MEDICAL STANDARDS

2020

RUGBY FOOTBALL LEAGUE
125 YEARS

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i. Disclaimer

The RFL has taken every care to ensure that the content of this booklet is current and correct at the time of going to print and it has been produced in good faith. However the RFL cannot guarantee its correctness and completeness and no responsibility is taken for any errors or omissions.

The information provided in this booklet has been provided to assist those working in the medical profession within Rugby League. It is not a substitute for the RFL Operational Rules as published from time to time by the RFL which in the case of any conflict take precedence over this document. 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.

NOTE ON SCOPE OF MEDICAL STANDARDS

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

Player includes Amateur players registered with the club.

NOTE ON TERMINOLOGY

In these Medical Standards the following terminology is used next to each sub heading e.g. A1, B2 and 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 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 the appropriate form including information about qualifications and contact details as required from time to time.

A2 DEFINITIONS OF MEDICAL STAFF TERMS USED IN THESE STANDARDS

DEFINITIONS

Doctor	A Doctor must be: fully registered with the GMC, practicing, possess the appropriate professional indemnity insurance, hold a current IMMOFP qualification. It is Best Practice to hold a Diploma in Sports Medicine or equivalent.
Physiotherapist	A physiotherapist must be: CSP & HCPC registered with a degree in physiotherapy, possess the appropriate professional indemnity insurance, hold a current IMMOFP qualification.
Advanced Nurse Practitioner (ANP)	NB Clubs or medical service providers must apply on an individual basis in order to use an Advanced Nurse Practitioner (ANP) who may only be used as set out below. An ANP must: be fully registered with the GMC; have proof of an Advanced Practice MSc; Advanced Life Support certification; have evidence of twelve months' relevant experience in an acute setting preferably A&E; and hold a current IMMOFP qualification. Applications will be considered by the Chief Medical Officer whose decision is final
Paramedic	NB Clubs or medical service providers must apply on an individual basis in order to use a Paramedic who may only be used as set out below. A Paramedic must: be registered with the HCPC as a paramedic; have evidence of 12 months or more experience in an acute setting; hold an honours batchelor degree or higher (or other qualifications deemed equivalent); hold a current Resuscitation Council Advanced Life Certificate; and hold a current IMMOFP qualification. Applications will be considered by the Chief Medical Officer whose decision is final.
Sports Therapist	A Sports Therapist must be: a graduate Sports Therapist with an accredited degree and a member of a recognised professional body

	and hold a current IMMOFP qualification. A Sports Therapist must be supervised by a Physiotherapist unless they can demonstrate one year's full time (or two part time) supervised experience in a professional or lottery funded environment, evidence should be submitted to the RFL for consideration by the Chief Medical Officer.
Sports Rehabilitator	A Sports Rehabilitator must be: a degree qualified BASRAT registered Sports Rehabilitator with appropriate professional indemnity insurance and hold a current IMMOFP qualification. A Sports Rehabilitator must be supervised by a Physiotherapist unless they can demonstrate one year's full time (or two part time) supervised experience in a professional or lottery funded environment, evidence should be submitted to the RFL for consideration by the Chief Medical Officer.
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).

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 Rehabilitators and Sports Therapists in a context which applies to all three roles. Where the context is role specific the individual role is identified.

A3 MEDICAL STAFF ATTENDANCE AT MATCHES & TRAINING - MANDATORY

For all matches the Doctor or Equivalent is to be present in the dressing room area for at least one hour prior to kick off and to remain for at least 30 minutes following the end of the match. Prior to leaving the Doctor or Equivalent must check with the away team Phyiso or Equivalent (where the away team does not have a Doctor or Equivalent present) to confirm that his/her services are not required before leaving the dressing room area.

A3a SUPER LEAGUE REQUIREMENTS – HOME & AWAY GAMES

The Mandatory Requirement is that each Club whether playing at home or away must have at least one of each of the following present in the dressing room before and after the match and on the bench (save when providing treatment either on the pitch or in the treatment room) during the match:

- Doctor
- Physiotherapist

It is also Mandatory for Super League clubs to have a second Doctor or Equivalent in attendance at home games. For the avoidance of doubt a game may go ahead

if the second Doctor or Equivalent is not in attendance and the matter will be referred to the RFL Compliance Department.

It is Best Practice for Super League clubs to have a second Physiotherapist or Equivalent in attendance both home and away and a second Doctor or Equivalent in attendance at away games.

A3b FULL TIME CHAMPIONSHIP & LEAGUE 1 CLUBS REQUIREMENTS – HOME & AWAY GAMES - Full Time Championship & League 1 Clubs

The Mandatory Requirement is that each Club whether playing at home must have at least one of each of the following present in the dressing room before and after the match and on the bench (save when providing treatment either on the pitch or in the treatment room) during the match:

- Doctor
- Physiotherapist

When playing away the Club has the same requirements as above but may have a Doctor or Equivalent or Physiotherapist or Equivalent.

A3c CHAMPIONSHIP CLUBS (OTHER THAN FULL TIME CLUBS) REQUIREMENTS

HOME GAMES

The Mandatory Requirement is that home Club must have one of each of the following present in the dressing room before and after the match (as set out in A2 above) and on the bench (save when providing treatment) during the match:

- Doctor
- Physiotherapist or Equivalent

AWAY GAMES

The Mandatory Requirement is that the away Club must have one of each of the following present in the dressing room before and after the match (as set out in A2 above) and on the bench (save when providing treatment) during the match:

- Physiotherapist or Equivalent

A3d LEAGUE 1 CLUBS (OTHER THAN FULL TIME CLUBS) REQUIREMENTS

HOME GAMES

The Mandatory Requirement is that home Club must have one of each of the following present in the dressing room before and after the match (as set out in A2 above) and on the bench (save when providing treatment) during the match:

- Doctor or Equivalent
- Physiotherapist or Equivalent

AWAY GAMES

The Mandatory Requirement is that the away Club must have one of each of the following present in the dressing room before and after the match (as set out in A2 above) and on the bench (save when providing treatment) during the match:

- Physiotherapist or Equivalent

A3e ACADEMY, U18s, RESERVES AND SCHOLARSHIP REQUIREMENTS

The Mandatory Requirement is that the home Club must have one of each of the following present in the dressing room before and after the match (as set out in A2 above) and on the bench (save when providing treatment) during the match:

- Doctor or Equivalent
- Physiotherapist or Equivalent

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The Mandatory Requirement is that the away Club must have one of each of the following present in the dressing room before and after the match (as set out above) and on the bench (save when providing treatment) during the match:

- Physiotherapist or Equivalent who should travel with the players on the return journey in case of delayed concussion or other injuries.

NB - For IMMOFP please see A9b for other recognised courses.

Please note that Advanced Nurse Practitioners, Paramedics, Sports Therapists and Sports Rehabilitators must have IMMOFP prior to covering a game or training.

A3f MEDICAL COVER AT TRAINING - MANDATORY

Super League & Full Time Clubs

It is Best Practice for a Physiotherapist(s) to be present at all training sessions and particularly those that involve contact. If a Physio is not present then it is Mandatory for a Sports Therapist or Sports Rehabilitator (meeting the definition for unsupervised work as set out above) with a current IMMOFP qualification to be present.

It is mandatory for all Super League coaching and support staff to have an approved First Aid qualification or approved First Aid training by 31 December 2020.

Championship, League 1 Clubs (other than Full Time Clubs) & Academy

It is Best Practice for a Physiotherapist or Sports Therapist or Sports Rehabilitator with a current IMMOFP qualification to be present. If none of the above are present then it is mandatory for a Qualified First Aider with a minimum Level 3

qualification to be present. The Qualified First Aider must be registered with the RFL on LeagueNet.

It is Best Practice for all coaching and support staff to have a first aid qualification.

A4 SUPER LEAGUE CLUB DOCTOR DUTIES - MANDATORY

Super League Clubs have a responsibility to deliver the following by having a Doctor who has agreed to provide duties outside match day requirements.The Super League Club Doctors have mandatory roles outside those on match days which are set out below:

- Ensure that the club has a team of correctly qualified and registered medical staff are present at all Super League home and away fixtures
- Ensure that correctly qualified and registered medical staff are available for all Academy, Reserve, Women's Super League and Scholarship home fixtures
- 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 Medical Emergency Action Plan in place
- Ensure that there is a Pre-Match Briefing for all team medical staff on duty at a match
- Ensure that the first aid provision at training sessions meets the Medical Standards
- Be responsible for ensuring that all Mandatory Medical Equipment is stocked, in date and in good working order
- Be available to players, physio and coaching 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
- Monitor players Return to Play under the Concussion Regulations in consultation with the physio staff and ensure that the RFL's reporting requirements are met
- Keep electronic contemporaneous records of treatments given and interventions made during matches and at training sessions and ensure that physios complete the Leeds Beckett University Injury Audit and other officially sanctioned research projects as notified from time to time. For the avoidance of doubt this will apply to First, Reserve and Academy as directed.
- 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 all First Team, Reserves, Academy 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 (it is recommended that all non-medical match day staff who sit on the bench are Qualified First Aiders).
- 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 Welfare department 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.

A5 EMERGENCY MEDICAL STAFFING SITUATIONS – FOR INFORMATION ONLY

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 above listed courses can be used subject to them completing a registration document, reading these Medical Standards and signing to confirm that they have read and will apply these Medical Standards such documentation to be provided to the RFL in the format required from time to time. This person can only work for a period of three months before an IMMOFP application is required. (In these circumstances the Doctor can carry out Concussion Assessments as set out in E3).

NB Advanced Nurse Practitioners, Paramedics, Sports Therapists and Sports Rehabilitators may not cover games until such time as they have successfully completed IMMOFP or an equivalent.

In the event that a club has a difficulty with the availability of acquiring a Doctor or Equivalent or Physiotherapist or Equivalent to cover one of its games, please contact Tom Hoyle, tom.hoyle@rfl.uk.com or Gavin Wild gavin.wild@rfl.uk.com who will send an email to all IMMOFP qualified personnel asking for assistance. Clubs are to agree and pay fees and expenses direct with reserve medical staff. For the avoidance of doubt it remains the responsibility of the club to provide appropriate medical cover as set out in these Standards.

A6 MATCH OFFICIALS - MANDATORY

Should a Match Official require medical treatment then the home club medical team should provide this promptly and in emergency situations without waiting for a request to do so. All medical personnel are obliged to treat Match Officials as required and failure to do so is Misconduct.

A7 MATCH DAY RULES RELATING TO MEDICAL STAFF - MANDATORY

Doctors or Equivalents P 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.

