should not be allowed to drive until medically cleared to do so.

E6.2 Follow Up Evaluations - Mandatory

Where following a HIA a player is not diagnosed as having had concussion, they **must** be subject to a follow up evaluation including SCAT5 and clinical judgement at 24 and 48 hour intervals to check that they have not had delayed onset symptoms.

E7 DOCTOR OR EQUIVALENT - CONCUSSION REPORTING REQUIREMENTS – MANDATORY

E7.1 Concussion Report (HIA Form)

A correctly completed Concussion Report (HIA form) must be submitted to the RFL for every player who is removed from the field of play with concussion or with suspected concussion **within 24hours of the incident** and applies to players at all levels as follows:

- For every player who shows symptoms of concussion post-match, (delayed on-set)
- Following a training incident
- For players who sustain a concussion whilst participating in a Community Game fixture (where the player is also registered to a professional club)
- When a player reports a concussion due to an incident which occurs outside the game

E7.2 SCAT5

Where following a Concussion Assessment the Doctor or Equivalent has judged that the player is not concussed a copy of the SCAT5 **must** be submitted to the RFL together with the Concussion Report (HIA form) irrespective of the time the concussion assessment takes place, I.e. if there is insufficient time left for the player to return to the field a SCAT5 assessment must be undertaken and a copy of the SCAT5 submitted. NB SCAT5 baselines must be available on matchday and where there is only a home Doctor or Equivalent present the away team shall ensure that SCAT5 baselines are provided to the home Doctor or Equivalent – see E3.4.

E7.3 Report to Away Club Medical Team

At matches where only the home Doctor or Equivalent is present, they MUST report the concussion and forward relevant documentation to the Medical Team of the away Club **within 12-hours** of the conclusion of the match so that the correct after care, including any referral to and appointment with a specialist, and GRTP protocol can be implemented.

E7.4 Dual Registration/Loan Players

Where a player on Dual Registration or Loan is concussed playing for their Dual Registered or Loan Club (receiving club) the Doctor or Equivalent must report the concussion and forward relevant documentation to the Doctor or Equivalent of the parent Club **within 12 hours** of the conclusion of the match.

E7.5 It is a club's responsibility to ensure that a doctor, providing locum cover, is made aware of the reporting requirements and advised they must submit all HIA documentation within 24-hours of the incident – applies to players at all levels

It is the responsibility of the Club to ensure that all relevant HIA documentation is submitted to the RFL. Failure to adhere to reporting requirements is misconduct and the club concerned will be referred to compliance.

E8 GRADUATED RETURN TO PLAY PROTOCOL - MANDATORY

Players diagnosed with a concussion (including any concussion from training and/or incidents outside sport, i.e, sustained in a car accident) MUST progress through a Graduated Return to Play (GRTP) protocol as set out in the table below.

The GRTP must be managed by a Doctor or Equivalent who may delegate the observation of progress to a healthcare professional save that the Doctor or Equivalent must confirm that the player is able to progress to Stage 5.

There are mandatory rest periods before GRTP can commence when a young player sustains a concussion:

- **For players eligible by age for the Academy but not the U16s & U15s Scholarship (in the applicable season) – the minimum rest period before GRTP can commence (subject to the player being asymptomatic) is 7 days**

- **For players eligible by age for the U15s & U16s Scholarship (in the applicable season) – the minimum rest period before GRTP can commence (subject to the player being asymptomatic) is 14 days.**

For the avoidance of doubt eligibility applies to players born between the dates shown below:

Under 18s - 1.9.2004 – 31.8.2006

Under 16s – 1.9.2006 – 31.8.2007

Under 15s – 1.9.2007 – 31.8.2008

NB: If a player is a member of the first team squad but falls into a category referred to above, the mandatory rest period applies to his age and NOT the team he is playing for. For example, a player who has played for the first team but is eligible by age to play for the Academy/Scholarship must follow the GRTP pathway for the Academy/Scholarship age group.

During the mandatory rest period, it is important to emphasise to the Player that:

- they require physical and cognitive rest. Activities which require concentration e.g., any screen time, reading, driving, education assignments, may make the symptoms worse and may delay recovery so should be avoided.

- If any signs or symptoms develop during the GRTP they must be reported to the Club Medical Officer as soon as they occur, either by the Player and/or coaching and training staff.

NB an important consideration in GRTP is that concussed players should not only be symptom-free but also, they should not be taking any pharmacological agents/medications that may mask or modify the symptoms of concussion.

E8.1 Recurrent or Difficult Concussions

Players who have:

- a second (or subsequent) concussion within 12 months;
- a history of multiple concussions;
- unusual presentations;
- persistent symptoms; or
- prolonged recovery (for the purposes of these Medical Standards prolonged recovery means a player who still shows concussive symptoms ten days or more after the concussive incident)

must be assessed and managed by a specialist (the specialist must be a neurologist, neurosurgeon or a concussion specialist) with experience in sports related concussion. It is the responsibility of the Club to ensure that the specialist they use has evidence of CPD appropriate to the opinion that they are giving, this should usually be evidenced in the form of their Appraisal. In addition, the club must check that the specialist is appropriately indemnified (has current Medical Defence Union insurance cover as a concussion specialist).

The player may not Return to Play until the specialist has given written confirmation that in their opinion they are fit to do so, however can commence the GRTP process, provided they are symptom free. The RFL may require such specialist's reports to cover/include such tests or examinations as it mandates from time to time.

Persistent symptoms (>10 days) are generally reported in 10-15% of concussions. Symptoms may not be specific to concussion, and it is important to consider other pathologies. Cases of concussion where clinical recovery falls outside the expected window (i.e., ten days) must be managed in a multidisciplinary manner by healthcare providers with experience in sports-related concussion and must include a specialist assessment as set out above.

E8.2 POST-CONCUSSION COGNIGRAM - MANDATORY

All players who have sustained a concussion must undertake a post injury Cognigram test between stages 4 & 5of the GRTP when sign and symptom free so it can be evaluated against their current baseline. Players must register a valid post injury test and be evaluated by the club doctor before returning to contact training - stage 5 of the GRTP (unless the Doctor or Equivalent has submitted their clinical reasoning for over-ruling a failure to achieve a valid Cognigram post injury test and received approval from the Chief Medical Officer – see below). Repeat of any baseline neuro-psychometric tests may be used as part of a suite of information provided to the RFL Chief Medical Officer to support a RTP decision in the context of an invalid Cognigram.

It is imperative the post-injury Cognigram test report is checked to ensure validity by logging into the player's record, selecting the current valid baseline (if there is more than one on a record) as the comparator and carefully reviewing the standardised change scores on each of the first four domains (modules) - see below.

