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i. SCOPE OF MEDICAL STANDARDS

The purpose of these Regulations is to protect the health and well-being of players associated with professional Clubs, including those participating the Women's Super League Academy U19 competitions. 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.

To assist with the delivery of these regulations, CPD sessions will be delivered approximately 3 times a year for Medical Staff**.** These will be hosted both online and in person and cover topics relevant to the sport. Club staff are expected to attend in line with the levels set out in these Medical Standards.

The Medical Standards is a RFL Policy which is binding on all Persons Subject to the Operational Rules – failure to adhere to these standards will be deemed misconduct and may result in compliance action.

The medical information contained is a minimum standard. It is not a substitute for medical and clinical Best Practice. The RFL does not warrant that information provided will meet the health or medical requirements of each individual case. Medical practitioners should use their knowledge and experience to ensure that they fulfil their duty of care to a player. The listed areas of these medical standards set out are for guidance purposes, they are not a substitute for the Operational Rules.

The RFL have support for the Medical function within the Professional Game. Please contact medical@rfl.co.uk and your email will be forwarded on to the relevant person. For specific queries regarding IMMOFP please contact:

Rhianna Burke IMMOFP Support
immofp@rfl.co.uk
M: 07515 753744

ii. NOTE ON TERMINOLOGY

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

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.

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

MISCONDUCT - means either On Field Misconduct or Off Field Misconduct as defined in the Tier 1-3 Operational Rules. The Compliance Manager has discretion to determine whether a matter is On Field Misconduct or Off Field Misconduct.

iii. STANDARDS OF CONDUCT

All members of registered Club Medical Staff are bound by the Operational Rules, which include (and aren't limited to);

Medical Standards
Safeguarding Policy
Adults at Risk Policy
RESPECT Policy
Betting Policy
Social Media policy
Anti-Doping Regulations
Social & Non-Prescribed Prescription Drugs Policy
Super League, Championship and League 1 Code of Conduct Policy
Overseas Travel Code of Conduct
Match Day Operations Manual
Betting & Related Activity Code of Conduct
Equity Statement
Welfare Policy

Failure to comply with Mandatory elements of these Policies constitutes Misconduct under section D1 of the Operational Rules.

Standards of behaviour are expected to fall within those set out within the Operational Rules and also within your Professional Code of ethical standards of work within Rugby League as required to under professional standards. For the avoidance of doubt, this includes conduct with other personnel (Club, Match Officials, The RFL or Broadcast partners).

Should any member of Medical Staff be abused or approached inappropriately regarding medical decisions, please ensure this is reported quickly with as much information as possible to compliance@rfl.uk.com

SECTION A

MEDICAL PERSONNEL

In line with GMC updated guidance 'Helping in Emergencies: You must offer help in an emergency, taking account of your own safety, your competence, and the availability of other options for care.

A1 MEDICAL STAFF REGISTRATION WITH THE RFL - MANDATORY

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

It is mandated that Clubs must:

- Undertake thorough and appropriate checks to ensure their team of correctly qualified and registered medical staff present at all home and away fixtures (in line with the table below), with appropriate medical indemnity for the roles undertaken; and
- Ensure that correctly qualified and registered medical staff are available for all fixtures and training sessions held by the Club; and
- Ensure Medical Staff have the required RFL Safeguarding qualifications. Please note L3 Adult & Child Safeguarding is not transferrable. In the absence of the appropriate qualifications a chaperone with the appropriate qualifications is present, as necessary please see the Qualification tables in the Operational Rules and the Safeguarding Policy for details.

A2 DEFINITIONS OF MEDICAL STAFF TERMS USED IN THESE STANDARDS

DEFINITIONS

Doctor	**A Doctor must:** • be fully registered with the General Medical Council (GMC) and is not subject to investigation or restriction on practice (i.e. suspension). Individuals must continue to meet revalidation requirements • have evidence of 24 months or more of clinical experience post-graduation from their medical degree. (Must have completed foundation training or equivalent). • be a medical doctor with relevant clinical experience such as Emergency care and/or Sports & Exercise Medicine. • Possess the appropriate indemnity insurance for working in Professional sport • hold a Level 3 Pre-hospital Immediate Care in Sport Course (IMMOFP or Equivalent)* *It is Best Practice to hold a Postgraduate Diploma or MSc in Sports Medicine or equivalent*
Physiotherapist	**A physiotherapist must:** • hold a degree in physiotherapy • registered with Health and Care Professions Council (HCPC) and the Chartered Society of Physiotherapists (CSP) and is not subject

	to investigation or restrictions to practice (i.e., suspension). Individuals must continue to meet revalidation requirements • hold a Level 3 Pre-hospital Immediate Care in Sport Course (IMMOFP, i-IMMOFP (where appropriate) or Equivalent)*.
Paramedic Or alternative, see notes*	**Clubs must apply for permission from the RFL. Individual applications will be considered by the Chief Medical Officer (CMO) and IMMOFP Course lead whose decision is final.** A Paramedic may only be used as set out below; **A Paramedic must**: • hold a BSc or Higher National Diploma (HND) or a Foundation degree in Paramedic Science • registered with the HCPC. Individuals must meet revalidation requirements. • not be under investigation or restricted practice (i.e., suspension) • have evidence of 24 months or more experience in an acute setting • Possess the appropriate indemnity insurance for working in Professional sport • hold a Level 3 Pre-hospital Immediate Care in Sport Course (IMMOFP or Equivalent)*. *An advanced clinical practitioner (ACP) who is Royal College of Emergency Medicine: Emergency Medicine credentialed, actively working in an NHS Emergency department and registered with the HCPC, with appropriate indemnity, with 24 months acute experience in that capacity and holding IMMOFP or equivalent may also be considered as an alternative to a paramedic through CMO dispensation.
Sports Therapist	**In order to apply for IMMOFP for the first time a Sports Therapist who holds no existing or recently expired equivalent qualification (within 12 months) must:** **- hold a qualification of i-IMMOFP, ITMMiF L4 (Football Association Qualification) or PHICIS L2 (Rugby Football Union Qualification) and** **- must have worked under supervision by a Physiotherapist for one year's full time (or two part time) in a professional or lottery funded environment, before working independently.** **NB. Holding only i-IMMOFP, ITMMiF L4 or PHICIS L2 qualification does not permit a Sports Therapist to provide on field medical game cover where IMMOFP is expressed as the required minimum level of qualification.** **A graduate Sports Therapist must:** • hold a BSc in Sports Therapy • Be registered as a member with a professional body such as Society of Sports Therapists *or* Sports Therapy Association *or* Sports Therapy Organisation . Individuals must meet the relevant revalidation requirements. • not be under investigation or restricted practice i.e. suspension

	• have any relevant professional indemnity insurance for work in Professional sport • hold a Level 3 Pre-hospital Immediate Care in Sport Course (IMMOFP or i-IMMOFP (or Equivalents*) (as required by Competition).
Sports Rehabilitator	**In order to apply for IMMOFP for the first time a Sports Rehabilitator who holds no existing or recently expired equivalent qualification (within 12 months) must:** **- hold a qualification of i-IMMOFP, ITMMiF L4 (Football Association Qualification) or PHICIS L2 (Rugby Football Union Qualification) and** **- must be supervised by a Physiotherapist for one year's full time (or two part time) experience in a professional or lottery funded environment.** **NB. Holding only i-IMMOFP, ITMMiF L4 or PHICIS L2 qualification does not permit a Sports Rehabilitator to provide on field medical game cover where IMMOFP is expressed as the required minimum level of qualification.** **A graduate Sports Rehabilitator must:** • hold a BSc Sports Rehabilitation • be a member of British Association of Sport Rehabilitators (BASRAT). Individuals must meet the required revalidation requirements. • have any relevant professional indemnity insurance for work in Professional sport • hold a Level 3 Pre-hospital Immediate Care in Sport Course (IMMOFP or i-IMMOFP (or Equivalents*) (as required by Competition).
Qualified First Aider	**A Qualified First Aider must**: • have a current Emergency First Aid in Sport Level 3 or equivalent qualification.

*** IMMOFP ALTERNATIVE QUALIFICATIONS/COURSES**

IMMOFP is a Royal College of Surgeons of Edinburgh (RCSEd) faculty of prehospital care endorsed course and part of the Cross Recognition of Emergency Care Courses in Sport Agreement. iIMMOFP RCSEd endorsement is in process. Only endorsed courses listed as advertised by the joint statement released by the Faculty of Sports and Exercise Medicine (FSEM), Faculty of Pre-Hospital Care (FPHC) and British Association of Sports and Exercise Medicine will be accepted as equivalent.

For the avoidance of doubt, this includes:

- Pre-Hospital Immediate Care in Sport (PHICIS L3) (NB if this accreditation is used the IMMOFP refresher must be completed in line with IMMOFP refresher cycles.)
- Medical Cardiac & Pitch Side Skills (SCRUMCAPS)
- Advanced Trauma Medical Management in Football (ATMMiF)

Any Doctor or Physiotherapist who has successfully completed an equivalent approved course must provide certification to their relevant clubs for their records. On approach of the expiry of the alternative qualification, they must complete an IMMOFP course, or renew the other relevant alternative qualification

For i-IMMOFP permitted equivalent qualifications are ITMMiF L4 or PHICIS L2. It is strongly recommended that the next qualification is i-IMMOFP or IMMOFP, and the individual follows the refresher programme as per Appendix 1.

NB:

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

A3 IMMEDIATE MEDICAL MANAGEMENT ON THE FIELD OF PLAY AND INTERMEDIATE MEDICAL MANAGEMENT ON THE FIELD OF PLAY

IMMOFP© AND I-IMMOFP© - MANDATORY

Save as otherwise provided in these Medical Standards it is mandatory for those medical personnel entering the field of play to hold a current IMMOFP or an i-IMMOFP qualification (or Equivalent) as per relevant competition. These persons must be qualified as a Doctor, Paramedic or Physiotherapist or Equivalent as set out in the table at A2. (See Appendix 1 for more details on IMMOFP). Doctors and Physiotherapists have a three-month grace period to obtain or be booked onto the next available course to gain an IMMOFP (or Equivalent) qualification.

The introduction of the i-IMMOFP course and adaptation of the required qualifications across different competitions in 2024 is aimed towards newly qualified Physiotherapists, Sports Therapists and Rehabilitators. This provides invaluable experience within Rugby League environments with a view to confidently upskilling to full IMMOFP over time, without compromising care to athletes. The i-IMMOFP course encompasses the bulk of the IMMOFP course without teaching the drug giving element of the course. For this reason, these Medical Standards set out there must always be an IMMOFP lead at all matches to provide this care and expertise. The table sets out below which qualification is required for Physiotherapists or Equivalents within each competition.