A7a PHYSIOTHERAPIST(S), SPORTS REHABILITATORS & SPORTS THERAPISTS

- Must wear an orange top.
- 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

A7b DOCTOR(S), ADVANCED NURSE PRACTITIONERS & PARAMEDICS

- Must wear a red top.
- Enter the field of play when they are medically required to do so using their clinical judgement.

A7c GENERAL

- The Doctor or Equivalent(s) and Physiotherapist or Equivalent(s) shall enter the pitch only from the designated technical area or bench and shall return to that area after coming from the pitch. They shall be subject at all times to the control of the Match Commissioner 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 should also refrain from making 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 an away match.

A7d 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 containers or other suitable container should be used. It is not acceptable to use a syringe.

A7e 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 in A7a) above. NB touch judges, ball crew and camera operatives all have right of way and it is the physio(s) responsibility to ensure that there is not a collision.

A7f COMMUNICATIONS EQUIPMENT FOR MEDICAL STAFF – BEST PRACTICE

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

- The medical staff must use a different set of radios to the coaching staff and operate on a wave length 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 wave length is not blocked as this could lead to vital medical communications failing.
- No member of coaching staff shall use medical staff communications equipment in any circumstances.

- The medical staff equipment must be clearly marked either by the use of green handsets (where possible) or by using green tape to identify the equipment.
- Match Commissioners shall be entitled to check both the medical staff and coaching staff communications equipment before and/or after matches
- 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 (this should be checked before every game).

A8 MEDICAL & FIRST AID PROVISION FOR SPECTATORS – FOR INFORMATION ONLY

In addition to the above medical personnel (present for the treatment of players and officials) Clubs should ensure that they fully understand and are aware of their obligations under the provision of their safety certificate and the Green Guide (Guide to Safety at Sports Grounds) regarding medical staff for spectators, e.g. crowd Doctors, first aiders, first aid room, ambulance etc.

Recommended training for crowd Doctors is Pre-Hospital Emergency Care Course (PHEC) and the Major Incidents Medical Management & Support Course (MIMMS) or equivalent relevant experience. The Ground Safety Officer is responsible for this provision.

A9 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 player to hold a current IMMOFP qualification. These persons must be qualified as a Doctor or Equivalent or Physiotherapist or Equivalent as set out in A2 above. (See Appendix 1 for more details).

A9a 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.

A9b RECOGNITION OF OTHER RELEVANT COURSES

Any Doctor or Physio who has successfully completed a Level II FPHC RCSEd course (ICIS, ATMMiF, EMMiITS) will, on receipt of relevant documentation, be entitled to receive a dispensation until the expiry of the other relevant course before they have to complete IMMOFP (or renew the other relevant course).

A10 RFL CPD PROGRAMME – BEST PRACTICE

Medical staff are expected to attend the RFL's CPD programme. The programme covers issues particularly relevant to RFL policies and to 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.

A11 TRAVEL TO FRANCE/CANADA – FOR INFORMATION ONLY

A11a MANDATORY MEDICAL EQUIPMENT IN FRANCE/CANADA

Please see section C4 for details of the set of RFL Mandatory Medical Equipment that is stored in France/Canada for visiting teams to use.

A11b MEDICAL TREATMENT IN FRANCE/CANADA

For matches in France all eligible players should obtain a European Health Insurance Card (EHIC) before travel (NB this may change when the UK exits the EU).

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 Operations Department 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.

A11c LEGAL ISSUES

The GMC advises that Doctor or Equivalents should consult their own Medical Defence Union to advise them of the legal implications of travelling to France or Canada with a Rugby League team and any obligations under French or Canadian law.

However please be advised 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/Canadian 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.

A11d FOREIGN DOCTORS PRACTISING WITH TEAMS VISITING THE UK

The General Medical Council introduced in 2007 an amendment to the Medical Act to enable overseas Doctors to practise medicine in the UK under a provision entitled 'special purpose' registration. Special purpose registration was introduced

for those Doctors who intended to be in the United Kingdom temporarily for the purposes of providing particular medical services exclusively to persons who are not nationals of the United Kingdom.

EU Doctors are able to seek registration under a separate process with the GMC as there is an entitlement to such registration for EU Doctors to provide services on a temporary and occasional basis (EU Doctors should contact the GMC - see below).

In short, where a Doctor is required to undertake work in the UK that involves clinical practice (for example, diagnosis, assessment or treatment of a medical nature) he or she must be registered with a license to practice through the GMC.

There is a team in place at the GMC who will support Doctors/ Unions through the application process. Should you have any GMC enquiries please contact Steph Styles SStyles@gmc-uk.org or +44 (0)161 923 6656.

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 the GMC recommendations. Medical staff leaving a club are responsible for ensuring that 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 the special 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 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 E14 below.

B6 RFL INJURY AUDITS & OFFICIAL RESEARCH - MANDATORY

It is compulsory for Club staff at all 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.

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

- Emma Rosewarne 07850 483736
- Kelly Barrett – 07739 819750

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:

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

B8 MEDICAL EMERGENCY ACTION PLAN

All clubs must ensure that their medical staff have a written Medical Emergency Action Plan which as a minimum should include:

- 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 A&E departments including relevant specialist departments
- Arrangements for transporting injured players post-match 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 should share its Medical Emergency Action Plan with the opposition team's medical staff on arrival at the ground, this should form part of the Pre-Match Briefing.

B9 PRE-MATCH BRIEFING – BEST PRACTICE

It is Best Practice for all team medical staff from both clubs to meet on match day at a suitable time prior to kick off for a pre-match briefing which should be led by the home club Doctor or Equivalent and include, but not be limited to:

- The Medical Emergency Action Plan
- The location of the medical room and any other venue specific information

- The location of the Pitchside Replay system and if there is not a dedicated operator, basic operating instructions for the system
- 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
- Any other relevant information

SECTION C

MEDICAL EQUIPMENT & FACILITIES

C1 MANDATORY MEDICAL EQUIPMENT (MME) - MANDATORY

The RFL have produced a list of equipment which must be present at all games. The home Club is responsible for ensuring that all the Mandatory Medical Equipment (MME) is present in the dressing room area at least one hour before kick-off.

In Super League and for Full Time Clubs in Championship and League 1, the away Club must also travel with a full set of MME, except when travelling to play Catalans Dragons, Toulouse Olympique or Toronto Wolfpack where 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 should liaise at least 7 days prior to any planned travel to Canada and France to ensure that the equipment is present and will be available for the match and any training sessions taking place.

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 set of MME available for each game (working on the assumption that equipment for the first game may not be available for the second).

Match Commissioners will carry out spot checks on MME at matches. See Section C3 for further details.

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.

C1a FULL LIST OF MANDATORY MEDICAL EQUIPMENT

1. Spinal Board and/or Scoop Stretcher and Trained Stretcher Bearers.

A Spinal Board and/or Scoop Stretcher with full complement of body straps or spider straps and head straps with head Immobiliser plus 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.

2. Cervical Stiff Neck Collar(s)

An assortment of 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.

3. Splints

For immobilisation of the limbs. Preferably box splints, which are hygienic, stored flat and ready to use (these come in full and half sizes for upper and lower limb). Alternatively, SAM splints or vacuum splints can be used.

4. Airways, Masks etc

- Oropharyngeal airway [assorted sizes]
- Nasopharyngeal airway [assorted sizes]
- Pocket Mask (1 way valve)
- Self-Inflating Valve mask

The fully equipped and annually serviced Oxygen kit bag from BOC will have some of the above contents supplied. Please complement these accordingly.

5. Automated External Defibrillator (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.

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.

6. Portable Suction

Hand held or powered - must be suitable for pitch side use.

7. Oxygen

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. Supplied & serviced yearly direct to the club from BOC.

8. Drug Box - further details below

Emergency drug box, to be utilised by both teams. It is the responsibility of Home Team Doctor to update and maintain the drug box at the club. Regular checks of the contents of the drug box are essential as some items have relatively short shelf lives.

- Adrenaline 1:1000 1ml vial
- 2 vials of Hydrocortisone 100mg for IV administration (200mg dose)
- Chlorpheniramine (Piriton) 10mg in 1ml vial for IV/IM use
- 10mls water for injection Rectal diazepam - (alternative in Toronto Zeneo mi Dazolam)

- Salbutamol UDV (Unit Dose Vial) 5mg per 2mls (to be nebulised using oxygen unit with mask and chamber supplied in BOC oxygen unit).
- 300mg Aspirin - oral (antiplatelet effect for use in Myocardial Infarctions)
- IV fluids 500ml sodium chloride 0.9%
- IV giving set (ensure IV infusion set)
- One of each - green, white and brown venflon
- Green/Blue/Orange needles (3 of each) xii)1ml, 2ml, 5ml, 10ml syringes (2 of each)

All mandatory drugs must be in-date at all times and replaced as soon as is practicable after use.

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.

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.

9. Foil Blanket and Ambulance Blanket

10. Sharp's Bin and Clinical Waste Bag

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 C6 for further details on clinical waste disposal.

11. 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.

12. Entonox (mandatory for Super League, Best Practice for others)

13. Penlight Torch

14. Suture Kit (dressing pack, normal saline irrigation sachets, toothed forceps, suture holder, scissors plus suture materials).

C1b EQUIPMENT - BEST PRACTICE

14. 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 & your patient is rapidly deteriorating.

15. Crutches

Adjustable with adequate ferrules

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. Various ET tubes

- Laryngoscope
- Stethoscope
- 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)
- Suture Kit (dressing pack, normal saline irrigation sachets, toothed forceps, suture holder, scissors plus suture materials). Should be present at every game and all medics ready to stitch as required at any point throughout a game.
- 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

Any other equipment that a Doctor or Equivalent considers necessary to carry out their duties

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 take into account the availability of medical personnel and equipment.

C3 MATCH COMMISSIONER CHECKS – FOR INFORMATION ONLY

Match Commissioners will carry out spot checks on medical equipment at Super League and Championship games. Should any of the Mandatory Medical Equipment not be present, the Match Commissioner 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 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 MANDATORY MEDICAL EQUIPMENT IN FRANCE/CANADA - MANDATORY

The RFL no longer provides Mandatory Medical Equipment for teams travelling abroad see above.

C5 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. This can be obtained from the local authority.

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

C6 DRESSINGS & STRAPPING - MANDATORY

Please be aware of the duty of care to other members of staff at the Club such as ground staff and cleaning staff who may come into contact with blood stained dressings and strapping post game/training.

These staff should be trained in procedures to handle such items and understand the risks involved and should be provided with adequate bleach solution as per regulations and disposable gloves.