The performance of a follow-up assessment (post injury Cognigram test) should be reviewed for decline. If performance on **any** of the first four domains has declined by **more than –1.0SD (on the standardized change score - outside (below) the blue shaded area on the graphs)** when compared to current (valid) baseline, then a further test must be conducted to determine if this decline is sustained or if performance is returning to baseline. A **player may not return to play until test scores on all the first four domains (modules) are -1.0SD or greater (accepted scores are from -1.0 to 0 or above ('above' includes scores in the + range) on the standardized change score)) or clinical reasoning to Return to Play has been applied for (See E8.2.1 below),. In addition, there should be no results in the abnormal range (a score of 79 or below) and no errors/incomplete tests on any of the first four domains (modules) which will render a post injury test invalid.**

Under no circumstances must a player make repeated attempts to "pass" a Cognigram test post-concussion and players must be limited to one test each calendar day with at least 24-hours in between tests.

The RFL will monitor the use of Cognigram and where a player takes more than one test within a calendar day or within 12-hours of a previous attempt this constitutes Misconduct and the Club and/or personnel involved may be subject to Disciplinary action

Please note Cognigram records for dual registered/loan players remains with the parent club on their Cognigram account. If the parent club is not managing the players GRTP the medical staff at both clubs are under an obligation to liaise and share information on the best way to manage the process to ensure appropriate management of the concussion. (Bearing in mind that Cognigram provides the parent club with the ability to launch an out of clinic test).

Cognigram is a vital tool when used in conjunction with symptom checklists and balance evaluation as an aid to the clinical decision-making process. However, it is important that Cognigram is not relied on as the only decision-making process as a significant percentage may have normal neuropsychological testing but still have other symptoms of concussion.

Allowing a player to Return to Play without first establishing a post-injury Cognigram test / valid post injury Cognigram test is Misconduct and the club concerned will be referred to Compliance.

E8.2.1 Failure to Establish a Valid Post Injury Cognigram – Applying for Clinical Reasoning to Return to Play

Where a Player has not achieved a valid post injury Cognigram test after a concussion within the GRTP process set out, but the Club Doctor or Equivalent believes through clinical judgement, that despite an adverse post injury test that he is fit to Return to Play he/she may submit clinical reasoning for deciding that the player has recovered from the concussion.

For the avoidance of doubt clinical reasoning must be in writing and submitted by the Club Doctor or Equivalent (who may consult with other medical personnel involved in the player's recovery) to the RFL's Chief Medical Officer, (sent via the RFL Medical Department) and must be accompanied by the invalid post injury Cognigram report. The Doctor or Equivalent must wait for the Chief Medical Officer's response and answer any questions before permission for the player to Return to Play is given.

For the purposes of these Rules the Chief Medical Officer may appoint a panel of Doctor or Equivalents each of whom may carry out the Chief Medical Officer's function under these Rules when

asked to do so by the RFL Head of Medical. Repeat of any baseline neuro-psychometric tests may be used as part of a suite of information provided to the RFL Chief Medical Officer to support a RTP decision in the context of an invalid Cognigram

E8.3 SUBMISSION OF RETURN TO PLAY DOCUMENTATION - MANDATORY

Return to Play (RTP) Form

Clubs must submit a Return to Play form, which must be completed and signed by the club Doctor or Equivalent to the RFL

Doctors may also ask each player to complete a written consent form which details they have undertaken their GRTP, are symptom free and are aware of the long and short-term risks associated with sustaining concussions. Templates are available from the RFL upon request.

Post Injury Cognigram Reports

A pdf of the Stage 4 valid Cognigram post injury test, ensuring a player's current valid baseline is shown as the comparator (or alternative where used) report must be submitted along with the RTP form.

Specialist Report(s) and Player's Written Acknowledgement of Receipt

The player must be provided with a copy of any specialist reports and must declare, in writing, that they have received, read, and understood the contents. (For players under the age of 18 a parent or guardian must countersign to state they have received read and understood the contents of the report(s).

A copy of all specialist reports along with the player's (and where applicable parent/guardian) written declaration of receipt and understanding of the contents must be submitted to the RFL at the same time as the RTP form and Cognigram post injury test report

It is the responsibility of the Club to ensure all relevant Return to Play documentation is submitted, at the same time, to the RFL and must be received before the player Returns to Play. Failure to do so is misconduct.

E8.3.1 Players sustaining a second or subsequent concussion

For players sustaining a second or subsequent concussion doctors are reminded of the need to take a conservative approach to their management. It is Best Practice for Doctors to supply their detailed clinical reasoning for approving the Return to Play and is in addition to any sign off to RTP by a specialist.

CONCUSSION MANAGEMENT - LOAN/DUAL REGISTERED PLAYERS

If the player receives a concussion whilst playing or training with the Receiving Club, the Receiving Club: (a) is responsible for the immediate care of the player; and (b) should inform the Employing Club immediately after the match / training session.

The medical staff from the two clubs are responsible for liaising to ensure that the player's Graduated Return to Play is managed in accordance with the Concussion Regulations.

Players on Academy and Scholarship Programmes, who also play Rugby Union (Professionally or within the Community Game) or Rugby League within Community Game the Professional Rugby League Club must ensure GRTP is managed in line with the RFL Medical Standards. Professional Club Medical Staff should contact the RFL if they are experiencing difficulties obtaining information from other teams.

Stage	Time	Activity Level	Exercise at each stage of GRTP	Objective
Zero	Head injury day	None	None	Assessment, treatment & recovery
Concussion Report to be completed & submitted to the RFL (all Clubs) GRTP PROTOCOL - ALL DAYS ARE POST DAY ZERO				
1	DAY 1 and DAY 2	No activity for 48 hours (adult) or 7 days (Academy) or 14 days (U16 Scholarship)	Symptom limited physical & cognitive rest.	Recovery
2	DAY 3	Light aerobic exercise	Walking, swimming or stationary cycling keeping intensity <70% maximum predicted heart rate.	Increase heart rate
3	DAY 4, 5 and DAY 6	Sport specific exercise	Running drills – no impact.	Add movement
4	DAY 7 and DAY 8	Non-contact training drills	More complex training drills eg passing drills. May start progressive resistance training.	Exercise, co-ordination and cognitive load.
Cognigram Return to Play test to be taken - Limited to one test every 24-hours Doctor or Equivalent must confirm that the player may progress to Stage 5 (all Clubs)				

Stage	Time	Activity Level	Exercise at each stage of GRTP	Objective
5	DAY 9, DAY 10 and DAY 11	Contact practice	Full unrestricted contact training MUST be preceded by a controlled contact session (i.e., tackle bag / wrestle)	Restore confidence and coaching staff to assess functional skills
6	DAY 12	Return to play	Normal training and/or match activity	Recovery complete