It is the Clubs responsibility to ensure that each member of Medical Staff understands their role, in with these Medical Standards, and does not act beyond the scope of their capabilities and does not enter the field of play without the appropriate IMMOFP/i-IMMOFP or Equivalent qualifications. Failure to do so is Misconduct and will be referred to Compliance.

A4 MEDICAL STAFF ATTENDANCE AT MATCHES & TRAINING - MANDATORY

MATCHES - MANDATORY

For matches, at all levels,

- The Doctor, and Physiotherapist or Equivalent must be present in the dressing room area at least one hour prior to kick off
- Must remain for at least 30 minutes following the end of the match.
- Where the away team does not have a Doctor present, the Home club's Doctor must check with the away team Physio or Equivalent to confirm that their services are not required before leaving the dressing room area and venue
- Match Officials must be treated by the home team medical team if required. This must be provided without delay in an emergency situation.
- Where players travel independently to matches (home and away) and training please consider this (in the event of any injury, including concussion) and note within the Clubs Emergency Action Plan.

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

A5 MATCH DAY RULES & RESPONSIBILITIES RELATING TO MEDICAL STAFF

A5a PHYSIOTHERAPIST(S), SPORTS THERAPISTS & SPORTS REHABILITATORS

- Must wear an orange top.
- Check all mandatory medical equipment is in good working order and in date
- Is allowed unlimited access to the playing field to assess or treat injured players.
- Must go directly to the player concerned and in instances of severe injury may indicate to the referee that the game should be stopped.
- Is not allowed to pass on tactical messages at any time.
- Must enter and leave the field as quickly as possible (i.e. running).
- Must not remain on the field in anticipation of delivery of treatment. Once treatments/checks have been administered the physio must leave the field of play immediately.
- Is not allowed to be involved in the on-field interchange process save that when he/she goes onto treat a player they can bring that player off i.e. escort them to the touch line - they 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
- May use a communication system which may be checked by appointed personnel from time to time, within the match.

A5b DOCTOR(S) & PARAMEDICS (Paramedic, only as 2nd Clinician i.e. the alternative to a 2nd Doctor)

- Must wear a red top.
- Has the final check of all mandatory medical equipment on matchday to ensure that it is in good working order and in date

- Enter the field of play when they are medically required to do so using their clinical judgement.
- Match Officials will call 'Time Off' upon sight of the Doctor or Paramedic entering the field of play.
- May use a communication system which may be checked by appointed personnel from time to time, within the match.

A5c GENERAL

- The Doctor or Paramedic and Physiotherapist or Equivalent(s) shall enter the pitch only from the designated technical area or bench or from the far touchline position where tracking play as the second physio (if applicable) and shall return to that area after coming from the pitch. They shall always be subject to the control of the Match Commissioner (where appointed) and Match Officials, and compliant with the Match Day Operations Manual C9.4
- Doctor or Paramedic and Physiotherapist or Equivalents must be located within the bench area other than when carrying out their official duties.
- NB touch judges, ball crew and camera operatives all have right of way, and it is the responsibility of the medical staff to ensure that there is not a collision.
- The Doctor or Paramedic and Physiotherapist or Equivalent(s) shall ensure that they refrain from involving themselves in any conflict between players and shall ensure that they refrain from making comments to opposition players.
- Persons entering the field of play must not make comments to match officials about their performance or decisions.
- Medical staff should arrive at the game no later than one hour prior to kick-off.
- Doctor or Paramedic need to be aware of their Duty of Care to players with regards to allowing a potentially seriously injured player to travel home unaccompanied following any match.
- All members of the Medical team (both home and away) must read, and fully understand all points in the medical Emergency Action Plan (EAP)
- If a medical team feel that, as a result of dealing with a serious injury, that the match should not continue until they are comfortable with the health of the player(s) concerned must communicate this clearly to the referee and/or match commissioner (when appointed). They must also communicate with the Referee and/or Match Commissioner when the match is safe to resume.
- Doctors or Equivalents must ensure that there is a Pre-Match Briefing for all team medical staff on duty at a match, which should take place as soon as practicably possible after arrival of the away team, approximately an hour before kick off. If a Match Commissioner is present they are welcome to attend the briefing, however, this is not mandatory. See section B9.
- A paramedic is present in the capacity to conduct emergency care and must not carry out Head Injury Assessments.

A5d TREATMENT ON THE PITCH, TOUCH-LINE OR BENCH

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

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

A5e COMMUNICATIONS EQUIPMENT FOR MEDICAL STAFF – BEST PRACTICE

It is considered Best Practice, at all levels, for medical staff to communicate by electronic communications equipment subject to the conditions set out below. Any breach of such conditions shall be Misconduct.

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

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

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

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

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

A5f The table below lists the Mandatory Medical Staff Requirements for each competition playing home and away games, and on training days.

Competition	Match Day Home Games – Mandatory	Match Day Away Games – Mandatory	Training Sessions *
Men's Super League	- Doctor (IMMOFP) - Second Doctor or Paramedic** (IMMOFP) - Lead Physiotherapist (IMMOFP) - Second Physiotherapist or Equivalent (IMMOFP Best Practice or i-IMMOFP)	- Doctor (IMMOFP) - Second Doctor or Paramedic** (best practice) (IMMOFP) - Lead Physiotherapist (IMMOFP) - Second Physiotherapist or Equivalent (IMMOFP Best Practice or i-IMMOFP) - An IMMOFP trained member of staff must travel with the players on the return journey in case of delayed concussion or other injuries/medical emergencies.	- IMMOFP Qualified Physiotherapist(s) or Equivalent - Ratio of 1 Medical Staff present to 13 Players at all times (Best Practice)
Full Time Championship & League 1 Clubs,	- Doctor (IMMOFP) - Lead Physiotherapist (IMMOFP) - Second Physiotherapist or Equivalent (Best Practice) (i-IMMOFP)	- Doctor (IMMOFP) - Physiotherapist or Equivalent (IMMOFP) - Second Physiotherapist (Best Practice) (i-IMMOFP) - An IMMOFP trained member of staff must travel with the players on the return journey in case of delayed concussion or other injuries/medical emergencies.	- IMMOFP Qualified Physiotherapist(s) or Equivalent
Academy U18 & Reserves	- Doctor (IMMOFP) - Physiotherapist or Equivalent (IMMOFP) - Second Physiotherapist or Equivalent (Best Practice) (i-IMMOFP)	- Physiotherapist or Equivalent (IMMOFP) - Second Physiotherapist (Best Practice) (i-IMMOFP) - An IMMOFP trained member of staff must travel with the players on the return journey in case of delayed concussion or other injuries/medical emergencies.	- IMMOFP Qualified Physiotherapist(s) or Equivalent
Championship Clubs (other	- Doctor (IMMOFP)	- Physiotherapist or Equivalent (IMMOFP)	- I-IMMOFP Qualified Physiotherapist or Equivalent

Competition	Match Day Home Games – Mandatory	Match Day Away Games – Mandatory	Training Sessions *
than full time clubs), WSL* *For Super League Clubs who run a Championship Women's side it is Best Practice to operate under these standards also	- Physiotherapist or Equivalent (IMMOFP)	- An IMMOFP trained member of staff must travel with the players on the return journey in case of delayed concussion or other injuries/medical emergencies.	
League 1 Clubs (other than full time clubs), WSL U19 and Scholarship Requirements	- Doctor (IMMOFP) - Physiotherapist or Equivalent (i-IMMOFP as a minimum)	- Physiotherapist or Equivalent (i-IMMOFP as a minimum) - An i-IMMOFP trained member of staff or where dispensation is granted by the CMO,a L3 Qualified First Aider. - An i-IMMOFP trained member of staff must travel with the players on the return journey in case of delayed concussion or other injuries/medical emergencies.	- I-IMMOFP Qualified Physiotherapist or Equivalent– Best Practice with a current IMMOFP qualification or - Qualified First Aider – Mandatory with a minimum Level 3 qualification. NB: The qualified First Aider must be registered with the RFL on GameDay.

* Clubs must ensure mandatory staffing levels are considered with particular emphasis when dual training sites are used simultaneously.

**** Where a Paramedic acts in place of a Second Doctor then they are only permitted to undertake roles that are covered under their insurance policy and must NOT undertake any Head Injury Assessments.**

Dispensation requests
In exceptional circumstances the CMO can consider requests for dispensation to a Club where it may fail to meet the mandatory medical staffing requirements. These requests will be considered on an individual basis and will be time limited, therefore, it should be remembered by Clubs that this is not a long-term solution to staffing issues.
Each Club may only request dispensation on 3 separate occasions during a Season, further requests maybe referred to Compliance.

A6 URGENT MEDICAL COVER SITUATIONS AT MATCHES – FOR INFORMATION ONLY

In the event a club has difficulty due to unavailability of a Doctor or Paramedic (where permitted) or Physiotherapist or Equivalent to cover one of its games, and has exhausted all possible options, it may email medical@rfl.co.uk no later tha7 days in advance of the match. An email will be sent to all IMMOFP qualified personnel requesting assistance (locum cover) on behalf of a club.

When requesting cover Clubs must ensure they provide the following information:

Professional required (Doctor or Physio);
Date & level of fixture, i.e. First Team, Under 18s etc.;
Venue;
Kick off time;
Point of contact at the Club requesting cover
Fee payable

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

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

In the event of not having a valid Pre-hospital Immediate Care in Sport Course (IMMOFP or Equivalent) the following must occur:

1. Completion of a IMMOFP course registration

2. GMC Certificate or screenshot of GMC registration from website, demonstrating at least 12 months since full registration

3. CV

4. Evidence of degree qualifications

5. Evidence of Medical indemnity insurance cover for working in sport

6. Confirmation by signed documentation that these Medical Standards have been read and the individual fully understand the role they are undertaking and will apply these Medical Standards with particular emphasis on the concussion protocols. Any Club or locum medical cover who has not read these Standards or is not comfortable in delivering them must not sign them or proceed with supplying cover.

All of the above must be supplied in advance of the match in question (at least 24 hours in advance of kick off).

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

Dispensation requests (unless in the event of exceptional circumstances to be considered by the CMO) are limited to cover one fixture/training session ONLY – the dispensation granted does not extend beyond the fixture or training session applied for. Requests will be capped at 3 requests per Season to ensure Clubs have adequate resource ahead of the season commencing.