C7 FACILITY STANDARDS - MANDATORY

Clubs must have a separate treatment room close to both teams' dressing rooms. This room is for the sole use of players and match officials only and not for the treatment of members of the public. A separate first aid room should be provided for members of the public and equipped as set out in the Green Guide.

C8 TRAINING GUIDELINES - MANDATORY

It is important that Clubs do not compromise on safety in training sessions so Clubs should carry out a risk assessment and ensure that relevant information about training sessions is included in the club's Medical Emergency Action Plan.

For required medical cover see A3e) above.

SECTION D

ANTI-DOPING

Significant changes to the WADA Code came into force on 1 January 2015.

The minimum sanction for deliberate cheating is now 4 years.

There is now less leniency for carelessness, meaning that players are more likely to receive a two-year ban for inadvertent doping.

To get any reduction in sanction, players must have substantial proof they were not at fault or intending to cheat.

Significant changes to the WADA List of Prohibited Substances in relation to asthma drugs come into force on 1 January 2016 with further changes coming into force on 1 January 2017.

The UKAD Advisor course will make sure that you are aware of the changes see D4.2 below.

If you have any questions regarding any aspect of anti-doping, please contact Matt Barnes by email on matt.barnes@rfl.uk.com.

D1 UK ANTI-DOPING – FOR INFORMATION ONLY

UK Anti-Doping (UKAD) is responsible for all anti-doping in the UK.

D2 SUPPLEMENTS - BEST PRACTICE

The RFL policy on supplements is to assess the need, assess the risk and assess the consequences. No guarantees can be made regarding the composition of supplements and whether or not they contain prohibited substances. Strict Liability applies in all doping cases and contaminated supplements will not be a valid defence for a player who provides a positive sample. However, clubs and players should attempt to minimise the risk by only using supplements from manufacturers who have robust quality control measures in place. There are organisations available who can test supplements and reputable manufacturers will use these services. One such example is Informed Sport www.informed-sport.com

D3 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.

D4 ANTI DOPING EDUCATION – MANDATORY

D4.1 100% me PLAYER EDUCATION

100% me is the player-centred education programme developed by UKAD and the RFL. Clubs are bound by the RFL Operational Rules to deliver a 100% me session to all players in the club on an annual basis. It is compulsory for all professional players at each club to have a 100% me education session taken by a UKAD Educator. The RFL will distribute names and contact numbers for UKAD Educators who have an understanding of Rugby League. Clubs are responsible for paying the fee which is fixed by UKAD. However the RFL will pay the Educator direct and deduct fees and expenses from distributions.

D4.2 100% me ADVISOR

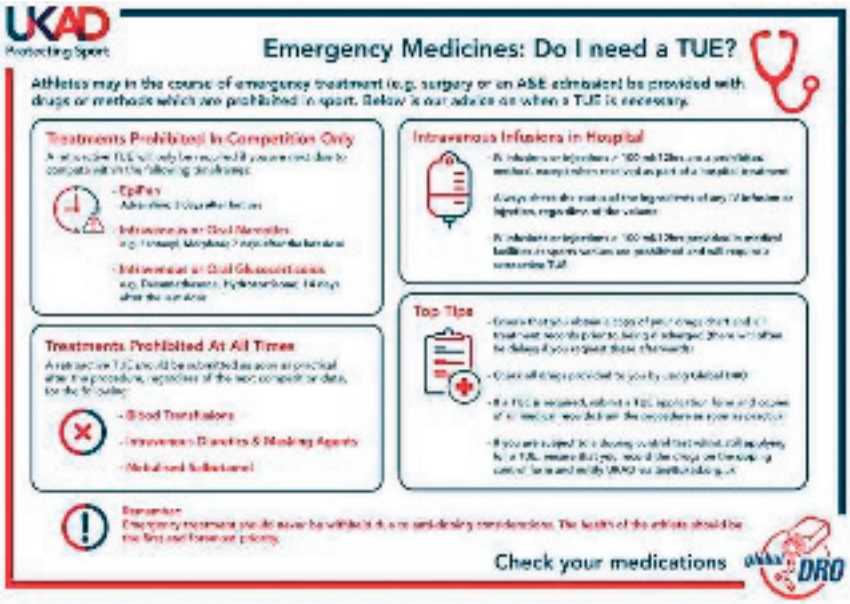
It is mandatory for club Doctor or Equivalents, physios and conditioners to have completed UKAD's online 100% me Advisor course to ensure that they are up to date with regards to the current anti-doping rules. There are no entry requirements for this programme. Training is via an on-line e-learning programme with an assessment at the end. Advisors remain accredited via an annual assessment. Visit www.ukad.org.uk/learningzone for the Advisor training. Please note you will need to be registered to access this course. To do this you will need to register on the website at www.ukad.org.uk/account/register. If you are already registered, you may log in with your current username and password. It is also compulsory for Player Welfare Managers and Heads of Youth to complete this course.

D5 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.

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



D6 PSEUDOEPHEDRINE – FOR INFORMATION ONLY

Pseudoephedrine is a Prohibited Substance. This means that any player who provides a sample containing Pseudoephedrine is likely to face a sanction. Pseudoephedrine is commonly found in cold remedies so players must be careful which remedies they take when they have a cold. A Player should consult club medical staff before taking any cold remedies. Many cold remedies do not contain Pseudoephedrine and these are often more effective. Therapeutic Use Exemptions will not be granted for cold remedies containing Pseudoephedrine.

Over-using Pseudoephedrine can lead to:

- Fast, pounding or uneven heartbeat
- Increased blood pressure
- Severe dizziness
- Easy bruising and bleeding Flu-like symptoms; chills, fevers, aches
- Anxiety and restlessness
- Unusual weakness

D7 METHYLHEXANEAMINE – FOR INFORMATION ONLY

Methylhexaneamine is a Prohibited Substance which has been the cause of a number of positive tests which has led to players receiving bans.

Methylhexaneamine is commonly referred to by a number of alternative names including, but not limited to, forthan, forthane, floradrene, geranamine, dimethylamylamine, DMAA,

dimethylpentylamine, 1,3-dimethylamylamine, geranium oil or geranium extract. Please note that not all of these synonyms appear on www.globalDRO.com .

The type of supplements that are more likely to contain Methylhexaneamine are those supplements which are designed to increase energy or aid weight loss. There is no guarantee that supplements are drug free, and the RFL and UK Anti-Doping recommend that any player who is considering the use of a supplement assess the risks in doing so.

Due to health concerns, the MHRA made it illegal in August 2012 to sell products containing Methylhexaneamine. The reasons given by MHRA were that it "has been linked to suspected adverse drug reactions worldwide, ranging from shortness of breath to heart attacks. It has also been linked to at least one fatality." The full MHRA press release can be found at http://www.mhra.gov.uk/NewsCentre/Pressreleases/CON180711. Medical staff and players should be aware that some less reputable companies continue selling products containing Methylhexaneamine.

D8 PLATELET DERIVED PREPARATIONS (PLATELET RICH PLASMA) – FOR INFORMATION ONLY

Platelet-derived preparations have been removed from the Prohibited List after consideration of the lack of any current evidence concerning the use of these methods for purposes of performance enhancement notwithstanding that these preparations contain growth factors. Despite the presence of some growth factors, current studies on PRP do not demonstrate any potential for performance enhancement beyond a potential therapeutic effect. Note that individual growth factors are still prohibited when given separately as purified substances as described in the Prohibited List.

D9 THERAPEUTIC USE EXEMPTIONS - CHANGES FOR 2018 – FOR INFORMATION ONLY

The TUE process has not changed since 2016, however please be aware that 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/.

D10 GLUCOCORTICOSTEROIDS – FOR INFORMATION ONLY

The use of Glucocorticosteroids administered via inhalation (e.g. Beclomethasone or Budesonide) or a non-systemic route does not require a TUE or a Declaration of Use. Non-systemic routes means intra-articular, peri-articular, peri-tendinous, epidural and intra-dermal injection.

Players still need to declare the use of Glucocorticosteroids on the Sample Collection Form when tested.

Glucocorticosteroids administered via a systemic route (i.e. orally, rectally, intravenous or intra-muscular) still require a full TUE.

Topical preparations (e.g. eye drops, nasal sprays, creams and ointments) containing Glucocorticosteroids are not prohibited and therefore do not require a TUE.

D11 ASTHMA

D11a BETA-2 AGONISTS - SALBUTAMOL, SALMETEROL AND FORMOTEROL – FOR INFORMATION ONLY

Salbutamol, Salmeterol and Formoterol 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 and Formoterol a player can take above which an Adverse Analytical Finding will be declared.

The limit for Salbutamol is a maximum of:

i) 1600 micrograms over 24 hours; and

ii) 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 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.

D11b 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 Operations department.

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, Academy, 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.

D11c 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

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

Objective medical evidence will have to be provided to obtain a TUE. 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.

D11d 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.

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.

D12 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.

D13 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

D14 CENTRES FOR ASTHMA TESTS TO PROVIDE EVIDENCE FOR TUE APPLICATIONS – FOR INFORMATION ONLY

Brunel University - Middlesex - Professor Alison McConnell 01895 266480 alison.mcconnell@brunel.ac.uk

Bronchodilator. £80 approx. @ Brunel or club (subject to 7 minimum tests and travel costs)

Northumbria University - Newcastle - Les Ansley les.ansley@unn.ac.uk 07999 418 119

Eucapnic hyperventilation (EVH) test. £150 approx (although discounted rates may be available for block bookings) @ club. Can also do EVH testing at clubs based in the London area.

Olympic Medical Institute - Harrow, London

Offer full diagnosis, assessment and management of breathing problems. Medical staff referrals only to Nick Fellows on 020 8423 7203 or nick.fellows@boa.org.uk

D15 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 50 ml.

D16 2018 MONITORING PROGRAM (INCLUDING NICOTINE) – FOR INFORMATION ONLY

In order to detect potential patterns of abuse, nicotine is currently on WADA's Monitoring Program. It is not WADA's intention to target smokers, rather to monitor the effects nicotine can have on performance when taken in oral tobacco products such as snus.

Nicotine is one of several stimulants included in the Monitoring Program, along with caffeine. The narcotics hydrocone, mitragynine, codeine and tramadol are also monitored. Out-of-competition use of glucocorticosteroids is also included.

The concurrent use of multiple beta-2 agonists, in order to establish patterns of use, remains on the Monitoring Program.

E CONCUSSION & MANAGEMENT OF HEAD INJURIES REGULATIONS – MANDATORY

E1 PURPOSE, SCOPE & INTERPRETATION

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 systems and protocols for managing head injuries are mandatory and have 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.