NOTE:

- THE DAY OF THE CONCUSSION IS DESIGNATED AS DAY ZERO.
- DAY ZERO MUST THEN BE FOLLOWED BY 48 HOURS / 7 DAYS / 14 DAYS OF REST (AS APPLICABLE) BEFORE ANY GRTP PROTOCOLS ARE COMMENCED.
- **For the avoidance of doubt stage 2 of the Return to Play protocol can ONLY commence AFTER 48 HOURS / 7 DAYS / 14 DAYS REST (AS APPLICABLE) IN ADDITION TO DAY ZERO and ONLY then if the player concerned is totally asymptomatic.**
- Players may only proceed to the next level of the GRTP if they are asymptomatic at the current level. If there are any post-concussion symptoms during the GRTP the player must drop back to the previous asymptomatic level and not progress again until at least a further 24-hour rest period has passed.
- Where a player has not recorded a Cognigram baseline/valid Cognigram baseline the medical practitioners must add 7 days (extended Graduated Return to Play) to his Return to Play protocol after which the player must set a Cognigram baseline (prior to Stage 5, Full Contact Practice). In circumstances where a player has established a neurological baseline, it may be possible to use it, subject to approval, by the RFL CMO to avoid an extended Graduated Return to Play.

E8.4 Concussion Records

Where a player joins a new club, the previous medical team must share the player's concussion records with the new club's medical team.

E9 STRUCTURAL HEAD INJURIES

If a structural head injury is suspected (for example if a player has a reduced conscious level, is in any way persistently confused or drowsy or has vomited more than once) then the player should be referred to hospital. In addition, the NICE HI guidelines should be followed regarding who should be referred to Hospital.

E9.1 Process

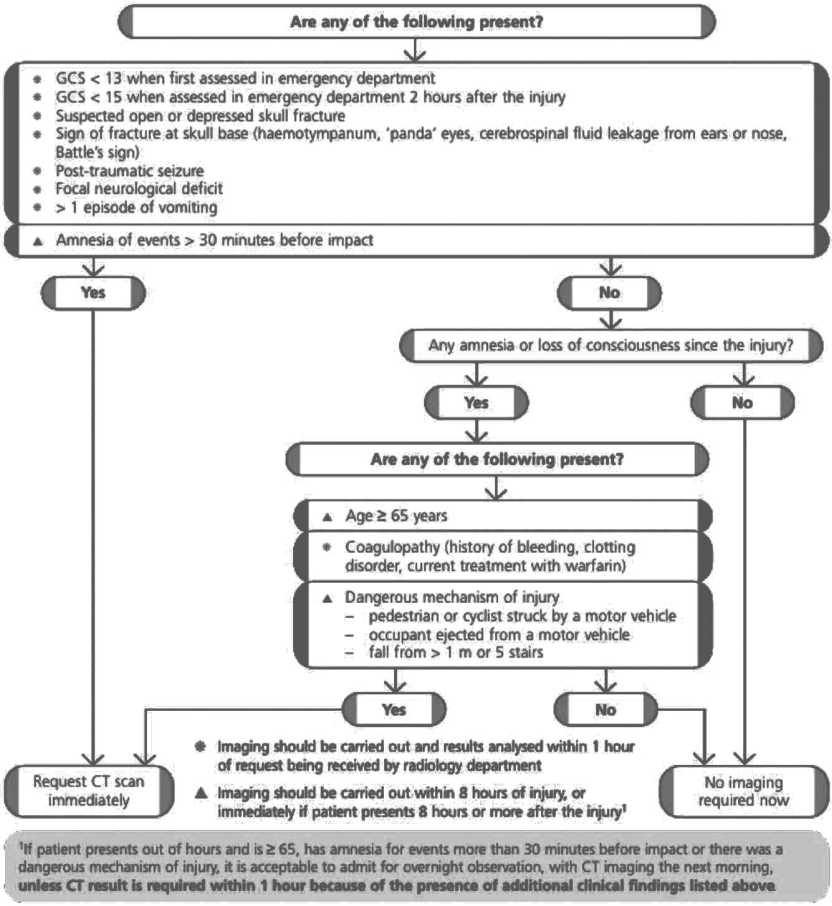
Please be aware that the only validated high level evidence based protocols available in the UK around HI management are the NICE recommendations. LOC and amnesia are pivotal components in these guidelines and clinicians must therefore afford these special significance in their clinical assessment, especially around which players to refer to Hospital.

A clinician's duty of care ends in making this referral. Subsequent management is the responsibility of the Hospital clinicians. It is recommended that any player referred to A&E following a head injury is accompanied by a responsible adult and that a short, relevant clinical summary is provided for the consultation with A&E staff.

Investigation for clinically important brain injury

CT imaging of the head is the primary investigation of choice.

Selection of adults for CT scanning of head



[1]If patient presents out of hours and is ≥ 65, has amnesia for events more than 30 minutes before impact or there was a dangerous mechanism of injury, it is acceptable to admit for overnight observation, with CT imaging the next morning, **unless CT result is required within 1 hour because of the presence of additional clinical findings listed above**

SECTION F

RFL MEDICAL POLICIES

F1 BLOOD BORNE INFECTIOUS DISEASES - GUIDELINES - MANDATORY

This section should be read in conjunction with the relevant Operational Rules relating to Blood Borne Diseases Section.

The aim of the guidelines below is to prevent the spread of disease via infected blood and other bodily fluids. The guidelines cover the following:

- Matches and Training - Bleeding Injuries
- Team Areas
- Blood contamination
- Equipment Guidelines
- On and Off Field Treatment of Bleeding Wounds
- Hepatitis B Vaccination

Super League clubs should consider working with a specialist infection prevention company to ensure that their facilities are appropriately maintained.

F1a MATCHES & TRAINING - BLEEDING INJURIES

It is the players' responsibility to report all wounds and injuries in a timely manner to medical and/or coaching staff, and their responsibility to wear appropriate protective equipment.

If a player suffers a cut at training or during a match, the player must leave the field as soon as practicable, and the following procedures will apply:

a) During Matches

In the presence of a clearly visible amount of blood on a player's jersey or other clothing or on a wound dressing or padding applied to any body part, the Player must leave the field of play for the jersey/dressing to be changed before they can be allowed to return to play to avoid the risk of transfer of infection.

Blood Bin Procedure

The following procedure will apply in all cases where a Player is bleeding on their person or clothing or equipment has been contaminated by blood:

- If the Referee notices a bleeding or blood contaminated Player, they will immediately stop play and call 'time-out' and signal to the Physio to attend to the Player.

- The Physio will immediately enter the field of play to assess whether the Player can be quickly treated on the field or whether they will require treatment off the field.