A7 MEDICAL DUTIES

- All Clubs must fulfil the following mandated areas relating to all Club related activity. It is the Clubs responsibility to manage and delegate this as appropriate within their Club. Ensure that there is an up-to-date Medical Emergency Action Plan (EAP) in place see section B5.
- Be responsible for ensuring that all Mandatory Medical Equipment is stocked, in date and in good working order. MME should be available to cover all relevant internal teams for training sessions (including split sites) as well as matches home and away (where required as per Section A5 g)
- Ensure there is medical provisions at times outside of match days, and a Doctor to be available to attend at least one training session per week (Mandatory for SL clubs, Best practice for all other clubs) to provide to advice and/or treatment to players as required. Such as to provide support during the concussion Graduated Return to Play (GRTP) process, provide assessment and treatment to players with 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).
- Ensure the club operates good clinical governance systems, this includes electronic contemporaneous records of all contacts by club's health care professionals including consultation, assessment, treatments given and interventions made during matches and at training sessions in line with medical confidentiality and General Data Protection Regulation (GDPR).
- Comply with the RFL concussion Protocols and reporting requirement as set out in these Medical Standards.
- Provide all First Team, Reserves, Academies and Scholarship players with an annual pre-season medical screening.
- Ensure coaching and support staff are appropriately trained to assist with extrication and any additional ancillary support in emergency medical situations.
- Co-operate with the RFL and any research partners regarding research projects, reporting of serious injuries and any relevant investigation or inquiries into clinical care delivery.
- 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.

– Inform Players to register at their own GP to provide medical care outside of the Club. The Doctor should support overseas players and their families with this.

It is not the responsibility of Medical Staff to ensure that players have appropriate medical cover to suit their demands and needs. However, it is Best Practice for the Club CEO to discuss with players what provision they have in place and refer them to the Club for them to assist with understanding of the Private Medical Cover or equivalent that they may have in place via the Club, so they can make informed choices on taking out additional insurance cover.

A8 MEDICAL TREATMENT – TEAMS TRAVELLING TO FRANCE – FOR INFORMATION ONLY

A8a MEDICAL TREATMENT IN FRANCE

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

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

RFL Insurance contact:
Rob Graham 07595 086874

MME FOR TRAVEL TO FRANCE

It is the responsibility of the travelling team to France to ensure that they have the required MME for all arranged training and fixtures. Please note, teams will need to liaise with their airline carrier in respect to airline regulations in advance of travel to ensure all equipment (specifically oxygen, drugs and AED) are permitted on the aircraft.

In relation to the Championship, Toulouse Olympique may be able to offer support with MME for travelling teams. If a club requires their MME to be supported by Toulouse, it is the away teams responsible for liaising with Toulouse at least 7 days prior to any planned travel to France to check availability. Please liaise with the medical department at the RFL to contact the relevant person at Toulouse.

Whilst Toulouse Olympique have an agreement in place to supply, where available, certain items for visiting teams there is no such agreement in place with

Catalans Dragons and visiting clubs must ensure they are fully self-sufficient for these trips.

A8b MEDICO-LEGAL ISSUES

It is advised that medical staff should consult their regulatory bodies and indemnity providers to understand any legal implications of travelling to France with a Rugby League team and any obligations under French law.

SECTION B

ETHICS, GOVERNANCE, PLANNING, INFORMATION & DATA

B1 MEDICAL NOTE KEEPING, RFL OFFICIAL RESEARCH AND INJURY AUDIT - MANDATORY

Medical Staff are expected to follow their professional and legal 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, encrypted and secure.

Medical staff should make a note of any Player who has received medical care or advice in any way whatsoever and retain such notes in line with their Professional Body (E.g., GMC for Doctors) recommendations. This includes those medical staff providing ad-hoc match cover. Medical staff leaving a club or providing ad-hoc cover are responsible for ensuring that a copy of the relevant notes is provided to colleagues on departure and kept for the statutory period. 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.

The RFL in conjunction with Leeds Beckett University (LBU) and other official research partners will notify Clubs of all RFL endorsed research projects. It is mandatory to engage in these RFL endorsed projects. This will apply to all Professional Clubs and Teams associated as directed, expected to include

All Super League first teams, Reserves, Academy and WSL First teams. Research projects shall include but are not limited to The RFL Injury Audit (run in conjunction with the (LBU)). Clubs are responsible for ensuring a suitably qualified member of the medical staff completes the audit accurately and in a timely manner. Failure to adhere will result in sanction as set out in the Operational Rules.

The club should ensure it has appropriate policies, procedures and audit processes to ensure good governance of all medical staff and medical services that are carried out.

B2 SHARING INFORMATION - MANDATORY

In the case of matches where the Away Team Doctor is not in attendance (relevant Part Time Championship, Part Time League 1, WSL, Reserves, Academies, or Scholarship) it is the responsibility of the Player's 'Parent Club' Medical team to provide relevant medical information, medication, or equipment and SCAT6 baselines to the Home medical staff.

B3 SHARING INFORMATION - DUAL REGISTERED /LOAN PLAYERS - MANDATORY

Club medical staff at both Clubs must liaise and share information as appropriate and in line with medical professional standards and any protocols published by the RFL from

time to time to ensure the best care for the player see F10. It is important to consider in the event of concussion who will have responsibility for managing the GRTP.

B4 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 and the information required does not breach any medical confidentiality.

RFL CONTACTS

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

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

The RFL will:

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

B5 MEDICAL EMERGENCY ACTION PLAN- MANDATORY

All clubs must ensure a written Medical Emergency Action Plan (EAP) for both matches and training. This should consider arrangements for all grounds and training facilities used by the club, which includes all potential clinical scenarios. The EAP should be shared with all medical staff at the club. It is best practice to pre-agree this with your local ambulance authority and share with match day paramedic teams.

This should include as a minimum, but not limited to, the following:

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

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

B6 PRE-MATCH BRIEFING – BY HOME CLUB MANDATORY

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

- The venue Medical EAP
- Other relevant venue specific information, i.e. location of any Ambulances/Paramedics if on site, and how to communicate if their assistance is needed
- Medical Staff roles and responsibilities during a potential emergency
- Process for calling additional ambulance support
- The location of the medical room
- The location of the pitchside replay system with clear instruction on operation if it is not manned.
- Any medical conditions or treatment requirements for individual players and SCAT6 baselines for the away team if the away team does not have a Doctor present.
- Any other information consider to be relevant to either team.

B7 ON-FIELD PROCESSES

The on-field processes section provides information and the regulation to assist in Medical Staff adhering to the rules set out in the Match Day Operations Manual (MDOM) and the On-Field Policy.

- Injured Players (Green Card) – Men's Super League Only
- 18th Player Replacement
- Blood Bin Procedure
- Match Day Rules and Responsibilities relating to Medical Staff
- Kick Off

Further information can be sought in the MDOM as required.

B7a INJURED PLAYERS (GREEN CARD) – MENS SUPER LEAGUE ONLY

If requested to do so by a physio or doctor due to a serious injury, the referee will stop play. If the player involved is not interchanged / taken off for a HIA, then the referee will instruct the player to leave the field until 2 minutes of game time has elapsed, whether they be an attacker or defender.

Where a Physio or Doctor communicates to a touch judge and/or the Referee (by any means) that play should be stopped due to a serious injury (other than a possible head injury requiring on-field assessment), and the Referee stops play, the player involved must either be interchanged or taken off the field of play before he is permitted to return to the field of play.

A Club may use one of their interchanges to allow the player to remain on the pitch. This must happen whilst the player remains in the playing area. If they

leave the playing area and wants to return within the defensive set they can but this would be classed as two interchanges.

As per the Match Officials On Field Policy any Club which is found to have used a head injury assessment for the purposes of avoiding this Rule C 5.5 (for example, where it is found that the players' injury was clearly other than a possible head injury) the Club will be deemed to have gained an unfair tactical advantage in the Match and be subject to penalty under the Operational Rules.

Where a Non-Super League Club plays a Super League Club (Challenge Cup) the Green Card Rule will apply.

B7b 18TH PLAYER REPLACEMENT

A Team may activate its 18th Player Replacement to replace another of its Players who has become ineligible to play in the following circumstances only:

Where <u>two</u> of that Team's Players in a Match have been designated ineligible to return to the field by the Team Doctor following a Head Injury Assessment.

Where one of that Team's Players has been designated ineligible to return to the field by the Team Doctor following an incident of foul play which results in the culprit being placed on report, sin-binned or sent off.

The 18th Player Replacement is not permitted to enter the field of play or have any involvement in the conduct of the Match except as provided by this rule.

The 18th Player Replacement is an additional reserve Player who may only take part in a Match if activated by team management in accordance with this rule. Until activated, the 18th Player Replacement:

- must sit with the reserve bench,
- is able to warm-up as all the other interchange replacements
- must wear the provided bib identifying them as the 18th Player Replacement at all times unless and until activated;
- is not permitted under any circumstances to be interchanged or otherwise enter the pitch.

The process for activation of a Team's 18th Player Replacement is:

- The Team Doctor must confirm to the Match Commissioner or Reserve Referee that two players have been ruled ineligible to return to the field of play following Head Injury Assessments.
- The Team Doctor must confirm which two Players have been ruled ineligible to return to the field of play following Head Injury Assessments.
- In televised matches which involve Super League first teams **<u>only</u>** players who have to leave the field due to injury as a result of foul play, can be counted towards the 18th Player Interchange being activated.

- The two injured Players will not be permitted to return to the field of play.
- The Match Commissioner will complete the 18th Player Replacement Form and the Team Doctor, and a member of the Medical Team must sign to confirm the 18th Player Replacement Form is accurate, true and correct. If no Match Commissioner is present the referee will sign the form at Women's Super League.
- Once the 18th Player Replacement Form has been completed and signed, the 18th Player Replacement must immediately remove their vest and is now eligible to play in the Match;
- The usual Interchange procedure shall follow thereafter.
- For the avoidance of doubt, a Club does not need to wait 15 minutes to activate the 18th man replacement, it can be activated immediately after the second failed HIA.

The activation of an 18th Player Replacement does not affect the number of interchanges spent or remaining available to a Team in a Match. Once activated, the 18th Player Replacement must be interchanged according to the Interchange processes, including with respect to any free interchanges.

- The designation of a Player(s) as ineligible to return to the field is irrevocable and no such Player is permitted to return to play in that Match regardless of any improvement in their medical condition.
- If another player is deemed ineligible to return to the field of play following a Head Injury Assessment there are no further replacement players allowed save for any interchanges permissible under the Head Injury Assessment rules or the standard Interchange procedure.
- The 18th Player Replacement cannot be activated where less than two players have been deemed as ineligible to return to the pitch following a Head Injury Assessment.
- Where one player is deemed to be ineligible to return due to foul player and their opponent is either placed on report, sin-binned or dismissed the 18th Player Replacement can be activated.

B7c BLOOD BIN PROCEDURE

- Where a physio or Doctor observes a player bleeding, they must enter the field as soon as possible and treat the player and limit the bleeding.
- If the Referee notices bleeding or blood contaminated Player, equipment or other Players have been contaminated by blood they must immediately stop play and call 'time-off' and signal to the Physio to attend to the Player.
- The Physio will immediately enter the field of play to assess whether the Player can be quickly treated on the field or whether they will require treatment off the field.
- If the Physio advises that the Player can be treated on the field, the Referee will instruct the player to drop out behind play for that purpose and the match will immediately recommence.
- If the Physio advises the Referee that they will have to treat the Player off the field, the match will not restart until the player has left the field. The Player may be interchanged, or alternatively the team can elect to temporarily play on with 1 less player.. (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 for a second time, 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 1 less player until the bleeding player returns.
- If the bleeding player has left the field for treatment and is not interchanged, they may return to the field of play at any time provided they do so from an on-side position. If the bleeding Player has been interchanged, they may only return to the field through the interchange official as a normal interchange player.
- A bleeding player returning to the field of play who has not been interchanged, is not to be regarded as a replacement/interchange player and therefore may take a kick for goal. Conversely, a bleeding player returning to the field of play who has been interchanged may not take a kick for goal at that time.