All Persons Subject to the Operational Rules are bound by these Regulations and may be charged under Section D1 of the Operational Rules for any breach of these Regulations. In addition Clubs and Chief Executive Officers are held ultimately responsible for the actions and/or omissions of Club Officials.

The RFL will monitor (such monitoring will include reviewing recordings of matches) incidents of apparent concussion during matches, concussion assessments, notifications of concussion and RTP and recurrent concussion. 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 Welfare Department or the RFL Compliance Department, are entitled to ask a Club and/or Doctor 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 Doctor is required to respond promptly. It is therefore especially important that all 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 Doctors to carry out an internal self-reflective review of their procedures.

Any Club who is eligible for and enrols in the Repetitive Concussion in Sport (RECOS) research programme may use the RECOS programme to fulfil its obligations under these Regulations where indicated in the Regulations. For the avoidance of doubt these Regulations take precedence over the RECOS programme and where in the opinion of the RFL a Club has not fulfilled its obligations through the RECOS programme these Regulations will apply.

The protocols set out in these Regulations are only for use by qualified Doctors working in the professional game. 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 follows the guidelines from the International Consensus on Concussion in Sport when drawing up its Concussion Regulations. The Regulations below have been updated following the principles agreed at the 2016 Berlin Conference and include a number of significant quotes from the text of the Consensus Statement on Concussion in Sport published by the 2017 Concussion in Sport Group (CISG). It is recommended that all medical staff read the full Consensus Statement which can be downloaded at http://bjsm.bmj.com/content/early/2017/04/26/bjsports-2017-097699 In addition, these updated regulations take account of comment and discussion at the RFL concussion CPD events held in season 2017.

E3 EXTRACTS FROM THE CONSENSUS STATEMENT ON CONCUSSION IN SPORT 2017

What is the definition of Sports Related Concussion (SRC)?

Sport related concussion is a traumatic brain injury induced by biomechanical forces. Several common features that may be utilised in clinically defining the nature of a concussive head injury include:

- *SRC may be caused either by a direct blow to the head, face, neck or elsewhere on the body with an impulsive force transmitted to the head.*
- *SRC typically results in the rapid onset of short-lived impairment of neurological function that resolves spontaneously. However, in some cases, signs and symptoms evolve over a number of minutes to hours.*
- *SRC may result in neuropathological changes, but the acute clinical signs and symptoms largely reflect a functional disturbance rather than a structural injury and, as such, no abnormality is seen on standard structural neuroimaging studies.*
- *SRC results in a range of clinical signs and symptoms that may or may not involve loss of consciousness. Resolution of the clinical and cognitive features typically follows a sequential course. However, in some cases symptoms may be prolonged.*

  The clinical signs and symptoms cannot be explained by drug, alcohol, or medication use, other injuries (such as cervical injuries, peripheral vestibular dysfunction, etc) or other comorbidities (eg, psychological factors or coexisting medical conditions).

Sideline evaluation

It is important to note that SRC is an evolving injury in the acute phase, with rapidly changing clinical signs and symptoms, which may reflect the underlying physiological injury in the brain. SRC is considered to be among the most complex injuries in sports medicine to diagnose, assess and manage. The majority of SRCs occur without loss of consciousness or frank neurological signs. At present, there is no perfect diagnostic test or marker that clinicians can rely on for an immediate diagnosis of SRC in the sporting environment. Because of this evolving process, it is not possible to rule out SRC when an injury event occurs associated with a transient neurological symptom. In all suspected cases of concussion, the individual should be removed from the playing field and assessed by a physician as discussed below.

Sideline evaluation of cognitive function is an essential component in the assessment of this injury. Brief neuropsychological (NP) test batteries that assess attention and memory function have been shown to be practical and effective. Such tests include the SCAT5,

which incorporates the Maddocks' questions[6 7] and the Standardised Assessment of Concussion (SAC).[8–10] It is worth noting that standard orientation questions (eg, time, place, person) are unreliable in the sporting situation when compared with memory assessment.[7 11] It is recognised, however, that abbreviated testing paradigms are designed for rapid SRC screening on the sidelines and are not meant to replace a comprehensive neurological evaluation; nor should they be used as a standalone tool for the ongoing management of SRC.

A key concept in sideline assessment is the rapid screening for a suspected SRC, rather than the definitive diagnosis of head injury. Players manifesting clear on-field signs of SRC (eg, loss of consciousness, tonic posturing, balance disturbance) should immediately be removed from sporting participation. Players with a suspected SRC following a significant head impact or with symptoms can proceed to sideline screening using appropriate assessment tools—for example, SCAT5. Both groups can then proceed to a more thorough diagnostic evaluation, which should be performed in a distraction-free environment (eg, locker room, medical room) rather than on the sideline.

In cases where the physician may have been concerned about a possible concussion, but after the sideline assessment (including additional information from the athlete, the assessment itself and/or inspection of videotape of the incident) concussion is no longer suspected, then the physician can determine the disposition and timing of return to play for that athlete.

We acknowledge that many contact sports are played at a fast pace in a disorganised environment, where the view of on-field incidents is often obscured and the symptoms of SRC are diverse, all of which adds to the challenge of the medical assessment of suspected SRC. Furthermore, evolving and delayed-onset symptoms of SRC are well documented and highlight the need to consider follow-up serial evaluation after a suspected SRC regardless of a negative sideline screening test or normal early evaluation.

The recognition of suspected SRC is therefore best approached using multidimensional testing guided via expert consensus. The SCAT5 currently represents the most well-established and rigorously developed instrument available for sideline assessment. There is published support for using the SCAT and Child SCAT in the evaluation of SRC. The SCAT is useful immediately after injury in differentiating concussed from non-concussed athletes, but its utility appears to decrease significantly 3–5 days after injury. The symptom checklist, however, does demonstrate clinical utility in tracking recovery. Baseline testing may be useful, but is not necessary for interpreting post-injury scores. If used, clinicians must strive to replicate baseline testing conditions. Additional domains that may add to the clinical utility of the SCAT tool include clinical reaction time, gait/balance assessment, video-observable signs and oculomotor screening.

The addition of sideline video review offers a promising approach to improving identification and evaluation of significant head-impact events, and a serial SRC evaluation process appears to be important to detect delayed-onset SRC.

Symptoms and signs of acute SRC

Recognising and evaluating SRC in the adult athlete on the field is a challenging responsibility for the healthcare provider. Performing this task often involves a rapid assessment in the midst of competition with a time constraint and the athlete eager to play. A standardised objective assessment of injury that excludes more serious injury is critical in determining disposition decisions for the athlete. The sideline evaluation is based on recognition of injury, assessment of symptoms, cognitive and cranial nerve function, and balance. Serial assessments are often necessary. Because SRC is often an evolving injury, and signs and symptoms may be delayed, erring on the side of caution (ie, keeping an athlete out of participation when there is any suspicion of injury) is important.
The diagnosis of acute SRC involves the assessment of a range of domains including clinical symptoms, physical signs, cognitive impairment, neurobehavioral features and sleep/wake disturbance. Furthermore, a detailed concussion history is an important part of

the evaluation both in the injured athlete and when conducting a pre-participation examination.

The suspected diagnosis of SRC can include one or more of the following clinical domains:

a. *Symptoms: somatic (eg, headache), cognitive (eg, feeling like in a fog) and/or emotional symptoms (eg, lability)*

b. *Physical signs (eg, loss of consciousness, amnesia, neurological deficit)*

c. *Balance impairment (eg, gait unsteadiness)*

d. *Behavioural changes (eg, irritability)*

e. *Cognitive impairment (eg, slowed reaction times)*

f. *Sleep/wake disturbance (eg, somnolence, drowsiness)*

If symptoms or signs in any one or more of the clinical domains are present, an SRC should be suspected and the appropriate management strategy instituted. It is important to note, however, that these symptoms and signs also happen to be non-specific to concussion, so their presence simply prompts the inclusion of concussion in a differential diagnosis for further evaluation, but the symptom is not itself diagnostic of concussion.

Remove

When a player shows any symptoms or signs of an SRC:

a. *The player should be evaluated by a physician or other licensed healthcare provider on site using standard emergency management principles, and particular attention should be given to excluding a cervical spine injury.*

b. *The appropriate disposition of the player must be determined by the treating healthcare provider in a timely manner. If no healthcare provider is available, the player should be safely removed from practice or play and urgent referral to a physician arranged.*

c. *Once the first aid issues are addressed, an assessment of the concussive injury should be made using the SCAT5 or other sideline assessment tools.*

d. *The player should not be left alone after the injury, and serial monitoring for deterioration is essential over the initial few hours after injury.*

e. *A player with diagnosed SRC should not be allowed to return to play on the day of injury.*

When a concussion is suspected, the athlete should be removed from the sporting environment and a multimodal assessment should be conducted in a standardised fashion (eg, the SCAT5). Sporting bodies should allow adequate time to conduct this evaluation. For example, completing the SCAT alone typically takes 10 min. Adequate facilities should be provided for the appropriate medical assessment both on and off the field for all injured athletes. The final determination regarding SRC diagnosis and/or fitness to play is a medical decision based on clinical judgement.

Re-evaluate
An athlete with SRC may be evaluated in the emergency room or doctor's office as a point of first contact after injury or may have been referred from another care provider. In addition to the points outlined above, the key features of follow-up examination should encompass:

a. *A medical assessment including a comprehensive history and detailed neurological examination including a thorough assessment of mental status, cognitive functioning, sleep/wake disturbance, ocular function, vestibular function, gait and balance.*

b. *Determination of the clinical status of the patient, including whether there has been improvement or deterioration since the time of injury. This may involve seeking additional information from parents, coaches, teammates and eyewitnesses to the injury.*

c. *Determination of the need for emergent neuroimaging to exclude a more severe brain injury (eg, structural abnormality).*

Neuropsychological assessment

Neuropsychological assessment (NP) has been previously described by the CISG as a 'cornerstone' of SRC management. Neuropsychologists are uniquely qualified to interpret NP tests and can play an important role within the context of a multifaceted—multimodal and multidisciplinary approach to managing SRC. SRC management programmes that use NP assessment to assist in clinical decision-making have been instituted in professional sports, colleges and high schools.

The application of NP testing in SRC has clinical value and contributes significant information in SRC evaluation.[12–17] Although in most cases, cognitive recovery largely overlaps with the time course of symptom recovery, cognitive recovery may occasionally precede or lag behind clinical symptom resolution, suggesting that the assessment of cognitive function should be an important component in the overall assessment of SRC and, in particular, any return-to-play protocol.[18 19] It must be emphasised, however, that NP assessment should not be the sole basis of management decisions. Rather, it provides an aid to the clinical decision-making process in conjunction with a range of assessments of different clinical domains and investigational results.