- If the Physio advises that the Player can be treated on the field, the Referee will instruct the player to drop out behind play for that purpose and the match will immediately recommence.

- If the Physio advises the Referee that they will have to treat the Player off the field, the match will not restart until the player has left the field. The Player may be interchanged, or alternatively the team can elect to temporarily play on with 12 players. (Note: other than for the initial assessment, the match will not be held up while the bleeding player receives treatment or is interchanged).

- If the Referee stops play twice for the same player and the same wound, the Player must be taken from the field for treatment and either interchanged or the team may elect to play on with 12 players until the bleeding player returns.

- If the bleeding player has left the field for treatment and is not interchanged, they may return to the field of play at any time provided they do so from an on-side position. If the bleeding Player has been interchanged, they may only return to the field through the interchange official as a normal interchange player.

A bleeding player returning to the field of play who has not been interchanged, is not to be regarded as a replacement/interchange player and therefore may take a kick for goal. Conversely, a bleeding player returning to the field of play who has been interchanged may not take a kick for goal at that time.

Stitching

Any Player who is bleeding and requires treatment by way of either stitches, stapling or otherwise**, must be taken to the team dressing room or medical room so this procedure can be conducted out of the view of the general public**. After the treatment the wound must be bandaged or covered to protect the injury and to eliminate the risk of further bleeding and to prevent the potential risk of transmission of blood-borne infectious diseases.

Contaminated Clothing

In any case where a Player's person, clothing or equipment has been contaminated by blood, whether through a wound to themself or through contact with a wounded player, the Referee shall direct the Team Trainer to enter the field of play to attend to the Player by

taking immediate steps to ensure that that player is free of any blood contamination before the Player shall be permitted by the Referee to re-join play. Until those steps have been taken, the player shall, at the minimum, drop out behind play.

Contaminated clothing and / or equipment should be treated with a solution of detergent and bleach.

b) During Training

The bleeding Player must be removed from the field/other environment immediately by the coach or must voluntarily leave the field/other environment and seek medical attention.

If the bleeding cannot be controlled, the Player must cease training for that session.

F1b TEAM AREAS

a) Dressing Rooms

The following apply:

- There must be hand basins (with hot and cold running water)
- Toilets, showers and benches must be cleaned with disinfectant after each training session and game.
- Any chairs used must be made from impervious material

In addition, the following apply:

- Drains must run freely.
- A liquid antiseptic soap dispenser, disposable hand towels, brooms and wash buckets must be readily available.
- Sponges must not be used at any time.
- Spitting is prohibited in or around the area.
- Urinating, other than in the toilet area, is prohibited.
- Sharing of equipment, including use of another's towel or use of clothing to stand/sit on whilst drying is strongly discouraged.
- Players should have a clean pair of flip flops to wear to and from the shower/toilet
- Communal baths are not allowed.

b) Medical Room(s)

The following apply:

1) The medical room(s) must be cleaned after each match and training session.
2) Rubbish bins must contain plastic liners, which are to be disposed of after each training session/match.

3) Clinical waste must be disposed of in Yellow Clinical Waste bags and disposed of in the correct manner (incineration under controlled situations either hospital or Local GP/ as per local Health Authority guidelines.)
4) Needles/syringes must be disposed of after use in a suitable waste disposal kit in a sharps bin, which when full must be incinerated in the proper manner (as per LHA guidelines).

c) Gymnasium

The following apply:

- Flooring should be of an impervious material with a sealed surface that is easily cleaned.
- Carpet or artificial turf type are not allowed.
- Players must have shoes, shirt and own towel for each session.

F1c BLOOD CONTAMINATION

a) Use of Detergent/Bleach Sprays

The following apply:

i) A spray container with 15mls of standard washing up liquid and 32 mls of standard household bleach and 250mls of water (see below) is to be standard equipment for each team both on the touchline and in the dressing rooms.
ii) Minor contamination of clothing and equipment must be sprayed and thoroughly soaked with the solution immediately the player leaves the field.
iii) The decontamination solution should be in contact with the blood spill for between one and five minutes.
iv) Prior to return to the field, the contaminated area must be thoroughly rinsed off with water.
v) All but minor blood contamination of clothing and equipment must result in the contaminated clothing and equipment being replaced prior to the player returning to the field.

As standard household bleach deteriorates with time, the decontamination solution must be made up on the day of the game. Do not use bleach which has passed its expiry date. A standard medicine glass can be used to ensure concentrations of detergent and bleach are correctly added to 250 mls of water.

Typically, a solution of one part household bleach to ten parts water should be prepared fresh daily and used as a disinfectant for contaminated areas.

A 0.5% concentration of bleach is not considered hazardous; however care must be taken to avoid contact with eyes or wounds and prolonged contact with the skin. Thorough rinsing with water will further reduce the risk.

b) Contaminated clothing/equipment

Contaminated clothing/equipment must be sealed in a plastic bag within a clearly marked bin and laundered separately in a hot wash at a minimum temperature of 80°C.

F1d EQUIPMENT REQUIREMENTS

- **Medical/First Aid Kit**

The kit must contain disposable protective gloves, hibiscrub (or equivalent) and plastic bags for disposal of contaminated equipment/clothing.

- **Drink Containers**

The following apply:

- Players are to be supplied with and use their own drink containers which they must bring with them and use at every training session
- During matches, Players must drink only from recommended water containers possessing spouts.
- Players should not make contact with or touch the nozzle of squeeze bottles.

WARNING: The potentially life-threatening meningococcal disease can be transmitted by sharing drink containers.

- **Team Kit Bag**

Spare jerseys, shorts and socks must be available in the event that blood contaminated clothing needs to be replaced.

F1e ON AND OFF FIELD TREATMENT OF BLEEDING WOUNDS

The control of bleeding should be carried out by the Trainer or Physio, it is mandated that he/she wear appropriate personal protective equipment.

The correct medical equipment to deal with bleeding wounds must be present at all times as laid out in RFL guidelines.

If a Doctor or Equivalent is not present at training and a Player requires sutures then the player must be sent to the local Casualty department either by car or 999 for the appropriate management of this injury. (For matches the location must be made known to both teams).

F1f HEPATITIS B SCREENING

SUPER LEAGUE & FULL TIME CHAMPIONSHIP & LEAGUE 1 CLUBS - MANDATORY

It is mandatory for Super League and Full-Time clubs to run a Hepatitis B screening session, it is up to the individual player whether he accepts but those that refuse must sign a waiver which is kept on record by the Club, which must be provided to the RFL Head of Medical upon request.

CHAMPIONSHIP & LEAGUE 1 CLUBS – BEST PRACTICE

It is Best Practice for Championship and League 1 clubs to offer players Hepatitis B screening.