B7e KICK OFF

The match should not be permitted to kick-off either half unless suitable medical personnel are in close proximity i.e. either pitchside, tunnel or medical room. This would be a minimum of two physiotherapists or equivalent and a doctor present for kick off.

SECTION C

MEDICAL EQUIPMENT & FACILITIES

C1 MANDATORY MEDICAL EQUIPMENT (MME) & MANDATORY DRUGS BOX

MME, as set out below, including Mandatory Drugs, which must be present at all games and training, in close proximity to the training session/match i.e. pitchside, not in a lock up or similar. It is the responsibility of the Club's Medical Team to check all MME is stocked, in date and in good working order. When scheduling fixtures, Clubs must consider the availability of medical personnel and equipment for safety.

Home Clubs Requirements - Mandatory

The home Club is responsible for ensuring that all the MME is present in the dressing room area and available for use, at least one hour prior to kick-off or from arrival of teams, whichever is the earliest.

Away Club Requirements – Mandatory

It is mandatory for all Clubs (inclusive of Academy, Reserves and Scholarship, Championship, League 1, WSL) to travel with a full set of MME.

MME Checks

At Super League Level where Match Commissioners will be present, spot checks on MME will be completed for both teams before games. An MME Inventory form must be completed by the Doctor prior to this check and signed off by the Match Commissioner once the spot check has been completed. The Match Commissioner will collect from the Doctor a signed inventory

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

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

C2 FULL LIST OF MINIMUM MANDATORY MEDICAL EQUIPMENT AND BEST PRACTICE MEDICAL EQUIPMENT

MINIMUM MANDATORY MEDICAL EQUIPMENT (MME)
AUTOMATED EXTERNAL DEFIBRILLATOR (AED) Ensure any preparation equipment required is also present such as scissors / razor etc.

The AED should be present pitch side at all times and is for sole use of the players. NB: Ensure battery and pads are in date. 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 all possible clinical scenarios.
AIRWAY EQUIPMENT:
Oropharyngeal Airways (assorted sizes to fit all players)
Nasopharyngeal Airways (assorted sizes to fit all players)
Non-rebreathe mask with oxygen tubing (Minimum 2)
Nebuliser mask with chamber & tubing
Supraglottic airway devices (e.g. iGel) – (assorted sizes to fit all players), inc Thomas tube holder.
Airway lubricant gel
Pocket mask (1-way valve)
Self-inflating bag – valve mask (with reservoir bag, face masks & oxygen tubing)
Pulse oximeter and batteries, including spares.
Magills forceps
Portable suction (Manual or battery-powered suitable for pitch side use)
OXYGEN: With ability to deliver variable flow rate oxygen. E.g. BOC CD cylinder or equivalent. Minimum 2 litre.
MEDICATION:
1 x Amiodarone 300mg, 10ml prefilled syringe
2 x Adrenaline 1:10,000, 10ml prefilled syringe
5 x Adrenaline 1:1000 (or adrenaline auto injector)
5 x 10mls water for injection
1 x 0.9% Sodium Chloride 500ml
1 x 10% Glucose 500ml
4 x Aspirin 300mg tablets
1 x GTN Sublingual Spray
1 x Glucogel
5 x Salbutamol 5mg / 2ml UDV (Unit Dose Vial)
2 x Penthrox unit 3ml inhalation vapour (Penthrox must not be used in those under 18 years old). Entonox as an alternative with microbiological filters required.
1 x 10mg Rectal diazepam
NEEDLES: 3 of each – Orange, Green & Blue
SYRINGES: 2 of each – 1ml, 2.5ml, 5ml & 10ml
CANNULAS: minimum of 4 in different sizes, must include large bore (14G, 16G)
INTRAVENOUS INFUSION SET x 2

TOURNIQUET (for IV Cannula Use only) x 2
SPINAL BOARD AND/OR SCOOP STRETCHER: including full complement of head immobiliser blocks, head straps and Body /spider straps. *Both spinal board and scoop stretcher are mandatory for Super League, and recommended for all other Clubs.* 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).
BASKET STRETCHER
CERVICAL STIFF NECK COLLAR(S) An assortment of collar sizes, or adjustable collars, must be available to fit every player within the club .
PELVIC BINDER For use in the event of a pelvic fracture
CRUTCHES AND SPLINTS For immobilisation of the limbs. Such as box splints, SAM splints or vacuum splints
FOIL BLANKET(S) & AMBULANCE BLANKET
SHARP'S BIN & YELLOW CLINICAL WASTE BAG
PENLIGHT TORCH
STETHOSCOPE
GLUCOMETER, including batteries and appropriate testing strips
PPE for dealing with clinical scenarios
WOUND CARE: Must include dressing pack, gauze, saline irrigation sachets, forceps, suture holder, scissors, suture materials & local anaesthetic (e.g. lidocaine). Staple device, skin glue or other equipment as required.
MEDICAL EQUIPMENT BEST PRACTICE
EMERGENCY CRICOTHYROIDOTOMY DEVICE AND/OR NEEDLE CRICOTHYROIDOTOMY EQUIPMENT: Provides a quick method to provide an emergency airway with minimal bleeding in an extreme emergency in the presence of severe oro-facial injury when an airway cannot be maintained, and the patient is rapidly deteriorating. To only to be used if within the practitioner's scope of practice.
OTHER MEDICAL EQUIPMENT • Sphygmomanometer • Thermometer • Eye irrigation materials - FluoresceinDrops, saline irrigation, Chloramphenicol ointment/drops, Eye pad & tape. Advanced resuscitation equipment such as laryngoscopes and ET tubes are 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:

In addition to the list above, Doctors may carry additional medication or equipment that they consider necessary to carry out their duties, this may include medication for minor illness and pain relief. It is important for practitioners to always act within their scope of practice.

C3 CLINICAL WASTE DISPOSAL - MANDATORY

Clinical waste disposal at clubs (NB this includes soiled strapping, blood-stained dressings and used gloves) 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 or where no Match Commissioner is appointed the Referee.

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

C4 FACILITY STANDARDS – TREATMENT ROOM - MANDATORY

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

As a minimum the treatment room must be as follows:

- Accessible to both teams and officials
- Access for a stretcher or basket from pitch to treatment room and also to an external exit accessible by ambulance.
- Adequate lighting
- Sink for hand washing and drying facilities
- Provisional of soap and hand disinfectant
- Adjustable Examination bed/couch
- Mobile medical trolley/table
- Floors to be non slip, impervious and washable
- Worktops, couches, chairs and related furniture to be easily cleanable to comply with infection control best practice
- Surface space for medical equipment
- Sharps bin
- Clinical waste bin
- Appropriate antimicrobial universal disinfectant equivalent spray or wipes.
- Internet access to allow for appropriate note keeping
- Treatment room specific Telephone Wi-Fi or landline to facilitate internal and external communication

SECTION D

D1 ANTI-DOPING

Both the athlete and medical practitioner have a responsibility under United Kingdon Anti-Doping (UKAD) regulations.

Athletes may be tested in and out of competition. They may be required to submit urine (90ml) or blood samples. Blood tests will be conducted by a suitably qualified phlebotomist and 8ml will be taken. In the 2024 season, Blood Spot testing may be introduced by UKAD. Education and information will be provided in advance of introduction.

Further information regarding the testing process and athletes rights and responsibilities can be found here

The Testing Process | UK Anti-Doping (ukad.org.uk)

CHANGES TO WORLD ANTI-DOPING AUTHORITY (WADA) PROHIBITED LIST FOR 2025

All medical staff should make sure they are aware of the changes made to the Code and the Prohibited List. The main changes to the Prohibited List can be found here: https://www.wada-ama.org/sites/default/files/2024-09/2025list_en_final_clean_12_september_2024.pdf

NB. Tramadol is prohibited In Competition from 1st January 2024. Any athlete found to be using tramadol in-competition faces the prospect of an Anti-Doping Rule Violation and a ban from sport. UKAD has released some initial information around tramadol which can be found here.

Tramadol is an opiate analgesic and misuse is of concern because of the risks of physical dependence, opiate addiction, and overdose. Tramadol is a prescription-only medicine in the UK. Athletes who may be using tramadol are reminded to speak to their doctor about seeking alternative pain medication that is permitted in sport.

If you have any questions regarding any aspect of anti-doping, please contact Richard Yates by email on richard.yates@rfl.co.uk .

D2 CHECKING MEDICATION & SUPPLEMENTS - MANDATORY

For an immediate answer to an enquiry about the status of medication or a component within medication for use in Rugby League log on to the Global Drug Reference Online Website v Global DRO - Home

NB to ensure the accuracy of the information returned, those inputting information must ensure it is accurate, including the nation of purchase. Following the search, save the reference or email a pdf to the athlete.

Please note supplements cannot be checked using the GlobalDRO system as they are not licensed medications. Supplements should only be used on a need's basis. To reduce the risk of using supplements which may be contaminated, Informed Sport can be used to check batch tested supplements.

When using GlobalDRO substances will appear with results showing their status 'In Competition' and 'Out of Competition', and/or 'Conditional'. In-Competition is defined as 11.59pm the day before the match and finishes once the testing process has been completed and the DCO's have left the match. Everything else is Out of Competition. NB be mindful of wash out periods of medication which may be provided out of competition, yet may have traces remaining at an In Competition test.

Conditional usage has limits to their usage – by clicking on the 'more information' link on the search details will be provided on the medications status.

D3 PROHIBITED SUBSTANCES AND TUE

If a medication contains a Prohibited Substance and there is clinical need to use this medication, a Therapeutic Use Exemption (TUE) will be necessary. Unless in an emergency situation or in the case of glucocorticoids where a retroactive TUE is applicable (see section below), and this must be completed before taking the substance.

D3a INTRAVENOUS INFUSIONS – PROHIBITED SUBSTANCES - 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.