It is recommended that all athletes should have a clinical neurological assessment (including evaluation of mental status/cognition, oculomotor function, gross sensorimotor, coordination, gait, vestibular function and balance) as part of their overall management. This will normally be performed by the treating physician, often in conjunction with computerised NP screening tools.

Brief computerised cognitive evaluation tools are a commonly utilised component of these assessments worldwide given the logistical limitation in accessing trained neuropsychologists. However, it should be noted that these are not substitutes for complete NP assessment.

Baseline or pre-season NP testing was considered by the panel and was not felt to be required as a mandatory aspect of every assessment; however, it may be helpful or add useful information to the overall interpretation of these tests. It also provides an additional educative opportunity for the healthcare provider to discuss the significance of this injury with the athlete.

Post-injury NP testing may be used to assist return-to-play decisions and is typically performed when an athlete is clinically asymptomatic. However, NP assessment may add important information in the early stages after injury.[20 21] There may be particular situations where testing is performed early to assist in determining aspects of management—for example, return to school in a paediatric athlete. This will normally be best determined in consultation with a trained neuropsychologist.[22 23]

Rest

Most consensus and agreement statements for managing SRC recommend that athletes rest until they become symptom-free. Accordingly, prescribed rest is one of the most widely used interventions in this population. The basis for recommending physical and cognitive rest is that rest may ease discomfort during the acute recovery period by mitigating post-

concussion symptoms and/or that rest may promote recovery by minimising brain energy demands following concussion.

There is currently insufficient evidence that prescribing complete rest achieves these objectives. After a brief period of rest during the acute phase (24–48 hours) after injury, patients can be encouraged to become gradually and progressively more active while staying below their cognitive and physical symptom-exacerbation thresholds (ie, activity level should not bring on or worsen their symptoms). It is reasonable for athletes to avoid vigorous exertion while they are recovering. The exact amount and duration of rest is not yet well defined in the literature and requires further study.

Refer

Persistent symptoms

A standard definition for persistent post-concussive symptoms is needed to ensure consistency in clinical management and research outcomes. The Berlin expert consensus is that use of the term 'persistent symptoms' following SRC should reflect failure of normal clinical recovery—that is, symptoms that persist beyond expected time frames (ie, >10–14 days in adults and >4 weeks in children).

'Persistent symptoms' does not reflect a single pathophysiological entity, but describes a constellation of non-specific post-traumatic symptoms that may be linked to coexisting and/or confounding factors, which do not necessarily reflect ongoing physiological injury to the brain. A detailed multimodal clinical assessment is required to identify specific primary and secondary pathologies that may be contributing to persisting post-traumatic symptoms. At a minimum, the assessment should include a comprehensive history, focused physical examination, and special tests where indicated (eg, graded aerobic exercise test).

Treatment should be individualised and target-specific medical, physical and psychosocial factors identified on assessment

Overall, these are difficult cases that should be managed in a multidisciplinary collaborative setting, by healthcare providers with experience in SRC.

Recovery

There is tremendous interest in identifying factors that might influence or modify outcome from SRC. Clinical recovery is defined functionally as a return to normal activities, including school, work and sport, after injury. Operationally, it encompasses a resolution of post-concussion-related symptoms and a return to clinically normal balance and cognitive functioning.

It is well established that SRCs can have large adverse effects on cognitive functioning and balance in the first 24–72 hours after injury. Injured athletes report diverse physical, cognitive and emotional symptoms during the initial days after injury, and a greater number and severity of symptoms after an SRC predict a slower recovery in some studies.

For most injured athletes, cognitive deficits, balance and symptoms improve rapidly during the first 2 weeks after injury. Many past studies, particularly those published before 2005, concluded that most athletes recover from SRC and return to sport within 10 days. This is generally true, but that conclusion should be tempered by the fact that many studies reported group-level findings only, not clinical outcomes from individual athletes, and group statistical analyses can obscure subgroup results and individual differences. There is also historical evidence that some athletes returned to play while still symptomatic, well before they were clinically recovered. Moreover, during the past 10 years, there has been a steadily accumulating literature that a sizeable minority of youth, high-school and collegiate athletes take much longer than 10 days to clinically recover and return to sport.

Having a past SRC is a risk factor for having a future SRC, and having multiple past SRCs is associated with having more physical, cognitive and emotional symptoms before participation in a sporting season. Therefore, it is not surprising that researchers have studied whether having prior SRCs is associated with slower recovery from an athlete's

next SRC. There have been inconsistent findings regarding whether specific injury severity characteristics, such as loss of consciousness, retrograde amnesia, or post-traumatic amnesia, are associated with greater acute effects or prolonged recovery. Numerous post-injury clinical factors, such as the initial severity of cognitive deficits, the development of post-traumatic headaches or migraines, experiencing dizziness, difficulties with oculomotor functioning, and experiencing symptoms of depression have all been associated with worse outcomes in some studies.

The strongest and most consistent predictor of slower recovery from SRC is the severity of a person's initial symptoms in the first day, or initial few days, after injury. Conversely, and importantly, having a low level of symptoms in the first day after injury is a favourable prognostic indicator. The development of subacute problems with migraine headaches or depression are likely risk factors for persistent symptoms lasting more than a month. Children, adolescents and young adults with a pre-injury history of mental health problems or migraine headaches appear to be at somewhat greater risk of having symptoms for more than 1 month. Those with attention deficit hyperactivity disorder or learning disabilities might require more careful planning and intervention regarding returning to school, but they do not appear to be at substantially greater risk of persistent symptoms beyond a month.

Return to sport
Graduated return to sport

The process of recovery and then return to sport participation after an SRC follows a graduated stepwise rehabilitation strategy, an example of which is outlined in table 1. This table has been modified from previous versions to improve clarity.

Table 1

Graduated return-to-sport (RTS) strategy

Stage	*Aim*	*Activity*	*Goal of each step*
1	*Symptom-limited activity*	*Daily activities that do not provoke symptoms*	*Gradual reintroduction of work/school activities*
2	*Light aerobic exercise*	*Walking or stationary cycling at slow to medium pace. No resistance training*	*Increase heart rate*
3	*Sport-specific exercise*	*Running or skating drills. No head impact activities*	*Add movement*
4	*Non-contact training drills*	*Harder training drills, eg, passing drills. May start progressive resistance training*	*Exercise, coordination and increased thinking*
5	*Full contact practice*	*Following medical clearance, participate in normal training activities*	*Restore confidence and assess functional skills by coaching staff*
6	*Return to sport*	*Normal game play*	

NOTE: An initial period of 24–48 hours of both relative physical rest and cognitive rest is recommended before beginning the RTS progression.

There should be at least 24 hours (or longer) for each step of the progression. If any symptoms worsen during exercise, the athlete should go back to the previous step. Resistance training should be added only in the later stages (stage 3 or 4 at the earliest). If symptoms are persistent (eg, more than 10–14 days in adults or more than 1 month in children), the athlete should be referred to a healthcare professional who is an expert in the management of concussion.

Graduated return-to-sport (RTS) strategy
After a brief period of initial rest (24–48 hours), symptom-limited activity can be begun while staying below a cognitive and physical exacerbation threshold (stage 1). Once concussion-related symptoms have resolved, the athlete should continue to proceed to the next level if he/she meets all the criteria (eg, activity, heart rate, duration of exercise, etc) without a recurrence of concussion-related symptoms. Generally, each step should take 24 hours, so that athletes would take a minimum of 1 week to proceed through the full rehabilitation protocol once they are asymptomatic at rest. However, the time frame for RTS may vary with player age, history, level of sport, etc, and management must be individualised.

In athletes who experience prolonged symptoms and resultant inactivity, each step may take longer than 24 hours simply because of limitations in physical conditioning and recovery strategies outlined above. This specific issue of the role of symptom-limited exercise prescription in the setting of prolonged recovery is discussed in an accompanying systematic review.[24] If any concussion-related symptoms occur during the stepwise approach, the athlete should drop back to the previous asymptomatic level and attempt to progress again after being free of concussion-related symptoms for a further 24 hour period at the lower level.

Residual effects and sequelae

This summary statement regarding the potential for long-term sequelae following recurrent head trauma must be read in conjunction with the systematic review paper, which details the background, search strategy, citations and reasoning for this statement.[25]

The literature on neurobehavioral sequelae and long-term consequences of exposure to recurrent head trauma is inconsistent. Clinicians need to be mindful of the potential for long-term problems such as cognitive impairment, depression, etc in the management of all athletes. However, there is much more to learn about the potential cause-and-effect relationships of repetitive head-impact exposure and concussions. The potential for developing chronic traumatic encephalopathy (CTE) must be a consideration, as this condition appears to represent a distinct tauopathy with an unknown incidence in athletic populations. A cause-and-effect relationship has not yet been demonstrated between CTE and SRCs or exposure to contact sports. As such, the notion that repeated concussion or subconcussive impacts cause CTE remains unknown.

Risk reduction

Role of pre-participation SRC evaluation

Acknowledging the importance of an SRC history, and appreciating the fact that many athletes will not recognise all the SRCs they may have suffered in the past, a detailed SRC history is of value.[26–29] Such a history may identify athletes who fit into a high-risk category and provides an opportunity for the healthcare provider to educate the athlete as to the significance of concussive injury.

A structured SRC history should include specific questions as to previous symptoms of an SRC and length of recovery, not just the perceived number of past SRCs. Note that dependence on the recall of concussive injuries by teammates or coaches is unreliable.[26] The clinical history should also include information about all previous head, face or cervical spine injuries, as these may also have clinical relevance. In the setting of maxillofacial and cervical spine injuries, coexistent concussive injuries may be missed unless specifically assessed. Questions pertaining to disproportionate impact versus symptom-severity matching may alert the clinician to a progressively increasing vulnerability to injury. As part of the clinical history, the health practitioner should seek details regarding protective equipment used at the time of injury for both recent and remote injuries.

There is an additional and often unrecognised benefit of the pre-participation physical examination insofar as the evaluation provides an educative opportunity with the player concerned, as well as consideration of modification of playing behaviour if required.

Prevention

While it is impossible to eliminate all concussion in sport, concussion-prevention strategies can reduce the number and severity of concussions in many sports. Until the past decade, there has been a relative paucity of scientifically rigorous evaluation studies examining the effectiveness of concussion-prevention strategies in sport.

The evidence for mouthguard use in preventing SRC is mixed, but meta-analysis suggests a non-significant trend towards a protective effect in collision sports, and rigorous case–control designs are required to further evaluate this finding.