F1g HEPATITIS B VACCINATION – BEST PRACTICE

It is mandatory for Super League and Full Time Championship and League 1 clubs to offer players and officials vaccination against Hepatitis B. It is up to the individual whether he accepts but those that choose not to be vaccinated must sign a waiver, a standard waiver document is available from and must be lodged with the RFL Head of Medical upon request.

F1h SEXUALLY TRANSMITTED INFECTIONS/DISEASES – BEST PRACTICE

It is recommended that clubs offer their players access to a STI/STD screening service.

F2 BLOOD BORNE INFECTIOUS DISEASES – REGULATIONS - MANDATORY

The Blood Borne Diseases Regulations are published in the Official Guide and on the RFL Website. http://www.rugby-league.com/the_rfl/rules/operational_rules

NOTIFICATION AND TESTING OF MEDICAL STATUS

The RFL shall appoint a Blood Borne Disease Officer ("BBDO"), who shall be the Head of Medical . The responsibility of the BBDO shall include receiving notification of a Participant suffering from a Blood Borne Disease and convening the Blood Borne Disease Tribunal and Blood Borne Appeal Tribunal.

It shall be the responsibility of the BBDO to ensure that the identity of the Participant and any medical information disclosed or produced in accordance with these Rules is kept confidential at all times.

A Participant aware or who ought reasonably to be aware that they have been diagnosed as having contracted and/or have contracted a blood borne disease shall notify the BBDO, club Doctor or Club Official of their medical status as soon as reasonably practicable.

Where any Doctor, club Doctor or Club Official is advised that a Participant has contracted a blood borne disease they shall notify the BBDO of this as soon as reasonably practicable.

Where anyone else subject to the Operational Rules is advised that a Participant has contracted a blood borne disease, and has received that Participant's consent to do so, they shall notify the BBDO of this as soon as reasonably practicable.

The BBDO may on notification request that the Participant undergo any necessary medical examination and or non-invasive test or sample collection in order to verify the diagnosis. Such examination or test shall be carried out by a suitably qualified medical practitioner appointed by the BBDO. The BBDO may also request that a Participant undergo any necessary medical examination and or non-invasive test or sample collection in order to verify the diagnosis if requested to do so by the Chair of either the Blood Borne Disease Tribunal or Blood Borne Disease Appeal Tribunal at any point prior to the hearing taking place or during any adjournment of the hearing.

Where a Minor is either aged 16 or over or is considered by the medical professional carrying out the examination or test to be 'Gillick' competent, the Minor's consent shall be sufficient. Otherwise, a person with parental responsibility must give prior written consent.

In the event that consent to undergo a medical examination or test is not forthcoming or in the event that a Participant withdraws their consent to waive their right to confidentiality or in the event that a Participant notifies the BBDO that they are no longer willing to be bound by the Rules, then that Participant shall no longer be entitled to participate in any events, competitions, games or other activities organised, convened or authorised by the RFL or any of its member or affiliate organisations, wherever held.

NOTICE OF BBDO'S ACTION

Upon receipt of notification that a Participant is suffering from a Blood Borne Disease, the BBDO shall issue a Provisional Suspension to the Person from participating in events, competitions, games or other activities organised, convened or authorised by the RFL or any of its member or affiliate organisations, wherever held and it shall be misconduct to act in contravention of such Provisional Suspension or to assist a Participant to contravene a Provisional Suspension.

In the event that the BBDO concludes that the evidence is sufficient to conclude that the Participant is not suffering from a Blood Borne Disease then the Person shall be notified as soon as reasonably practicable and shall subsequently be permitted to resume participating in events, competitions, games or other activities organised, convened or authorised by the RFL or any of its member or affiliate organisations, wherever held.

In the event that the BBDO concludes that the evidence is sufficient to conclude that the Participant is suffering or may be suffering from a Blood Borne Disease then the Participant shall be notified as soon as reasonably practicable and the BBDO shall convene a Blood Borne Disease Tribunal to carry out a risk assessment as to whether or not the Participant should be permitted to participate in the sport having regard to the need to protect the rights and the health and safety of other participants in the sport.

In the meantime, and until the Blood Borne Disease Tribunal has issued its decision the Provisional Suspension shall continue.

BLOOD BORNE DISEASE TRIBUNAL

The BBDO shall appoint a Panel of persons suitable to be appointed to the Blood Borne Disease Tribunal or Blood Borne Disease Appeal Tribunal in any particular case. The panel shall be of sufficient size to allow the appointment of any individual tribunal within a reasonable period of time, having regard to the number of cases being notified to the BBDO and having regard to geography and the need to convene the panel as quickly as possible.

HEARINGS BEFORE THE BLOOD BORNE DISEASE TRIBUNAL

If the Tribunal is satisfied that the RFL has established that the Respondent is suffering from a Blood Borne Disease, the Tribunal must then carry out a risk assessment to determine on balance whether the rights and the health and safety of other participants in the sport are prejudiced so as to justify imposing a Permanent or Ongoing Suspension on the Respondent from being entitled to participate in any events, competitions, games or other activities organised, convened or authorised by the RFL or any of its member or affiliate organisations, wherever held.

The Tribunal shall issue a Permanent Suspension where it is satisfied on balance that the Respondent's medical condition is such that the rights and the health and safety of other participants in the sport will always be prejudiced.

The Tribunal shall issue an Ongoing Suspension where it is satisfied on balance that the Respondent's medical condition is such that the rights and the health and safety of other participants in the sport are currently prejudiced but that the medical condition is such that they may not always be prejudiced. In that event the Respondent shall be entitled to apply to the BBDO after such Minimum Period of Ongoing Suspension has expired in order for the BBDO to reconvene a Blood Borne Disease Tribunal.

Any party who wishes to appeal a decision of the Blood Borne Disease Tribunal must lodge a written notice of appeal with the BBDO, specifying the grounds for appeal, within 14 days of receipt of the written reasoned decision of the Blood Borne Disease Tribunal that is being challenged on appeal.

F3 CARDIAC SCREENING - MANDATORY FOR SUPER LEAGUE, CHAMPIONSHIP AND LEAGUE 1 CLUBS

F3.1 GENERAL

Cardiac screening of Rugby League players within the professional game was introduced in order to identify those players who may have conditions that could predispose them to sudden cardiac death. It is mandatory for Super League clubs to arrange appropriate cardiac screening (and follow up screening and/or consultations where required) for all their first team, reserve and academy Players and Best Practice to screen their Scholarship players. It is compulsory for Championship and League 1 clubs to take part in the RFL organised cardiac screening programme OR to arrange their own appropriate screening

It is not compulsory (though strongly recommended) that each player registered at a Club, on the date on which the screening session takes place, agrees to be screened. Where a player makes an informed decision to refuse/decline to be screened it is compulsory for him to complete a waiver form (in the format provided by the RFL) All completed waiver forms must be submitted by the club to the RFL.