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

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

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

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

D3b PROACTIVE TUE APPLICATIONS

The UKAD TUE Wizard is a useful tool in checking whether a Player requires a TUE in advance of taking medication. For the avoidance of doubt

Professional Players are all in the TUE National Pool. TUE Decision Tree | UK Anti-Doping (ukad.org.uk)

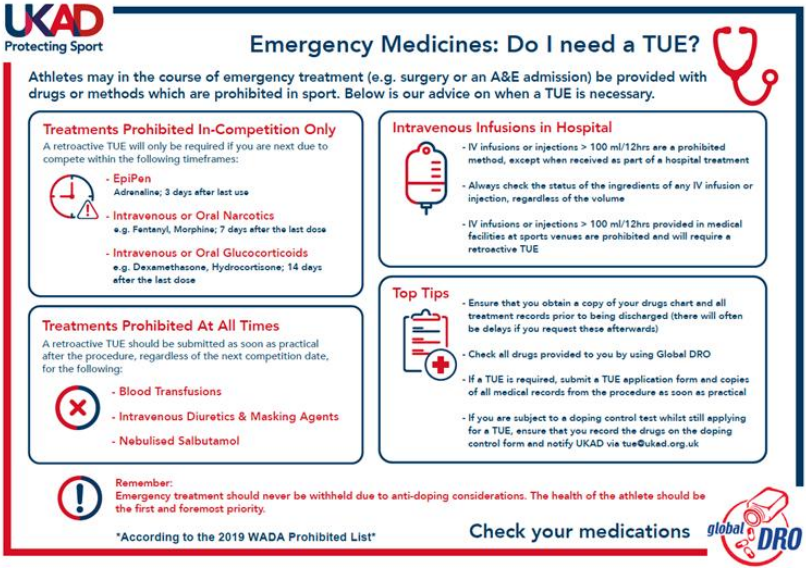
TUEs can take a number of days to process so early dialogue with UKAD is vital to ensure that the TUE can be granted **before** the medication is taken. Further information regarding TUEs can be found by visiting http://www.ukad.org.uk/medications-and-substances/tues/.

How to apply for a TUE | UK Anti-Doping (ukad.org.uk)

D3c RETROACTIVE TUE APPLICATIONS

In the event of emergency treatment or following an Adverse Analytical Finding for glucocorticoids, an athlete may require a retroactive TUE application to be completed within 5 working days of the UKAD notification. It is important that a medical file is compiled in readiness for any such requirement, including any discharge notes provided to the athlete. National TUE Pool | UK Anti-Doping (ukad.org.uk)

Emergency treatment should never be withheld due to anti-doping considerations. The health of the athlete should be the first and foremost priority. Medical staff should consult the UKAD website for further information, or refer to the below infographic.



D4 SPECIAL TOPICS

UKAD have compiled a list of common medical conditions which often require a TUE and the associated procedures and guidance to follow. Should any player report to you with symptoms that result in a diagnosis of, or an existing diagnosis of any of the following, please check any medications which may be prescribed and if a TUE as required.

Adrenaline auto-injectors
Asthma
ADHD
Diabetes
Emergency medications
Glucocorticoids (Including washout periods)
Hay Fever
Tramadol

All associated documentation can be found here Special topics | UK Anti-Doping (ukad.org.uk)

D5 BETA-2 AGONISTS - SALBUTAMOL, SALMETEROL, FORMOTEROL AND VILANTEROL– FOR INFORMATION ONLY

All beta-2 agonists are prohibited in sport at all times with the exception of inhaled salbutamol, formoterol, salmeterol and vilanterol. These substances are only prohibited above a specified threshold as set out in the table below (NB. It is very unlikely that an athlete would require a prospective TUE for the routine use of one of these substances since the recommended licensed therapeutic doses are within these thresholds).

All players who require the use of a prohibited beta-2 agonists that are competing at a level within the National TUE Pool are required to obtain a TUE in advance with UKAD.

Medication (Inhaled)	TUE Action Required	Upper Limit Micrograms (mg)
Salbutamol	None*	Divided dosage of 600mcg over 8 hours and max dosage of 1600mcg over 24 hours.
Salmeterol	None*	200mcg over 24 hours
Formoterol	None*	54 micrograms over 24 hours
Terebutaline	TUE	N/A
Vilanterol	None*	25 micrograms over 24 hours

*Unless exceeded, in which case a TUE is required.

Note: The presence in urine of salbutamol in excess of 1000 ng/mL or formoterol in excess of 40 ng/mL is not consistent with therapeutic use of the substance and will be considered as an Adverse Analytical Finding (AAF) unless the Athlete proves, through a controlled pharmacokinetic study, that the abnormal result was the consequence of a therapeutic dose (by inhalation) up to the maximum dose indicated above.

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

The 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.

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.

All other Beta-2 Agonists (e.g. Terbutaline) are prohibited WADA Prohibited List 2025 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.

It is recommended that any player currently using ANY Beta-2 Agonist speaks to their Doctor to ascertain if they really need 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.

E CONCUSSION & MANAGEMENT OF HEAD INJURIES REGULATIONS – MANDATORY

E1 PURPOSE, SCOPE & INTERPRETATION

The RFL takes player welfare very seriously and follows an evidenced based, yet cautious approach in collaboration with other professional sports bodies when drawing up its concussion regulations. The RFL have reviewed and incorporated their recommendations from the Concussion In Sport Group (CISG) Consensus Status (Amsterdam, 2022).

The RFL will monitor (such monitoring will include reviewing recordings of matches) incidents of apparent concussion during matches, concussion assessments, notifications of concussion, recurrent/subsequent concussions and Return to Play (RTP) and the actions taken. Where appropriate the RFL may refer any concerns for independent review and requests may be made to justify and substantiate the clinical information and reasoning which underpinned the decision making. The outcomes of such may result in potential educational or compliance actions. Should an independent review identify clinical concerns that there was a missed concussion with Criteria 1 signs the RFL has the right to stand the player in question down for a minimum of 12 days in line with Graduated Return to Play (GRTP) protocols, as set out in the E6.

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

E2 PRE-SEASON BASELINES AND ASSESSMENTS

Prior to players engaging in any contact activity it is mandatory for them to complete a baseline SCAT6 and a Cognigram baseline, annually. Baselines are clinical tools that are used following a head injury to aid in diagnosis and management, including the GRTP. The baseline reset date will be the first day of pre-season training, prior to any contact training . It is the responsibility of a player's Parent club to ensure baseline testing on any Dual Registered or Loan Players is undertaken, unless other agreed with the Loan club.

It is good practice for doctors to interview players to record a structured concussion history including specific questions on number of past concussions - across all sports and non-sporting activity. A detailed history would also include severity of symptoms, and recovery course.

E2.1 COGNIGRAM – DIGITAL CONGITIVE ASSESSMENT SYSTEM

It shall be considered serious Misconduct to allow anyone other than the player to whom the record belongs to take a Cognigram test.

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

Cognigram - Normative Database and Comparison Score

As part of the Cognigram report a player (inclusive of First Team, Reserves, Academy & Scholarship, trialists, & Women's Super League & Women's U19s) will be scored compared to a normative population sample. This determines if a player achieves a valid baseline.

The Normative Comparison Score is intended to show the extent to which performance on the current assessment differs from that of healthy age-matched individuals presented on a scale consisting of three categories: Normal, Borderline and Low. The score is a standardized t-score with a mean of 100 and standard unit (SU) of 10.

New Cognigram baselines for the forthcoming season must be established in pre-season prior to any contact training. . A Player is not eligible to participate in ANY training session with risk of head contact, with particular attention to contact or wrestle, or to play in a match until a valid Cognigram baseline has been established.

It is the responsibility of each club, to review its own Cognigram account to ensure all its players have established a valid baseline. The following criteria must be met:

Results returned as NORMAL or BORDERLINE on any of the four individual modules is considered valid for a baseline test.

- Baseline results, on any of the four individual modules, must not contain any of the following, which will render the entire test invalid:
  - A result returned as LOW - should be investigated further with the player and a re-test arranged.
  - A score of 79 or below
  - There should be no Completion of Performance Criteria Flags on ANY of the outcomes
- If a test does not meet Completion or Performance criteria a score cannot be calculated for that test and a re-test is required. When Completion or Performance criteria are not met a blue number within a blue circle will be displayed on the x axis adjacent to the date of the test

E2.2 Player Unable to Establish a Valid Cognigram Baseline

If a player is repeatedly producing invalid Cognigram baseline results and otherwise shows no signs of a head injury or clinical concern after a full clinical review by the club Doctor..

In this situation, the club should arrange for an alternative baseline screening process, to be established. The RFL recommend this is conducted in conversation with a specialist in sports related concussion (Individual must be an appropriately indemnified doctor and on the GMC specialist register for

Sport and Exercise Medicine, Neurology or neurosurgery and experienced in managing concussion), this may form a multimodal assessment process. The results of any alternative baseline must be submitted to the RFL Medical Department along with details of the clinical review noted above. SCAT6 in isolation CANNOT be used as an alternative to a Cognigram baseline.

E.2.3 Dual Registered/Loan Players – Mandatory

Transfer of Player Profiles

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

Players should only hold one Cognigram profile throughout their playing career, containing all their test data, which provides Club Medical Staff a record of changes over time.

If a player is permanently transferred Cognigram can move their profile to their new club's Cognigram account. The Cognigram profile transfer can only take place if a written request to do so is made to the RFL who will then contact Cognigram who will make the necessary arrangements for the transfer.

It is preferable for the Cognigram profile of a loan/dual registered player to remain on the parent club account, this may mean the loan club should liaise with the parent club to issue a Cognigram test for completion and communicate the results.

E2.4 SCAT6 BASELINES – MANDATORY

SCAT6 baselines should be made available in an easy to interpret format to be used as part of the Head Injury Assessment (HIA) process in training and on all match days. It is particularly important for SCAT6 baselines to be available in-season where the away team does not have a Doctor present. Clubs must share baselines with the RFL upon request.

. The SCAT6 contains optional elements, it is Best Practice for clubs to complete all elements of the SCAT6. However, if there is a clinical justification why an element is not performed, this should be noted on the SCAT6 for review by any future clinician utilising the baselines.

For downloads on SCAT6 and SCOAT (Sports Concussion Office Assessment Tool) please visit **CISG Tools - Concussion in Sport Group (CISG)**

Medical staff should also be wary of the possible "ceiling" effect with SCAT6 assessments, and that this forms a part of the clinical decision making for concussion. Where a player's baseline SCAT6 performance is high clinicians should place particular emphasis on multi-modal assessments and clinical signs or symptoms. Any variation from baseline in one or more sections is strongly in favour of a diagnosis of concussion following head injury, unless there is a clear alternative diagnosis.

E2.5 OTHER NEUROLOGICAL ASSESSMENTS

It is best practice for all players to have a full neurological examination and additional baseline screening for use in complex concussions, This can include but is not limited to: Vestibular Oculomotor Screening, NIH toolbox, SCOAT6 and King Devick.

E3 RECOGNISE AND REMOVE

E3.1 MATCHES &/OR TRAINING

E3.1.1 Removal from Play or Training - Mandatory

Where medical staff suspect a player has a confirmed or signs +/- symptoms of possible a Head Injury Assessment (HIA) MUST be carried out away from the playing/training environment.