Conclusion

This consensus document reflects the current state of knowledge and will need to be modified according to the development of new knowledge. It should be read in conjunction with the systematic reviews and methodology papers that accompany this document (British Journal of Sports Medicine, issues 9 and 10, 2017). This document is first and foremost intended to inform clinical practice; however, it must be remembered that, while agreement exists on the principal messages conveyed by this document, the authors acknowledge that the science of concussion is incomplete and therefore management and return-to-play decisions lie largely in the realm of clinical judgement on an individualised basis.

E4 PRE-MATCH REQUIREMENTS

In order to effectively manage Concussion Assessments and Graduated Return to Play protocols it is essential that clubs have appropriate baselines in place and concussion records.

E4.1 COGSTATE BASELINES

NB CogState costs are recharged to clubs on an annual basis.

E4.1.1 Mandatory Baselines

It is mandatory for all players to establish a pre-season CogState baseline before taking part in contact training. Players are not eligible to play until a valid pre-season baseline has been established.

Players born on or after 1st September 2003 **do not have to complete a CogState baseline** as the CogState system is not suitable for players under the age of 16.

For players below the mandatory age for CogState testing, Club Doctors should establish a SCAT5 baseline following the same timescales as for a CogState baseline to assist in their clinical judgement in deciding on readiness to RTP using sign and symptom resolution.

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

E4.1.2 Failure to Establish CogState Baseline

Any Club allowing a Player to take part in contact training or play without establishing a baseline will be guilty of Misconduct. See below for procedures to follow when a Player fails to record a baseline.

If a player is repeatedly producing invalid baseline results and otherwise shows no signs of a head injury 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 such as King Devick to be established.

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.

E4.1.3 Players changing Club Mid-Season

For a player who has a valid baseline with another club, his CogState file can be transferred across to the new club file if the RFL is advised. If this procedure is not followed, then any RTP tests conducted at a new club without an existing baseline will result in an automatic fail.

E4.1.4 Dual Registered/Loan Players

Parent clubs should carry out the CogState tests on Dual Registered Players; however, the receiving club must check that they have a valid baseline before taking to the field. Playing a player without a valid baseline is Misconduct.

E4.2 SCAT5 BASELINES

Clubs must ensure that they have established a SCAT5 baseline for each of their players which must be logged with the RFL and made available on match days for medical staff to use, home or away. 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.

E4.3 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

E4.4 CONCUSSION RECORDS

It is mandatory for Doctor or Equivalents to obtain a full concussion record for all new players from their previous club (whether that be in the UK or overseas).

Where it does not form part of the concussion record it is good practice for Doctors to interview new 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.

Records should include non-sporting concussions.

E5 MATCHES &/OR TRAINING

E5.1 Removal from Play (or Training)

All players with diagnosed 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. Where the Medical staff are unsure whether the Player is concussed a Concussion Assessment must be carried out 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, if there is a concern that a player may be concussed he must undergo 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. Any Player removed from the field

of play more than once during the same match for a Concussion Assessment should not be allowed to return to play that same match.

E5.2 Signs and Symptoms of Concussion

Where Medical Staff observe, become aware of or are reliably informed that a player has presented Category One symptoms he must be removed from the field of play and may not return.

Where Medical Staff observe, become aware of, or are reliably informed that a player has presented with Category Two symptoms or otherwise suspect that a player may have concussion he must be removed from the field of play for a Concussion Assessment. There must be a rest period of five minutes before the Concussion Assessment takes place.

Where the Medical Staff have removed a player for a Concussion Assessment but subsequently become aware that the player has or had Category One symptoms the player cannot return to the field of play.

i) Category One Symptoms

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

ii) Category Two Symptoms

- Possible loss of consciousness
- 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 or facial fracture

Any other sign that may indicate concussion

E5.3 Pitchside Replay

It is mandatory for each Super League Club and Full Time Club to have a pitchside replay facility (which is also available to the visiting club). It is Best Practice to have a dedicated Pitchside Replay operator who can operate the system for the medical staff.

It is Best Practice for all other Clubs to have such facility and Clubs without the facility are expected to bear this in mind when upgrading systems and/or equipment at their ground.

E5.4 Match Officials

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 leaves the field.

If a Match Official has concerns that a player may have suffered a concussion, he may stop play and call the medical team onto the field of play to express his concerns and ask them to examine the player.

E5.5 Concussion Assessment

1) The Doctor or Equivalent must wait five minutes before beginning a Concussion Assessment during which time they should view the playback of the incident where this facility is available. If at this stage they become aware that the player had a Category One symptom the player cannot return to play and must be diagnosed as concussed.

2) The Concussion Assessment must not take place on the pitch-side but in the medical or dressing room.

3) SCAT5 must be used as part of the Concussion Assessment as well as clinical judgement. However, the assessing Doctor or Equivalent in their match-day clinical assessment may not overrule an adverse SCAT5. In addition, Club Doctor or Equivalents may elect to use additional assessment tools such as King Devick as part of their Return to Play protocols.

4) Where a Doctor or Equivalent is aware or becomes aware that a Player has at least one Category One symptom, the Doctor or Equivalent **must diagnose him as being concussed for the purposes of these rules** and may NOT use his clinical judgement or the results of SCAT5 (or any other assessment tool) to return the Player to the field.

5) Where the Player has not had any Category One symptoms and has passed his SCAT5 then the Doctor or Equivalent may use his 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

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

7) Each player must only be subject to one Concussion Assessment per game

Failure to comply with this Rule constitutes Misconduct and the Club (and any relevant individual) may be subject to disciplinary action. **It should be remembered 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. Within SCAT5 it is highlighted that 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 the 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.

Where possible Doctor or Equivalent should also use pitch side replay facilities to identify in particular if a player has suffered Category One or Two Symptoms.

E5.6 Informing the Match Commissioner & 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 Concussion Assessment and medical staff must also inform the Match Commissioner of any Concussion Assessments undertaken during the half time interval.

1) Where the Medical staff have already diagnosed concussion the player must not return to play or train on the same day and an interchange (subject to availability) should be made immediately.

2) Where the Medical staff suspect concussion the Concussion Assessment period will begin as the Player leaves the field of play. (The team may have a free interchange which starts as the player leaves the pitch.)

3) The player may not return to the field (when it is judged that he does not have concussion) 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. In circumstances where the player's treatment takes longer than 15 minutes eg wound toilet, repair *and* concussion assessment, with the caveat the player has

passed the Concussion Assessment, the player can return to play (RTP), yet will count as a further player interchange against the team's quota.

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

a. 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.
b. The Match Commissioner shall then release the Player to the Interchange Official.
c. 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.
d. 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 of six tackles for his team. 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.

E6 POST MATCH

E6.1 Immediate After Care

Where a player is diagnosed with concussion he should not be allowed to drive himself home but should (assuming hospitalisation is not indicated) be taken home by a responsible adult and where possible 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 particularly over at least the next four hours. The responsible adult should also be advised of the warning signs and symptoms of deterioration and asked to contact emergency services should deterioration take place.

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 Serial Evaluation

Where following a Concussions Assessment a player is not diagnosed as having concussion he must be subject to a follow up evaluation using SCAT5 and clinical judgement at 24 and 48 hours to check that he has not had delayed onset symptoms.

E6.3 Graduated Return to Play

All players diagnosed with a concussion (this includes concussions from training and/or incidents outside sport) must go through a Graduated Return To Play (GRTP) protocol as set out below.

- the day of the concussion is designated as day zero.

-day zero will then be followed by 48 hours of complete rest BEFORE any GRTP protocols are commenced.

To avoid all doubt stage 1 of the return to play protocol ONLY commences AFTER 48 HOURS REST IN ADDITION TO DAY ZERO and only then if the player concerned is totally asymptomatic.

There are mandatory rest periods before starting the GRTP when there is a young player involved, these are different for younger age groups:

- Players eligible by age for the U18 Academy but not the U16 Scholarship (in the applicable season) – the rest period before GRTP is 7 days

- Player eligible by age for the U15 & U16 Scholarship (in the applicable season) – the rest period before GRTP is 14 days.

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

Under 18s - 1.9.2001 – 31.8.2003

Under 16s – 1.9.2003 – 31.8.2004

Under 15s – 1.9.2004 – 31.8.2005

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 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 U18s must follow the GRTP pathway for the U18s age group.

In the period of mandatory rest it is important to emphasise to the Player that he requires physical and cognitive rest. Activities which require concentration e.g. videogames, text messaging, education assignments, may make the symptoms worse and may delay recovery so should be avoided.

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

Players should only continue 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 then the player should drop back to the previous asymptomatic level and not try to progress again until at least a further 24 hour rest period has passed.

Where a player is unable to record a valid RTP on CogState between stages 5 and 6 the club Doctor or Equivalent must check the content of the detailed CogState report before deciding to use clinical judgement to override the CogState report. If the club Doctor or Equivalent believes, despite an adverse CogState report, that the player is fit to RTP he must submit his clinical judgement (in writing) and a copy of the CogState report to the Chief Medical Officer (via the RFL Welfare Department) and receive the Chief Medical Officer's comments and answer any questions from the Chief Medical Officer before deciding whether to sign the player off to Return to Play. 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 Welfare Department.

Where a player has not recorded a CogState baseline prior to the season the medical practitioners must add 7 days to his Return to Play protocol.

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.

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 CogState.

Players suffering a second or subsequent concussion

1.1 For players suffering a second or subsequent concussion (where there are Category 1 signs or symptoms doctors are reminded of the need to take a conservative approach to their management. Doctors will be required to submit detailed clinical reasoning for approving the return to play.

Stage	Time	Activity Level	Exercise at each stage of GRTP	Objective
Zero	Head injury day-DAY ZERO	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 (U18 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	Sport specific exercise	Running drills – no impact.	Add movement
4	DAY 5	Non-contact training drills	More complex training drills eg passing drills. May start progressive resistance training.	Exercise, co-ordination and cognitive load.
Doctor or Equivalent must confirm that the player may progress to Stage 5 (all Clubs)				
5	DAY 6	Full contact practice	Normal training activity	Restore confidence and coaching staff to assess functional skills
CogState Return to Play test to be taken				
6	DAY 7	Return to play	Normal training and/or match activity	Recovery complete

NB Players who are eligible by age for the U18 Academy and , U16 or U15 Scholarship must rest for the appropriate time period for their age before beginning the GRTP set out above.

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.

Where a player has not recorded a CogState baseline prior to the season the medical practitioners must add 7 days to his Return to Play protocol.

E6.4 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 Rule 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 or a 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 has current Medical Defence Union insurance to cover his role as a concussion specialist.