It is recommended as Best Practice for all screening be scheduled for and completed pre-season.

On completion of the screening session it is mandatory for the club to submit an attendance list to the RFL.

It is highly recommended that all registered players are screened annually; however, those players who are aged under 25 years and those over the age of 25 years who have not been screened in the last 2 years and those who have had COVID since their last screening should be considered a priority.

Where a player is diagnosed as having a cardiac abnormality then subject to the specialist's opinion and advice, which shall be paramount, and after a thorough education process, usually a Player may if they wish to, make an informed decision to continue to play in which case he must sign a deed of waiver in such form as the RFL requires. It is the responsibility of the club Doctor or Equivalent to make sure that all the club's medical team and the club Doctor or Equivalent of any subsequent club are aware of such a cardiac condition.

F3.2 SCREENING PROVIDERS

The RFL has procured the services of Cardiac Consultant, Dr. Richard Lawrance to conduct its cardiac screening programme.

The cost per screen is lower than that charged by C-R-Y and includes: a12-ead ECG, consultation with Dr. Lawrance (as necessary) and ECHO follow-up on the same day if required.

Clubs do not have to use Dr. Richard Lawrance and may choose to use their own provider as long as the provider delivers the same service including specialist follow up and sends accurate registers of attendance, counter-signed by the Club CEO, to the RFL Head of Medical Standards. Where the Club chooses to use an alternative provider, the Club is responsible for the cost of all follow up specialist appointments and the results of such follow ups must be provided to the RFL.

It is the responsibility of clubs to hold copies of the ECGs of all screened players and waivers.

F3.3 CARDIAC SCREENING REQUIREMENTS

The Club must supply a venue with appropriate space (and equipment as required (I.e. a massage bench, private space for post-ECG consultation)) to conduct the ECG examinations and allocate and inform its players of their individual appointment times. It is recommended that a member of the Club medical staff is also present at the screening session. A full list of all players attending is required and each player will be required to complete a pre-screening questionnaire in advance

All ECGs will be reviewed on the day of the screen and the player will be informed at the same time if any further follow-up investigations are required for them and any relatives deemed necessary. As necessary, the player's club doctor will also be informed of any adverse findings.

Because of the costs incurred the RFL may set a minimum number of players required to attend a screening session. For clubs whose numbers do not meet the minimum number threshold, the RFL would suggest clubs in the same geographical area to consider arranging a mutually convenient venue and share a session between them.

The time taken to conduct each screen is approximately 10 minutes.

F3.4 SCREENING - CHAMPIONSHIP CLUBS AND LEAGUE 1 CLUBS

Clubs should make contact direct with Dr Richard Lawrance to arrange a mutually convenient date, time and place Clubs are responsible for arranging for their players to attend as required by the RFL and for meeting any travel costs the player may have. The RFL will recharge clubs for the costs of the programme out of central distributions.

Clubs may also opt to use an independent provider in line with screening providers set out above.

The RFL will retain a register of those players who have been screened but not the results.

F4 TURNING PLAYERS OVER ON THE FIELD OF PLAY - MANDATORY

Under no circumstances must an injured player be moved by a fellow player. Only relevantly trained and qualified medical personnel may move injured players. `

The RFL asks Club Doctor or Equivalents and/or Physiotherapist or Equivalents to explain to its playing staff the potential hazards to injured players of attempting this and reassure players that injured players are not at risk of "swallowing their own tongue".

F5 PROTECTIVE & OTHER EQUIPMENT – FOR INFORMATION ONLY

F5a HEAD GUARDS

The overwhelming view of international experts in sport-related head injury is that soft helmets do not prevent brain injury (as opposed to superficial head injury) and because of the phenomenon of 'risk compensation' there is a risk that encouraging helmet use in players may paradoxically increase the head injury rates. Because of this medical consensus, the RFL does not support the mandatory wearing of protective head guards in Rugby League.

F5b MOUTH GUARDS

It is strongly recommended that players wear a mouth guard when playing or taking part in contact training sessions. Clubs are not responsible for paying the cost of any medical or dental treatment caused by a player's failure to wear a mouth guard, save where the club has expressly consented in writing to the Player not wearing a mouth guard. It is recommended that Players wear a custom mouth guard which has been made by a Dentist, rather than a generic mouth guard of the 'boil and bite' variety.

Please note that Rugby League Full Time and Part Time Player's Contract of employment states that Players must "wear a mouth guard at all times when playing unless expressly permitted in writing not to do so by the Club."

Players should be encouraged to wear mouthguards for their general benefits but also to obtain data which can be gathered via the mouthguard project which commences in the 2022 season.

F5c BOXES

Players may wear boxes as long as these are padded to prevent injury to opponents.

F6 MENTAL HEALTH COUNSELLING SERVICES – FOR INFORMATION ONLY

The RFL has a fully funded confidential counselling service available to players as follows:

Rugby League Cares

Assistance can be obtained by contacting Steve McCormack, RL Cares Welfare & Development Manager, on 07477873902 or Steve.McCormack@rlcares.org.uk, in strict confidence or by contacting Sporting Chance direct as follows:

Sporting Chance
Website www.sportingchanceclinic.com
Email info@sportingchanceclinic.com or craig@sportingchanceclinic.com
Phone +44 7664 542481 (Craig Dexter) or 07500 000777 (24 hours service)

F7 MENTAL HEALTH FIRST AID (MHFA) - MANDATORY

Mental Health First Aid (PWM & HOY) or Mental Health First Aid Lite (Coaches, Conditioners, PPM & Physios) training is compulsory for the job roles as shown in brackets above. From time to time the RFL may approve alternative courses.

F8 INSOMNIA – FOR INFORMATION ONLY

Clubs should be aware of the insomnia suffered by many players and may wish to provide workshops outlining good sleep hygiene habits or direct players to https://www.sleepio.com/

F9 SOCIAL & NON-PRESCRIBED PRESCRIPTION DRUGS POLICY

The RFL has adopted a Social & Non-Prescribed Prescription (NPP) Drug Policy to meet a number of objectives:

i) To prevent players from causing long or short-term damage to their health/mental well-being through misuse of illegal or non-prescribed substances
ii) To ensure that players can be offered appropriate treatment before misuse and/or addiction jeopardises their career
iii) To protect other players who may be put at risk by players who train or play under the influence of social or NPP drugs
iv) To protect the reputation and integrity of the game

The most effective way to meet these objectives is to have an integrated approach to education, deterrence and rehabilitation by adopting a RFL Social & NPP Drug Policy for Super League with three interlinked strands:

- Education Programme
- Testing Programme
- Rehabilitation, welfare &/or disciplinary procedures

1 Education Programme

Clubs are required to ensure that players are educated about the programme annually.