<u>All players must be removed who:</u>

- Are diagnosed with concussion; or
- Have any of the signs or symptoms set out below; or
- Medical staff suspect may have concussion

Any player removed from the field of play more than once during the same match for a HIA is not allowed to return to play during that same match, no matter the outcome of the second HIA. If a definitive diagnosis was not identified the player does not have to be diagnosed as concussed, or follow the GRTP.

E3.1.2 Signs and Symptoms of Concussion

CRITERIA ONE SIGNS/SYMPTOMS

For the avoidance of doubt, where Medical Staff observe, become aware of or are reliably informed that a player has presented one or more Criteria One signs or symptoms, they must be immediately diagnosed as concussed and permanently removed from activity. A medical assessment is warranted for clinical reasons but a HIA to consider return to the activity is not appropriate due to permanent removal criteria. i.e. A formal HIA process to return to the field will not be carried out as a player cannot return if Criteria 1 Signs or Symptoms are present. The part of the process required to determine whether the player can return to the field is not required.

Criteria One Signs/Symptoms

- Confirmed loss of consciousness
- Suspected loss of consciousness, for example, no purposeful movement for >5 seconds
- No protective action in fall to ground, loss of cervical or body tone
- Tonic posturing
- Convulsion
- Ataxia / balance disturbance
- Not orientated in time, place or person
- Definite confusion
- Dazed, i.e. blank or vacant stare
- Memory impairment
- Definite behavioural change atypical of the player
- Oculomotor signs
- Player reports significant concussion symptoms

CRITERIA TWO SIGNS AND SYMPTOMS

Players aged U18 displaying Criteria 2 signs or symptoms must have additional caution applied due to developing brains. The application of recognise and remove may be implemented as a cautionary approach.

Where Medical Staff observe, become aware of, or are reliably informed that a player has presented with one or more Criteria Two signs or symptoms or otherwise suspect that a player may have concussion they must be removed from the field of play/other environment outside the field of play, for a HIA. There must be a rest period of five minutes before the HIA takes place.

Where Medical Staff have removed a player for a HIA but subsequently become aware that they have, or have had one or more Criteria One signs or symptoms they cannot return to the field of play/other environment outside the field of play and must be diagnosed as concussed they must be managed as above.

- Any uncertainty of possible or possible transient Criteria 1 signs or symptoms
- Injury event with potential to result in concussive injury
- Head impact where diagnosis is not immediately apparent
- Possible confusion
- Possible behavioural changes
- Any other sign or reported symptom that may indicate a suspected concussion

E3.2 PITCH SIDE REPLAY - MANDATORY

Each Super League Men's, Women's Super League, Championship and League One Club must have a dedicated Pitch Side Replay facility installed and which is operational at all its home fixtures. This applies to all levels of

Competition (where that Club has a team), with the exception of WSL U19s where it will be Best Practice for 2025 and Mandatory from 2026 onwards, Review of the Pitch Side replay system is to support medics with the recognition and removal of players with suspected concussion. It also forms an integral part in the HIA process. On match-days the Pitch Side Replay facility must be made available to medical staff of both competing teams.

It is Best Practice have a dedicated Pitch side Replay operator who can operate the system for use by medical staff. This must be located near the dugout and or medical room, so as it can be utilised as part of the HIA process. Any malfunctions or technical issues must be resolved as a priority

Pre-match a visiting club's medical staff must be shown the location of the Pitch Side Replay facility, how to use it and how and to whom any malfunctions should be reported. **The system must be tested in advance of and must be in full working order/operational ahead of kick off**.

Concussion Spotters (Men's Super League only)

The RFL will provide an update on the Concussion Spotter Trial for 2025 in due course.

E4 HEAD INJURY ASSESSMENT (HIA) PROCESS – MANDATORY

E4.1 **A HIA has to take 15 minutes from when the player is removed from the field to conduct the HIA process. The HIA must not be conducted pitch side and instead must occur in a quiet space, such as the dedicated medical room or changing room (if appropriate e.g., not at half time)**

The first 5 minutes must allow the player a period of supervised rest, whilst also providing an opportunity for the Doctor to review the pitch side replay.

a) **Following the 5-minute rest period, the Doctor must complete a clinical evaluation inclusive of a SCAT6 assessment to** determine if there is any suspicion of concussion. Players should be also be assessed medically for signs of significant neurological symptoms that could indicate a structural brain injury, neck injury, or other bodily injury. The Doctor clinical assessment MAY NOT overrule an adverse SCAT6. Similarly, a "normal" SCAT6 does not mean the doctor cannot diagnose the player as concussed. The Doctor may elect to use additional assessment tools as they deem relevant as part of their clinical evaluation.
Where a Doctor does not know the player, they should err on the side of caution when applying clinical judgement.

b) Following the clinical evaluation, where the Doctor judges there is no concussion or suspected concussion, the player may return to the field, the Player may do so at the end of the 15-minute HIA period, but not earlier than the end of the 15 minutes.

c) If a second player is removed for a HIA whilst the Doctor is already conducting the first assessment the Doctor will get 10 additional minutes to conduct the second assessment.

E4.2 STRUCTURAL HEAD INJURIES

It is recommended that medical staff are familiar with the National Institute of Health and Care Excellence (NICE) regarding assessment and early management of head injury.

Signs and symptoms of concussion may mimic more serious structural head injury. If a possible structural head injury is suspected, then the player must be referred to hospital. The NICE HI guidelines should be followed regarding who should be referred to hospital. Any player referred to A&E following a head injury must be accompanied by a responsible adult and a short, relevant clinical summary should be provided for the consultation with A&E staff.

E4.3 Players Refusing to Leave the Field of Play During a Match – 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 departs.

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

In a circumstance where a Match Official calls for a medical examination, the purpose of the examination and next steps would be for the Doctor to determine. This would be whether a HIA is required or alternatively, the view may be that no further action is necessary. However, as a minimum the pitch side replay system must be consulted (where available).

For clarity: On medical matters, the ultimate responsibility and decision-making rests with the player's doctor or equivalent. The Doctor decision is final. However, the Match Official may raise further issues in the match, with the above process being followed.

E4.4 Concussion Interchanges - Informing the Match Commissioner and/or Interchange Officials

Match Commissioners or Reserve Officials (as applicable) must be informed (by a visible tap on the head) by the medical staff as the player leaves the pitch whether the player is leaving the field for a HIA; medical staff must also inform the Match Commissioner or Reserve Officials of any HIAs undertaken during the half time interval or post-match where appropriate, with all HIA

outcomes reported to the Officials. Full details of interchange process are within the Match Day Operations Manual.

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

For clarity, where a player is removed by Medical Staff as a result of Criteria 1 or 2 signs or symptoms in the last 15 minutes of the match, the free concussion interchange can still be activated even in the event of all 8 substitutes being used. Should match time extend beyond the 15-minute assessment period (including Golden Point), and the player passes the HIA, the assessed player may return to the field and the free interchange card passed to the Interchange Official. Should the player 'fail' the HIA, the team must then play with 12 players.

If the player is diagnosed as being concussed, or if the Concussion Assessment takes longer than 15 minutes the "free" interchange becomes permanent. This is the case if any other treatment is required at the time of the HIA. This will result in an additional interchange should the player return.

Should a Doctor require additional time to conduct a HIA due to concurrent HIA's or other demands on their time, they may request a delay with the Match Commissioner or Reserve Official, whose decision shall be final and binding. Full details are contained within the MDOM. See E4.1 (d) for further information.

Should 2 players fail HIA within the same, the team may use their 18th Player as concussion interchange.

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

E5 POST MATCH AND TRAINING

E5.1 Immediate After Care – Mandatory (3-48 hours)

Where a player is diagnosed with concussion:

- They should not be left alone for the initial 3 hours to monitor for clinical deterioration due to evolving brain injury.
- They should be taken home by and left in the care of a responsible adult (assuming hospitalisation is not required). The responsible adult should be given an information sheet. This must include signs and symptoms that may indicate a more serious structural injury to the brain. The player should be supervised for at least the next 24 hours.
- Any worsening of clinical condition requires medical attention. They should not be allowed to drive a vehicle for at least 24 hours and must be cleared to do so by a Health Care Professional (HCP)

- They should be advised to avoid recreational drugs, alcohol, non-steroidal anti-inflammatory medication, sleeping tablets and any other sedating medication. Doctors should also review any regular medication taken by the Player and consider if this remains appropriate.

- Avoid screens, bright lights, loud or busy environments to optimise cognitive rest

E5.2 Serial clinical evaluations

When a player has been removed for a confirmed or suspected concussion, including those subject to a HIA who return to the field, they must be undergo serial assessment. This is to monitor for potential clinical deterioration in those diagnosed as concussed, and for those who were not initially suspected of concussion, any late presentation.

The re-evaluation should include as a minimum a clinical assessment which inclusive of a SCAT6 (These do not need to be returned to the RFL, but must be held on file at the Club).

Each SCAT6 assessment should be assessed compared to a baseline recording, and compared to previous examination in this injury event.

Re-evaluation 1:

- Post-game same day assessment.
- Should take place in a face to face capacity.
- This assessment must be carried out by an appropriately experienced doctor or physiotherapist.
- A full clinical assessment including SCAT6 is recommended, however, should the initial HIA be within a very short time frame of the conclusion of a match, some of the content may be clinically reasoned as to not duplicate.
- If the team are travelling, the assessment could be delayed until after the travel, as opposed to prior to leaving the stadium.

Re-evaluation 2:

- 24-72 hours post-game assessment.
- Should take place in a face to face capacity.
- This assessment must be carried out by an appropriately experienced doctor or physiotherapist and include a full clinical assessment including SCAT6.

Re-evaluation 3: only for individuals diagnosed with a concussion.

- 72-96 hours post game assessment
- This assessment must be carried out by an appropriately experienced doctor or physiotherapist and include a full clinical assessment including a SCOAT6.
- If this is at a players baseline, this can be used as pert of the GRTP protocol requirement.

- For players with results not in keeping with baseline further serial SCOAT6 beyond this point should be use to aid with rehabilitation and return to play decisions.

E6 GRADUATED RETURN TO PLAY PROTOCOL (GRTP)

Players diagnosed with a concussion must progress through an individualised and multi-disciplinary GRTP protocol, the stages of which are set out below.