In such circumstances the player may not Return to Play until the specialist has given written confirmation that in his opinion he is fit to do so. The RFL may require such specialist's report to cover such tests or examinations as it mandates from time to time. The player must be shown the report and must sign to state that he has read and understood the contents of the report (for players under the age of 16 a parent or guardian must countersign to state they have read and understood the contents of the report). A copy of the specialist's report and the player's (or parent/guardian) confirmation must be provided to the RFL with the Return to Play report which must be received before the player takes to the field to play or train.

Subject to availability clubs may use the RECOS specialist clinic to fulfil their obligations under this paragraph E6.4

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 (ie, 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.

In the case of Dual Registration and/or Loan both Clubs are under an obligation to work together and share information to ensure the appropriate management of concussion including Graduated Return to Play.

E6.5 POST-CONCUSSION COGSTATE

During the GRTP players should undertake a CogState test so that their reading can be evaluated against the baseline set at the start of the season. Under no circumstances should a player make repeated attempts to "pass" a CogState test

post-concussion and players must be limited to one test every 24 hours. The RFL will monitor the use of CogState and where a player takes more than one test within 24 hours this constitutes Misconduct and the Club and/or personnel involved may be subject to Disciplinary action.

It is imperative to ensure the outcome of post-injury CogState tests by logging into the actual account and reviewing the test report to confirm its validity. **Please DO NOT go by the result on the upload screen.** On occasion in the past the upload screen has registered a test as valid with the actual report subsequently being invalid. Any club who is found to have played a player who has not recorded a valid post-injury test will be referred to compliance.

CogState is a vital tool when used in conjunction with symptom checklists and balance evaluation as an aid to the clinical decision-making process. It is important that CogState 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.

E6.6 RETURN TO PLAY

All players suffering a concussion must complete a Return To Play (RTP) test when sign and symptom free as part of the GRTP (see above - The RTP CogState test should be taken between Stages 5 and 6 of the GRTP) Players must register a valid RTP test before they are signed off to RTP unless the Doctor or Equivalent has submitted his clinical reasoning for over-ruling a failure to achieve a valid CogState RTP and has received approval from the Chief Medical Officer. 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 CogState

Please note the CogState record for dual registered/loan players remains with the parent club and a post-injury test can only be taken on the parent club's account. If the parent club are not managing the players GRTP the medical staff at both clubs should liaise on the best way to manage the process.

E7 DOCTOR OR EQUIVALENTS' REPORTING REQUIREMENTS

E7.1 Concussion Report

A correctly completed Concussion Report must be submitted to the RFL for every player who is removed from the field of play with concussion or with suspected concussion within 24 hours of the incident and applies to all levels. A Concussion Report must be submitted to the RFL for every player who shows symptoms of concussion post-match or following a training incident or when the player reports a concussion due to an incident which occurs outside the game within 24 hours.

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 with the Concussion Report irrespective of the time the concussion assessment takes

place. For instance, if there is insufficient time left for the player to return to the field a SCAT5 assessment needs to 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.

E7.3 RTP Form

Following 7.1 or 7.2 above Clubs must submit a RTP form, signed by the club Doctor or Equivalent, to the RFL before the player is eligible to play again. A copy of the valid CogState (or SCAT5 where used) report must accompany the RTP form.

E7.4 Clinical Reasoning

Where a Player has not achieved a valid CogState test after a concussion but the Doctor or Equivalent believes that he is fit to RTP he/she must submit his clinical reasoning for deciding that the Player has recovered from the concussion together with the invalid CogState reports) (or SCAT5) and the player's baseline report and wait for the Chief Medical Officer's comments and questions before the Player may RTP. 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.

E7.5 Report to Away Club Medical Team

At matches where only the home Doctor or Equivalent is present he/she is required to 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 and GRTP protocols can be followed.

E7.6 Dual Registration/Loan Players

Where a player on Dual Registration or Loan is concussed playing for his Dual Registered or Loan 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.

E7.7 Specialists' Report

Where required by these Rules a copy of the specialist's report and the declaration by the Player that he has read and understood the contents of the specialist's report must be submitted to the RFL prior to Return to Play.

E7.8 Concussion Records

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

Failure to comply with the reporting requirements shall be Misconduct.

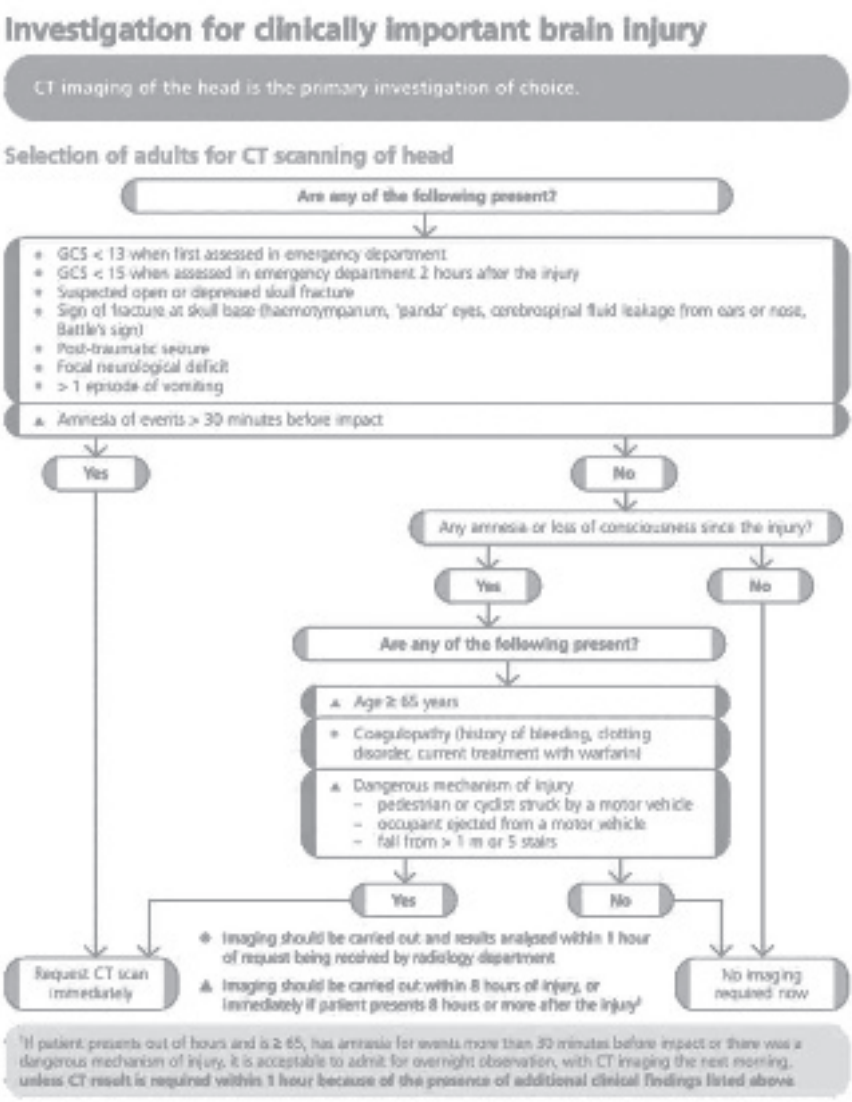
E8 STRUCTURAL HEAD INJURIES

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.

E8.1 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
Are any of the following present?
GCS < 13 when first assessed in emergency department
GCS < 15 when assessed in emergency department 2 hours after the injury
Suspected open or depressed skull fracture
Sign of fracture at skull base (haemotympanum, 'panda' eyes, cerebrospinal fluid leakage from ears or nose, Battle's sign)
Post-traumatic seizure
Focal neurological deficit
> 1 episode of vomiting
▲ Amnesia of events > 30 minutes before impact
Yes
No
Any amnesia or loss of consciousness since the injury?
Yes
No
Are any of the following present?
▲ Age ≥ 65 years
● Coagulopathy (history of bleeding, clotting disorder, current treatment with warfarin)
▲ Dangerous mechanism of injury
– pedestrian or cyclist struck by a motor vehicle
– occupant ejected from a motor vehicle
– fall from > 1 m or 5 stairs
Yes
No
● Imaging should be carried out and results analysed within 1 hour of request being received by radiology department
▲ Imaging should be carried out within 8 hours of injury, or immediately if patient presents 8 hours or more after the injury[1]
Request CT scan immediately
No imaging required now
[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.

Medical, coaching and/or playing staff who fail to comply with these Guidelines may be referred to the RFL Compliance Department for disciplinary action.

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 the course of a match, the player(s) 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 he can be allowed to return to play to avoid the risk of transfer of infection.

Blood Bin Procedure – FAILURE TO COMPLY CONSTITUTES MISCONDUCT

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

If the Referee notices a bleeding or blood contaminated Player he 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 he 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 he 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 a bleeding player has left the field for treatment and is not interchanged, he may return to the field of play at any time provided he does so from an on-side position. If the bleeding Player has been interchanged, he 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 himself 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 immediately by the coach or must voluntarily leave the field 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.

In addition the following:
- 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) First Aid Room

The following apply:

- The first aid room must be cleaned after each match.
- The rubbish bin must contain plastic liners, which are to be disposed of after each training session/match.
- 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.)
- 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:

- A spray container with 15mls of standard washing up liquid and 32 mls of standard household bleach is to be standard equipment for each team, on the touchline and in the dressing rooms.
- Minor contamination of clothing and equipment must be sprayed and thoroughly soaked, with the solution immediately the player leaves the field.
- The decontamination solution should be in contact with the blood spill for between one and five minutes.
- Prior to return to the field, the area must be thoroughly rinsed off with water.
- 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 insure 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 GUIDELINES

a) Medical/First Aid Kit

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

b) 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.

c) 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 (the location of which must be made known to both teams) either by car or 999 for the appropriate management of this injury.

F1f HEPATITIS B SCREENING - 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, a copy of which must be lodged with the RFL Welfare Department. 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 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 the RFL Welfare Department, a copy of which must be lodged with the RFL Welfare Department

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 This is an extract of relevant regulations.

F2.1 SCOPE AND APPLICATION

The RFL has adopted these Blood Borne Disease Rules ("the Rules") to impose controls on blood borne diseases in the sport of Rugby League in order to protect the rights and the health and safety of other participants in the sport. This is done by way of a risk assessment, based on reputable medical opinion, for each individual case brought to the attention of the RFL.

These rules shall apply to all Participants.