2 Testing Programme

UKAD will facilitate the screening with results sent to the RFL who will pass to the Clubs to be dealt with in line with the Policy.

3 Rehabilitation, Welfare and/or Disciplinary Procedures

The same policy applies across all Super League clubs as follows:

Self-Declaration

Where a player approaches the RFL or an appropriate member of club staff (PWM, HOY, medical staff, coaching staff) and self-declares that he has been using a Social or NPP Drug prior to screening being carried out then the process described under First Violation will be followed save that it will not count as a First Violation.

First Violation

Following a first violation for Social Drugs or NPPD the players will be required to attend an Initial Case Review with the RFL Head of Medical Standards, Anti-Doping and Integrity and his Club Doctor or Equivalent and/or Player Welfare Manager. Following the Review, the Player will be required to attend an Assessment with a representative of the RFL's Counselling & Addiction Service (Sporting Chance). Following the Assessment, the player will be required to attend such counselling and/or drug treatment programme as the RFL's Counselling and Addiction Service recommends. Subject to the player agreeing to attend the assessment and engaging with the counselling/treatment programme there will be no further action. (NB if the player fails to engage then the Violation is treated as a Second Violation)

The Player will be subject to a targeted testing programme for such period of time as the RFL thinks fit however the Player cannot register a Second Violation until the First Violation Review and Assessment have been completed.

Second Violation

Following a second violation for Social Drugs in addition to review and assessment clubs will be able to take such internal disciplinary action as they consider necessary including dismissal and/or fines (subject to the provisions and procedures of the Standard Players Contract or the Operational Rules as appropriate) or agree to continue the process set out under the First Violation.

In the case of a second violation for NPPD the process set out in under the First Violation will continue, however clubs may take disciplinary action including a fine and written warning but not including dismissal.

Third Violation

For Social Drugs the process will be as set out for the Second Violation.

In the case of a third violation for NPPD the club will be able to take disciplinary action including a fine and written or depending on previous action for the Second Violation, a final written warning but not including dismissal.

Subsequent Violations

For any subsequent violations the club may take disciplinary action and/or dismiss (subject to the provisions and procedures set out in the Standard Players Contract or the Operational Rules as appropriate).

Notes: A NPPD drug is defined as a prescription drug for which the player cannot provide evidence of a prescription. For the purposes of this policy Benzodiazepines and Tramadol are considered to be NPPDs, not social drugs. Please note that Tramadol is on the Prohibited list from 1st January 2024.

In order to determine the NPPD finding the Club Doctor or Equivalent may be consulted. In cases where the drug has been prescribed the CMO will review the prescription with the Club Doctor or Equivalent to determine the rationale for the prescription.

Where a player tests positive for a "social" drug in competition i.e. an Anti-Doping Rule Violation he will still be eligible for the rehabilitation programme set out above although the RFL's Anti-Doping Rules will apply to the sanction.

Where a player tests positive for a substance which is prohibited `in competition` the RFL will inform UKAD as a matter of policy though UKAD would only take the matter further if there was evidence the player had used a stimulant in competition or where trafficking was involved.

F10 SKIN CANCER – BEST PRACTICE

Medical staff should ensure that players and coaching staff are aware of the increased risk of skin cancer from spending long periods of time in the sun. Players and coaching staff should be advised to use an effective sunscreen and where appropriate wear clothes and hats that provide protection. Medical staff should consider adding skin cancer screening to their annual screening programme.

F11 DUAL REGISTRATION & LOAN PROTOCOLS – BEST PRACTICE

The full Protocols are available from Clubs or the RFL, however the parts which are particularly applicable to Medical Standards are set out below.

Employing Club -The Club that holds a contract of employment with the Player

Receiving Club - The Club that a player is with temporarily either on dual registration or loan.

1 DUTY OF CARE

The Employing Club has a legal duty of care to a player whether they are playing and/or training with the Employing Club or playing and/or training with the Receiving Club. The Receiving Club also has a legal duty of care to a player on loan or dual registration to it.

In relation to the Employing Club this includes a responsibility to ensure that it is sending its employee to a safe environment which has all appropriate health and safety policies in place.

The Employing Club is responsible for ensuring that the potential additional hours do not lead to a breach of the Minimum Wage Legislation.

2 MEDICAL STANDARDS

The Employing Club is responsible for ensuring that the Player is receiving medical treatment (in accordance with his contract of employment) whilst they are on loan or dual registration.

The Employing Club is also responsible for ensuring that all medical screening required by the Medical Standards is carried out and that any follow up examinations or treatment is carried out promptly.

3 MEDICAL RECORDS

The Employing Club is responsible for ensuring that the appropriate parts of the player's medical records are shared with the Receiving Club's medical staff. For the avoidance of doubt concussion records and any cardiac anomalies must be shared with the Receiving Club's medical staff. In the case of cardiac anomalies, the Employing Club is responsible for ensuring that there are appropriate systems in place at the Receiving Club.

The Receiving Club is responsible for reporting any injuries or illnesses to the Employing Club.

4 MEDICAL TREATMENT

The Receiving Club must report all injuries to the Employing Club and the Employing Club must be consulted before the player is referred for medical treatment (other than in emergencies).

The Employing Club is responsible for ensuring that the player receives prompt medical treatment as required by the Standard Players' Contract. Where the Receiving Club has agreed to pay for (or insure) medical treatment, in relation to the Player, the Employing Club remains liable for these costs if the Receiving Club defaults on payment.

F12 GENERAL MEDICAL ISSUES – BEST PRACTICE

F12.1 Tetanus

It is Best Practice for Doctors or Equivalent to ensure that players are up to date with tetanus boosters.

F12.2 MMR

It is Best Practice for Doctors or Equivalent to ensure that players have had their MMR vaccinations.

F13 INFECTION CONTROL POLICY

Hygiene processes and practices by Clubs and individuals are essential in stopping the entry of and spread of infectious diseases within Club environments and transmitting to other Clubs.

The below lists high level considerations of maintaining hygiene and infection control:

- Encourage all to undertake good personal hygiene at home and within Rugby League. With a regular focus on hand hygiene
- Clean surface policy
- Cleaning and covering of any wounds and change soiled clothing
- Management of unwell individuals, encouraging anyone who is unwell to stay at home until symptoms have resolved.
- Correct use and disposal of PPE by Medical Staff
- Provide information to all members of staff at the Club regarding screening and vaccination programmes
- Medical team to have a clear escalation plan and reporting processes in the event of notifiable diseases within the Club to UKHSA and/or local Health Protection Teams.