PROFESSIONAL GAME ADULT (OVER 18) GRTP TABLE		
Stage	**Rehabilitation**	**Day***
0	Injury	0
	SUBMIT HIA FORM TO RFL	
1	Relative physical and cognitive rest for the initial 24 hours. Symptom limited screen time and activities of daily living. i.e.: walking. *Objective: Recovery*	1 & 2
2	**CAN BE STARTED PRIOR TO COMPLETE SYMPTON RESOLUTION****	
	2a Light aerobic exercise (<55% max HR) 2b Moderate aerobic exercise (<70% max HR) May start light resistance training *Objective: Increase heart rate*	3 4
3	Individual sport-specific exercise, or small group skill-based work with low risk of fall, accidental contact, and minimal risk of Head Acceleration Events (HAEs) *Objective: Add movement including rotation and change of direction*	5 & 6
	COGNIGRAM MUST BE PASSED BEFORE PROGRESSING AND DOCTOR SIGN OFF MUST BE SYMPTOM FREE PRIOR TO PROGRESSION FOLLOWING STAGE 3, AND PRIOR TO CONTACT TRAINING, SCOAT6 MUST BE COMPLETED.	
4	Non-contact training drills, i.e., team training with no contact. *Objective: Exercise, co-ordination and simultaneous cognitive load.* SXOT	7 & 8
5	Progressive introduction to full contact. i.e., controlled contact, building up into unrestricted full contact *Objective: Restore confidence and assess functional skills*	9, 10 & 11
6	Return to play	12
*	Reflects earliest day this could be completed as part of RTP process.	
**	Mild and brief exacerbation of symptoms (i.e., an increase of no more than 2 points on a 0–10 point scale for less than an hour when compared with the baseline value reported prior to physical activity. If more than mild exacerbation of symptoms (i.e., more than 2 points on a 0–10 scale) occurs during Steps 1–3, the athlete should stop and attempt to exercise the next day at the previous stage. Athletes experiencing concussion-related symptoms during Steps 4–6 should return to Step 3 to establish full resolution of symptoms before engaging in higher-risk activities, undergo a SCOAT6 and have domain-specific interventions implemented.	

PROFESSIONAL GAME YOUTH (UNDER 18) GRTP		
Stage	**Rehabilitation**	**Day***
0	Injury	0
SUBMIT HIA FORM TO RFL		
1	Complete physical and cognitive rest for minimum first 24-48 hours. Symptom limited activity of daily living. i.e.: walking. *Objective: recovery*	1-2
2	**CAN BE STARTED PRIOR TO COMPLETE SYMPTOM RESOLUTION ****	
	2a Light aerobic exercise (<55% max HR)	3&4
	2b Moderate aerobic exercise (<70% max HR) May start light resistance training *Objective: Increase heart rate*	5&6
3	Individual sport-specific exercise, group skill-based work with low risk of fall, accidental contact, and minimal risk of Head Acceleration Events (HAEs) *Objective: Add movement*	7- 14
COGNIGRAM MUST BE PASSED BEFORE PROGRESSING AND DOCTOR SIGN OFF MUST BE SYMPTOM-FREE PRIOR TO PROGRESSION FOLLOWING STAGE 3, AND PRIOR TO CONTACT TRAINING, SCOAT 6 MUST BE COMPLETED.		
4	Unrestricted non-contact training drills, i.e. team training with no contact. *Objective: Exercise, co-ordination and cognitive load.*	15-17
5	Progressive introduction to full contact. i.e., controlled contact, building up into unrestricted full contact. *Objective: Restore confidence and assess functional skills*	18-20
6	Return to play	21
*	Reflects earliest day this could be completed as part of RTP process. Please refer to age-graded -Stage 1.	
**	Mild and brief exacerbation of symptoms (i.e., an increase of no more than 2 points on a 0–10 point scale for less than an hour when compared with the baseline value reported prior to physical activity. If more than mild exacerbation of symptoms (i.e., more than 2 points on a 0–10 scale) occurs during Steps 1–3, the athlete should stop and attempt to exercise the next day at the previous stage. Athletes experiencing concussion- related symptoms during Steps 4–6 should return to Step 3 to establish full resolution of symptoms before engaging in higher-risk activities.	

The GRTP must be overseen by a Doctor who may delegate to other members of the medical team. The Doctor must confirm that the player is able to progress to Stage 4.

An important consideration when determining if a person is symptom-free must take into account that they should not be taking any pharmacological agents/medications that may mask or modify the symptoms of concussion.

Where applicable, players who are required to return to work or education, this must be prioritised before returning to play.

For players on Academy and Scholarship Programmes, who also play Rugby Union. Professionally or within the Community Game, or Rugby League within the Community Game the Professional Rugby League Club must ensure GRTP is managed in line with the RFL Medical Standards. Professional Club Medical Staff should contact the RFL if they are experiencing difficulties obtaining information from other teams. Communication with Community Clubs and the players parent is vital to ensure clarity and awareness.

For the avoidance of doubt eligibility applies to players born before the date shown below irrespective of the team which the player is playing for :

Under 18 as at 31st August 2024

E7 DOCTOR - CONCUSSION REPORTING REQUIREMENTS – MANDATORY

A correctly completed Concussion Report (HIA form), must be submitted to the RFL for every player who undergoes an assessment for suspected concussion or is diagnosed as concussed. This applies to matches, training or activities away from the registered Club activity (such as late presentation, car accident or other sporting activity away from the Club). The form must be completed within 24-hours of the incident.

It is a club's responsibility to ensure that a Doctor, providing locum cover, is made aware of the reporting requirements, and advised they must submit all HIA documentation within the timelines set out above – applies to players at all levels

At matches where only the home Doctor is present (or the player is on loan) any concussion must be reported to the parent Club. The Concussion report as a minimum and any relevant documentation must be forwarded to the Medical Team of the away or Parent Club within 12-hours of the conclusion of the match so that the correct after care, including any referral to and appointment with a specialist, and GRTP protocol can be implemented.

E7.1 RETURN TO PLAY FORM

On completion of GRTP the club Doctor must complete and submit a Return to Play form to the RFL prior to the player taking part in a match.

Doctors may also ask each player to complete a written consent form which details they have undertaken their GRTP, are symptom free and are aware

of the long and short-term risks associated with sustaining concussions. Templates are available from the RFL upon request.

E7.2 POST INJURY COGNIGRAM REPORTS

Prior to undertaking Stage 4 of the GRTP players must establish a valid Cognigram post injury test result, ensuring a player's current season valid baseline has been manually selected and is showing as the comparator. A pdf copy of the test report must be submitted with the RTP form. This won't be checked by the RFL and must be held on file by each Club.

A post injury test is considered valid if the results on all four individual modules are recorded at -1.0SU or above.

A post-injury test is considered invalid - stand-alone or combination - in any of the following scenarios:

- If performance on any of the four individual modules has declined by more than -1.0SU. In this scenario it should be investigated further with the player, and a re-test arranged.
- A result on any of the four individual modules returned as LOW recorded at 79 or below
- No Completion or Performance Criteria Flags on ANY of the outcomes

If a test does not meet Completion or Performance criteria a score cannot be calculated for that test and a re-test is required. When Completion or Performance criteria are not met a blue number within a blue circle will be displayed on the x axis adjacent to the date of the test

Further information and examples of completion criteria and performance criteria flags can be found in the Cognigram Clinician User Manual.

On the change score graph the area between 1.0SU and -1.0SU (Standard Unit, is considered to be within expected levels of variation for an individual and valid for a post-injury test. **For clarity any Change Score recorded at -1.0SU or above is a valid result.**

A Change Score that falls below -1.0SU could be considered meaningful, as it is >1.0SU from the individual's baseline assessment. A reference line is displayed at 2.0 and –2.0 SU in either direction of performance (on the Change Score graph). This reference line can be used to indicate meaningful decline or improvement relative to a baseline assessment.

A Player is limited to completing one Cognigram post injury test in a 24- hour period.

Where an alternative baseline has been used, a copy of the post injury test scores must be submitted with the RTP form. (See E2.2)

If it is realised that a Player has not recorded a valid Cognigram baseline for the current season, and has suffered a concussion, the medical team must inform the RFL immediately. A special assessment mut be carried out before the Player progresses through the GRTP . The club concerned must make

clear to any specialist the rationale for the referral. It is at the specialist's discretion when a Cognigram can be completed, that is reflective of a valid baseline for the current season. A copy of the report from the specialist along with a new valid Cognigram baseline must be submitted to the RFL. Upon receipt and review of the specialist's report by the RFL CMO, only then will the RFL CMO confirm whether the player can avoid an extended GRTP which is not guaranteed.

The Club may be required to evidence Cognigram baselines for the entire Club to the RFL upon discovery of a player not holding a valid Cognigram baseline.

E7.2.1 Failure to Establish a Valid Post Injury Cognigram – Applying for Clinical Reasoning to Return to Play

Dispensation can be sought where a Player repeatedly fails to achieve a valid post injury Cognigram test, but the Club Doctor believes through clinical judgement, that despite an adverse post injury test they have completely recovered from their concussion. The Medical Team should consider a battery of alternative neurocognitive testing to support this application or alternative neurocognitive testing platform. Particular attention should be made to the area (refer to failed graph in the Cognigram report) in which the player has failed their Cognigram.

Clinical reasoning must be supplied, in writing, and submitted by the Doctor to the RFL's CMO, and must be accompanied by the invalid post injury Cognigram reports. The Doctor must wait for the CMO's response and answer any questions before permission for the player to progress through the GRTP.

E7.3 SPECIALIST REPORTS

Where a player requires specialist review, they must not RTP until the specialist has given written confirmation that in their opinion they are fit to do so. The RFL require a copy of the specialist's review (with signed acknowledgement from the Player (or parent/guardian where the player is under 18) to be returned at the time of RTP forms.

The RFL will consider specialist reports only from a doctor registered with the General Medical Council (GMC) on the specialist registers for either Sport and Exercise Medicine or Neurology or Neurosurgery. The clinician must have experience of managing concussion and appropriate professional indemnity. It is the clubs responsibility to choose an appropriate clinician that meets the minimum requirements above.

The player must be provided with a copy of all specialist reports and must declare, in writing, that they have received, read, and understood the contents. For players under the age of 18 a parent or guardian must

countersign to state they have received read and understood the contents of the report(s).

For players sustaining a second or subsequent concussion in a 12-month period Doctors/Equivalent are reminded of the need to take a conservative approach to their management.

The following criteria require a clinical review by an appropriate specialist with relevant experience and indemnity for managing sports related concussion. The doctor must be GMC registered and on the specialist register for either neurology or neurosurgery, or sport and exercise medicine.

- a second or subsequent concussion within 12 months;
- a history of multiple concussions;
- unusual presentations;
- persistent symptoms or prolonged recovery (21 days)

The player may not Return to Play until the specialist has given written confirmation that in their opinion they are fit to do so, however can commence the GRTP process up to but not beyond Stage 4 until review and permitted to do so by specialist.

E8 SPORTS CONCUSSION OFFICE ASSESSMENT TOOL (SCOAT)

The Sport Concussion Office Assessment Tool 6 (SCOAT6) is a clinical screening, evaluation, and management guidance tool for sport-related concussion (SRC) that incorporates the essential domains for comprehensive concussion care. The SCOAT was designed for use by healthcare professionals in the sub-acute phase of injury, typically from 72 hours (3 days) to 1 month after injury

. SCOAT is most effectively used when compared to the SCAT6 completed within 72 hours of the injury.