Any Participant agrees to be bound by and abide strictly by these Rules and:

- To provide all requested assistance to the RFL in the application and enforcement of these Rules;

- To waive medical confidentiality only in so far as it is necessary to apply and enforce these Rules, including providing express consent to any Doctor or Equivalent to advise the RFL, the Person's employer and any other Doctor or Equivalent of the Person's medical status and/or history in order to protect the rights and the health and safety of other participants in the sport and in order to allow the RFL to apply and enforce the Rules;

- To the processing of data, including sensitive and personal data, pursuant to the General Data Protection Regulation 2018 in order to protect the rights and the health and safety of other participants in the sport and in order to allow the RFL to apply and enforce the Rules;

- To make him/herself available to undergo any necessary medical examination and or non-invasive test, including blood test, or sample collection, including blood sample collection;

- To submit to the jurisdiction of the Blood Borne Disease Tribunal;

- To submit to the jurisdiction of any Blood Borne Disease Appeal Tribunal.

Further to each Participant's obligation to comply with these Rules, it is the responsibility of each Participant:

- To be as fully aware of their medical condition as is reasonable in all of the circumstances;
- To advise their Doctor, their employer and their employing club's Doctor of their medical condition as soon after reasonably that they are aware or ought reasonably to be aware that they have been diagnosed as having contracted and/or have contracted a blood borne disease;
- To ensure that they protect the rights and the health and safety of other participants in the sport.

These Rules shall only apply to Blood Borne Diseases, which shall include, but not be limited to, HIV and Hepatitis.

These rules shall come into effect on 6 June 2006 and shall not be retrospective but shall apply any Participant who at the date of the implementation of the Rules has been diagnosed as suffering from or who is suffering from a Blood Borne Disease and to any Participant who is diagnosed as suffering from or who is suffering from a Blood Borne Disease subsequent to the date of implementation.

NOTIFICATION AND TESTING OF MEDICAL STATUS

The RFL shall appoint a Blood Borne Disease Officer ("BBDO"), who shall be the Welfare Director. 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 has been introduced in order to identify those players who may have conditions that will predispose them to sudden cardiac death. It is mandatory for Super League clubs to arrange appropriate cardiac screening (and follow up screening or consultations where required) for all their professional players and Best Practice to screen 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 the Club at the time of the screen agrees to undertake the screening. Where a player makes an informed decision to refuse the screening he must complete a waiver form (in the format provided by the RFL) which must be submitted to the RFL.

All results from screening (or waivers) must be provided to the RFL.

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 he wishes 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 developed a relationship with Cardiac Risk in the Young (CRY) who offer Cardiology Support at reduced costs. The current cost is £50 per player for the 12-lead ECG only service and includes consultation with one of the CRY cardiologists and ECHO follow-up on the same day if required.

Clubs do not have to use CRY 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 Welfare Department. 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.

F3.3 CRY REQUIREMENTS

The Club must supply a venue with appropriate space for a CRY technician to conduct the ECG examinations and inform players of their individual appointment times. It is recommended that a member of the Club medical staff is also present. CRY require a full list of all players attending in advance and each player may be required to complete a pre-screening questionnaire.

All ECGs will be reviewed by CRY and should further follow-up be required CRY will arrange that on behalf of the player and any relatives deemed necessary. There would be no further cost implications to the Club, unless they assisted with transportation costs of the player to subsequent appointments.

There are no set minimum numbers of players to attend, but because of the costs CRY incur in an ECG only screening a minimum of 75 players is required. For this reason, the RFL would suggest for clubs wishing to screen less than this number that they consider contacting local clubs and arranging a mutually convenient venue and share the day between them.

The timings required per player is 10 minutes for the test to be conducted.

F3.4 SCREENING - CHAMPIONSHIP CLUBS AND LEAGUE 1 CLUBS

The RFL will arrange a screening programme with CRY to make most efficient use of resources. 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 over the season out of central distributions.

The RFL will also keep a register of those players who have been screened but does not have access to the results.

F4 RFL SAFEGUARDING POLICY - MANDATORY

Medical staff should be aware of the RFL Safeguarding Policy and should know who the club's Club Welfare Officer is. All medical staff must have an enhanced DBS carried out through the RFL eBulk system with the cost being recharged to the club. The RFL appreciate that medical staff will have DBS checks carried out through their employers, however due to the lack of portability of DBS checks, it is essential for the individuals to undertake checks through the RFL.

F5 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".

F6 PROTECTIVE & OTHER EQUIPMENT – FOR INFORMATION ONLY

F6a 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.

F6b 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."

F6c BOXES

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

F7 HOT WEATHER CODE – BEST PRACTICE

When a Club's medical staff believe that the heat and/or humidity is such that players require additional water the Doctor or Equivalent should approach the Match Commissioner (or Referee if there is no Match Commissioner) to request one or both of the special measures below. Doctor or Equivalent. The Match Commissioner shall consider this request and where reasonable shall grant it. He shall ensure that the other Club, the Match Officials, home Club officials and broadcast partner are aware of his decision.

The positioning of water containers around the ground (ensuring that there is no danger to players or spectators) is considered logical to enable players to help themselves.

If there have not been sufficient natural pauses (e.g. tries) for water to be brought onto the field, there will be a two-minute break at an appropriate natural pause in the game approximately half way through the first and second halves to allow players to take on extra water.

F8 MENTAL HEALTH COUNSELLING SERVICES – FOR INFORMATION ONLY

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

Sporting Chance

Assistance from Sporting Chance can be obtained by contacting the RFL Welfare Director, Emma Rosewarne, in strict confidence on her mobile 07850 483736 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)

F9 MENTAL HEALTH FIRST AID (MHFA) - MANDATORY

From 2014 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.

F10 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/

F11 SOCIAL & NON-PRESCRIBED PRESCRIPTION DRUGS - MANDATORY

Misuse of these substances is widespread in society. Notwithstanding this neither 'social' nor non- prescribed medication (especially non-prescribed Benzodiazepines or narcotic analgesics including Tramadol) have any place whatsoever in professional sport. Social drugs are already proscribed under the WADA code and consequently form part of the mandatory testing process undertaken by UK Anti-Doping. Non-prescription drugs referred to above are not WADA proscribed and this anomaly can occasionally be exploited by athletes ingesting these substances often purchased over the internet. There is a widespread medical consensus that these substances are not conducive to a professional sportsman participating in a contact sport requiring a high level of coordination and in addition are highly addictive. Consequently, under the leadership of the RFL Chief Medical Officer the RFL Board of Directors have approved a policy which commenced during the course of the 2016 season to introduce a RFL testing programme to identify players who have ingested Benzodiazepines or powerful narcotic analgesics. Formal introduction of this policy was preceded by a comprehensive education programme Amendment and modification of this testing policy including any possible subsequent sanctions will be informed by the RFL CPD programme to further highlight the significant level of importance the RFL and its senior medical leadership attaches to this issue.

F12 SOCIAL & NON-PRESCRIBED PRESCRIPTION DRUGS POLICY

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

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

Clubs may run screens at their own cost with the provisos that all screens are dealt with in line with the Policy. (NB clubs must take care to ensure that screening is carried out in a way that ensures confidentiality)

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 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.

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.

F13 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.

F14 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 he is 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 he is 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.

5 CONCUSSION MANAGEMENT

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.

F15 GENERAL MEDICAL ISSUES – BEST PRACTICE

F15.1 Tetanus

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

F15.2 MMR

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

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 A2 above.

New Doctors or Physiotherapists have three months to successfully complete an IMMOFP course, or until the first available course if there are no courses available within this time frame. IMMOFP courses are in demand therefore please book well in advance to obtain a place on a course to suit renewal needs. Please note that Advanced Nurse Practitioners, Paramedics, Sports Rehabilitators and Sports Therapists must all successfully complete IMMOFP before entering the field of play.

RE-ACCREDITATION & RE-CERTIFICATION

The IMMOFP qualification has to be reaccredited with recertification in year 4 as set out below. Reaccreditation will be required for all candidates qualifying for IMMOFP courses from January 2018:

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

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.

Individuals should check their certificate for the expiry date. The RFL will send out reminders to remind individuals of the expiry date of their IMMOFP qualification and to advise on the dates of forthcoming courses. However, keeping the qualification up to date and booking on a course in time is a personal responsibility for medical staff.

EXAMINATION AND IMMOFP PROCEDURES

For staff currently employed by an RL club payment will be made via a deduction from the clubs Central Distributions. Independent candidates must pay for the course in full via BACS 6 weeks prior to attending. We reserve the right to offer your place to another candidate if payment is not received within this time frame.

The course manual will be sent out only on receipt of payment in full.

Candidates are required to read the manual before the course and complete the pre-course multiple choice paper.

The pre-course multiple choice paper will be sent out to candidates four weeks before the course date and is required to be returned to Tom Hoyle in the RFL Operations Department, Red Hall by the specified deadline. Failure to return the paper within this timeframe will result in the candidate being marked zero for this element of the course.

This multiple-choice paper 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.

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.

Please bear in mind that the course finishes between 16:00 and 17:00 on Friday afternoon therefore candidates who pass may find it difficult to attend fixtures due to be played that evening.

Candidates, who fail the course, will not be able to enter the field of play until such time as a pass is achieved. The RFL Operations Department will inform the relevant Club of the failure on the Friday evening of the second day of the course.

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	30 question MCQ paper
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	30% of overall mark	Objective marking criteria for professional performance within the practical scenario
CPR exam	20% 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 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 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.

COURSE FEES

The cost for attending the two-day course is £500 per candidate for RFL affiliated members and £700 for non RFL affiliated candidates.

COURSE DATES FOR 2020

IMMOFP COURSE DATES 2020		
	MONTH	**DATES**
1	JANUARY	Wednesday 29th & Thursday 30th
2	FEBRUARY	Friday 21st
3	MARCH	Thursday 19th & Friday 20th
4	APRIL	Thursday 9th
5	JUNE	Wednesday 17th & Thursday 18th
6	JUNE	Friday 26th
7	SEPTEMBER	Thursday 24th & Friday 25th
8	OCTOBER	Friday 9th
9	NOVEMBER	Thursday 5th & Friday 6th
10	NOVEMBER	Wednesday 25th

The course will now take place at The Tetley's Stadium, Dewsbury and the costs are:

COURSE	CLUB STAFF	INDEPENDENT CANDIDATE
1-DAY	£300	£400
2-DAY	£550	£750

For all enquiries relating to IMMOFP courses, please contact Tom Hoyle, RFL Competitions & Disciplinary Officer on tom.hoyle@rfl.uk.com

CONTACTS

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Counselling Services
Sporting Chance
Alex Mills alex@sportingchanceclinic.com or 07736 398804
24-hour hotline 07500 000777 W: www.sportingchanceclinic.com


RUGBY
FOOTBALL
LEAGUE
125 YEARS