APPENDIX 1 – IMMOFP

Personnel applying for their first IMMOFP course will be required to submit evidence that they have the appropriate qualifications as set out in the table at A2.

New Doctors or Physiotherapists have three months to successfully complete an IMMOFP or equivalent course, or until the first available course if there are no courses available within this time frame.

IMMOFP courses are in demand and booked on a first come, first served basis therefore please book well in advance to obtain a place on a course to suit renewal needs.

Medical staff have two months from the date of expiry to reaccredit their qualification (or until the first available course if there are no courses available within this time frame) or they will be prohibited from entering the field of play. Doctors or Physiotherapists who have submitted evidence of their relevant qualifications and booked onto the next available IMMOFP course are able to provide cover and enter the field of play to provide treatment.

Medical Staff should check their certificate for the expiry date. Ahead of the season, the RFL will send out a reminder to Clubs of the expiry date of their IMMOFP qualified staff and to advise on the dates of forthcoming courses. However, keeping the qualification up to date and booking on to a course in sufficient time is a personal responsibility for medical staff.

RE-ACCREDITATION & RE-CERTIFICATION

It is mandatory the IMMOFP qualification has to be reaccredited with recertification as set out below. Reaccreditation is mandatory on an annual basis for all candidates qualifying for IMMOFP courses as set out in the table below. Each IMMOFP candidate (or equivalent qualification) must attend annually in order to maintain their qualification.

YEAR 1	Two-day IMMOFP course
YEAR 2	One-day refresher course
YEAR 3	One-day refresher course
YEAR 4	Two-day IMMOFP course

EXAMINATION AND IMMOFP PROCEDURES

For staff currently employed by a Rugby League club, payment will be made via a deduction from the clubs Central Distributions upon enrolment to the course, as agreed by responsible Club personnel. Independent candidates must pay for the course in full via BACS within 7 days of date of invoice which will be generated once a place has been confirmed by the RFL. We reserve the right to offer your place to another candidate if payment is not received within this time frame. Clubs are discouraged from 'block booking' multiple spaces for the same candidate. Please note that payment will be taken for all bookings and only refunded should the place(s) be filled 5 weeks in advance of the course date.

No new candidates will be enrolled onto the two-day course within 5 weeks prior to the course date, unless with agreement from the RFL and the candidate in writing.

The two-day course manual and course lectures will be shared by email only on receipt of payment in full. Cancellations will only be accepted up to 5 weeks prior to the course start date thereafter without refund and payment deducted from central distributions for club staff. A medical note must be provided for cancellation due to illness for a refund or course transfer.

Candidates are required to read the manual before the two-day course and complete the on-line pre-course multiple choice form.

A link to the on-line two-day pre-course multiple choice form will be sent out to candidates by email, four weeks before the course date and is required to be completed by the specified deadline. Failure to complete the on-line form within this timeframe will result in the candidate being marked zero for this element of the course.

This multiple-choice form is part of the IMMOFP assessment procedure and is worth 5% of the overall mark.

The RFL, strongly advise, that candidates should not be attending a course immediately preceding a weekend fixture where they are scheduled to provide medical cover as candidates who fail to pass may not enter the field at that fixture. Should a candidate not gain the required pass mark, they are responsible for booking on a course at a later date which provides adequate preparation time.

Where a candidate has to attend a course immediately prior to the weekend of a game he/she is scheduled to cover, arrangements must be made with the Club concerned to have an appropriately qualified member of the medical team available to take the candidates place should they fail to pass the course.

Candidates, who fail the course, will not be able to enter the field of play until such time as a pass is achieved. These individuals may provide assistance with stretcher bearing and off-field. It is the responsibility of the candidate to inform their Club of the failure immediately after the course. The RFL will notify the Club of the result prior to the Clubs next fixture.

COURSE ELEMENTS

Candidates are assessed on five elements of the course according to an objective marking criteria, with an overall pass mark of 75% needed to pass the course. The assessment will compromise the following:

Element	Marks Allocated	How this will be assessed
Pre-course MCQ	5% of overall mark	40 question on-line MCQ form
On-course workstation	10% of overall mark	On-going, on-course assessment. Candidates will be assessed by instructors delivering the workstations with respect to their practical engagement in the learning tasks undertaken.
Practical Scenario exam	25% of overall mark	Objective marking criteria for professional performance within the practical scenario
CPR exam	25% of overall mark	Objective marking criteria for professional performance within the practical scenario
Theory paper	35% of overall mark	50 question MCQ paper

There is an overall pass mark for the course, which has been set at 75% (of all accrued element scores). Any candidate who does not achieve the overall required mark across all elements will be deemed to have been unsuccessful in achieving the required standard of the course. In this instance, they will no longer be able to run on the field of play with immediate effect, until such times as they have attended and passed another IMMOFP course.

IMMOFP RE-SIT PROCEDURES

Any candidate who does not achieve the overall required mark across all elements will be deemed to have been unsuccessful in achieving the required standard of the course. In this instance, they will no longer be able to run on the field of play with immediate effect, until such time as they have attended and passed another IMMOFP course. This is in line with industry best-practice, where any medical course that has elements of ongoing assessment is deemed not to be suitable for re-sit

opportunities for individual elements of the course. For clarity, individuals may still provide medical support to a team/Club however must not enter the field of play or act outside of their scope of qualification.

For course dates and fees for 2023 follow this link: https://www.rugby-league.com/governance/medical/immediate-medical-management

The course costs are (excluding VAT):

COURSE	CLUB STAFF	INDEPENDENT CANDIDATE
1-DAY	£375	£450
2-DAY	£675	£825

Venue: TBC

APPENDIX 2

EDUCATION

MEDICAL STAFF CPD PROGRAMME – BEST PRACTICE/MANDATORY

Medical staff are expected to attend the RFL's CPD programme. The programme covers topics and issues encountered which are particularly relevant to RFL policies and the treatment of injuries commonly suffered within rugby league. There will usually be three CPD events a season and it is highly recommended that colleagues (whatever the level of Club) attend at least two of these events every season.

From time to time the RFL will organise mandatory CPD events, each Super League club and Full Time Club will be expected to have at least their Head Doctor and Lead Physio present at these events who must disseminate the information to other members of the club's medical team.

UKAD EDUCATION COURSES

It is mandatory for club Doctor or Equivalents, physios and conditioners to have completed UKAD's online Introduction to Clean Sport course (or alternative as made available by UKAD) to ensure that they are up to date with regards to the current anti-doping rules. There are no entry requirements for this programme. Training is via an on-line e-learning programme with an assessment at the end. Advisors remain accredited until the UKAD advised expiry date. If you are already registered, you may log in with your current username and password. The course and registration portal is hosted on About the | UK Anti-Doping (ukad.org.uk)

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