The assessment can be carried out by a Physiotherapist, Sports Therapist of Sports Rehabilitator (HCP) , with oversight and interpretation from the clubs Doctor.

SECTION F

RFL MEDICAL POLICIES

F1 BLOOD BORNE INFECTIOUS DISEASES - GUIDELINES - MANDATORY

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

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

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

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.

In training

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

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

If a trained HCP is not present and a Player has a wound that needs closing then the player must be sent to the local relevant medical department for appropriate management of this injury.

Matches

If a player suffers a wound during a match, the player must receive treatment as soon as practicable in line with the blood bin procedure.

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 covered where practicable and possible, to reduce the risk of further bleeding and 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 either their own, or someone else's blood, the Referee shall direct the Physio 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 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.

Spare jerseys, shorts and socks must be available if blood contaminated clothing needs to be replaced for matches and training purposes.

F1b HEPATITIS B SCREENING

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

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

Ideally, this should be conducted in pre-season ahead of contact training to minimise any risk of exposure.

CHAMPIONSHIP, LEAGUE 1 & WSL CLUBS – BEST PRACTICE

It is Best Practice for Championship, League 1 & WSL teams to offer players Hepatitis B screening annually. Ideally, this should be conducted in pre-season ahead of contact training to minimise any risk of exposure.

F1c HEPATITIS B VACCINATION – BEST PRACTICE

It is mandatory for Super League and Full Time Championship and League 1 clubs to offer players, medical staff, and those who may be involved in handling blood-stained equipment/clothing, a vaccination course against Hepatitis B. It is Best Practice to do this at all other levels.

It is up to the individual whether they accept but those that choose not to be vaccinated must sign a waiver, a standard waiver document is available from and must be lodged with the RFL Head of Medical upon request.

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

The RFL shall appoint a Blood Borne Disease Officer ("BBDO"), who shall be the Head of Medical .

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 (this includes but is not limited to Hepatitis B, Hepatitis C and HIV) 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.

NOTIFICATION IN THE EVENT OF A POSITIVE BLOOD BORNE DISEASE TEST

Clubs must report positive results of BBD to the BBDO.

The responsibility of the BBDO shall include 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. The player must be removed from contact training or matches pending the Tribunal.

Where anyone else subject to the Operational Rules is advised that a Participant has contracted a blood borne disease, , 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, or may be 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 AND HEARING PRIOR TO 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 and expertise to conduct an appropriate risk assessment.

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, WOMENS SUPER LEAGUE, CHAMPIONSHIP AND LEAGUE 1 CLUBS

F3.1 GENERAL

It is mandatory for Clubs to arrange appropriate cardiac screening (which may or may not be facilitated in conjunction with the RFL) and is recommended to identify athletes who may have cardiac abnormality that could predispose them to sudden cardiac death for;

First Team (Men's)
Women's Super League
Reserves
Academy Players

Scholarship Players

It is best practice to cardiac screen players prior to commencement of club activities. If this is not possible, clubs should ensure a cardiac related history is taken and a cardiac screening questionnaire is completed prior to activity. Should there be any concern raised by the screening checklist then the player should be cardiac screened prior to commencing physical activity.

F3.2 CARDIAC SCREENING REQUIREMENTS

Cardiac screening must include as a minimum:

- Cardiac Screening questionnaire, including personal and family history to identify potential risk factors for cardiac problems.
- Physical examination

- ECG (electrocardiogram) test interpreted by a medical practitioner experienced in reading sports ECG and who has access to the player's cardiac screening questionnaire

- Further examinations or investigations may be warranted based on the outcome of the Cardiac Screening questionnaire or ECG. This should be organised and overseen by an experienced cardiologist with an interest and expertise in sports cardiology.

- Accurate registers of attendance counter-signed by the Club CEO, to the RFL Head of Medical.

F3.3 FREQUENCY OF SCREENING

It is compulsory as set out in F3.1 that each player registered at a Club receives cardiac screening unless the player makes an informed decision to refuse/decline to be screened. If they decline to be screened they must complete a waiver form (in the format provided by the RFL). Where a Club signs a Player after the initial screening date, it is the Clubs responsibility to review the Players previous screening records from their previous Club. If that player has not been screened, or evidence cannot be provided to demonstrate screening has taken place, that player should be screened by their new Club as soon as practicably possible.

It is recommended as Best Practice for all screening to be scheduled for and completed during pre-season. This should be conducted for each Player, every two years as a minimum. On completion of the screening session, it is mandatory for the club to submit an attendance list 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, a Player must make an informed decision, if they choose to continue to play to continue to play they must sign a deed of waiver and must have a detailed letter documenting this discussion, including the risks to the player from a sports cardiology specialist. This must be countersigned by the Player and sent to the RFL. It is the responsibility of the Club Doctor to make sure that all the club's medical team and the Club Doctor of any subsequent club are aware of such a cardiac condition, however, the RFL may ask the club to confirm they have considered this unique situation in their EAP..

F3.4 SCREENING PROVIDERS

Where Clubs arrange their own screening providers for Cardiac screening, they must satisfy the criteria above.

The Club is responsible for ensuring Players who require follow up specialist appointments have access to this in a timely manner and cover all costs relevant to this.

It is the responsibility of Clubs to retain the cardiac screening outcomes, ECG and waivers where relevant for all players for their medical records.

F4 TURNING PLAYERS OVER ON THE FIELD OF PLAY - MANDATORY

Medical Staff must educate players and non-medical staff and Physiotherapist or Equivalents on the potential hazards of moving injured players without appropriate training.

F5 PROTECTIVE & OTHER EQUIPMENT – FOR INFORMATION ONLY

F5a HEAD GUARDS

The RFL is aware of ongoing research into head guard technology and the potential to reduce the risk of head impacts and concussion. At the current time the expert view is that soft helmets do not prevent brain injury in sport. They may reduce the risk of superficial lacerations. There is some suggestion that the phenomenon of 'risk compensation' there is a risk that encouraging helmet use in players may paradoxically increase the head injury rates. The RFL does not support the mandatory wearing of protective head guards in Rugby League.

F5b MOUTH GUARDS

It is strongly recommended that all players wear a mouth guard when playing or taking part in contact training sessions for the reduction of dental injury. 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, 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."

Instrumented Mouth Guards (IMG)s are mandated in Super League Men's and Women's competitions. Medical exemptions will be considered through an application process. A player who plays without an IMG will not be permitted to return to the field following removal for a HIA if they are not deemed concussed. Importantly this does not affect any ability to provide medical assessment and the HIA should be provided for clinical review, but this will not influence return to field. **F5c BOXES**

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

F5d PADDING/PROTECTIVE EQUIPMENT

. Any additional equipment or strapping and padding must only be used as necessary and in a manner which does not pose risk of injury to other Players.

F6 MENTAL HEALTH COUNSELLING SERVICES – FOR INFORMATION ONLY

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

Rugby League Cares

Wellbeing support can be obtained by contacting your Club welfare officer or directly via Steve McCormack, RL Cares Welfare & Development Manager, on 07477873902 or Steve.McCormack@rlcares.org.uk, in strict confidence.

F7 MENTAL HEALTH TRAINING) - MANDATORY

Adult Mental Health Aware training is compulsory for the Physiotherapists role as set out the RFL Operational Rules qualifications table and should be provided by the Club. From time to time the RFL may approve alternative courses.

F8 INSOMNIA – FOR INFORMATION ONLY

Clubs should be aware of the insomnia suffered by many players and may wish to review players mental and physical health, consider their caffeine intake and avoid sedative medication. You may wish to provide workshops outlining good sleep hygiene habits or direct players to https://www.sleepio.com/

F9 SOCIAL & NON-PRESCRIBED PRESCRIPTION DRUGS POLICY

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

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

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

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

1 Education Programme

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

2 Testing Programme

UKAD may be able to facilitate the screening with results sent to the RFL who will pass to the Clubs to be dealt with in line with the Policy. Clubs are able to facilitate additional in house testing as necessary. This is recommended to be conducted by a third party provider.

3 Rehabilitation, Welfare and/or Disciplinary Procedures

The same policy applies across all Clubs as follows:

Self-Declaration

Where a player approaches the RFL or an a member of club 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 player and/or nominated representative will be required to attend an Initial Case Review with the RFL Head of Medical Standards, Anti-Doping and Integrity and their Club Doctor and/or Player Welfare Manager. Following the Review, the Player may be required to attend an Assessment with a representative of the RL Cares wellbeing service.. 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 may be subject to a targeted testing programme for such period of time 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 or NPP Drugs in addition to review and assessment clubs will be able to take such internal disciplinary action as they consider necessary including dismissal and/or fines (subject to the provisions and procedures of the Standard Players Contract or the

Operational Rules as appropriate) or agree to continue the process set out under the First Violation.

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

Third Violation

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

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

Subsequent Violations

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

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

In order to determine the NPPD finding the Club Doctor may be consulted.

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 (Tramadol is not categorised as a stimulant within the WADA Prohibited List 2024) or where trafficking was involved.

F10 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 or an agreement with the Player

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

1 DUTY OF CARE

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

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

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

2 MEDICAL STANDARDS

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

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

All Clubs are bound by these Medical Standards and must ensure they adhere to the standards both as an employing club and a receiving club.

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, this is particularly important with concussions.

It is Best Practice at the time of the loan to discuss and confirm in writing which Club is responsible for undertaking the GRTP for a player with concussion.

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.

F11 INFECTION CONTROL POLICY

All Clubs must ensure they have clear policy and hygiene processes in place to limit the introduction of and transmission of infection at all sites. This is to maintain the health and wellbeing of all at the Club, plus reduce the potential for impact on performance of the players of both teammates, opposition, and health of the wider general population. When illness is present within the squad, it is important for staff to review infection control policy and upregulate any mitigations that would be appropriate for the specific situation. NHS guidance on workplaces and schools can be useful as a reference point to when considering spread of illness.

REPORTING

- Ensure all players are aware they must promptly report illnesses or if they are feeling unwell to medical staff. Encouraging anyone who is unwell to stay at home until symptoms have resolved. Medical team to have a clear escalation plan and reporting processes in the event of notifiable diseases within the Club to UKHSA and/or local Health Protection Teams.
- In the event of a notifiable disease arising at the Club, this must be reported to the RFL Head of Medical, as a matter of urgency.

VACCINATIONS

- Medical teams should be aware of players vaccine status.
- It is best practice to ensure players are up to date with tetanus boosters and MMR vaccinations.
- It is recommended to offer seasonal flu vaccines.
- Ensure compliance with RFL medical standards on mandated Hepatitis B vaccination and screening programs.

SCREENING

- Wellbeing screenings recommended to help identify anyone high risk of illness when in Rugby League environments.
- Clubs may use apps or other means of completing daily checks on players to assess their general health and wellbeing, including mental health. The reports should be assessed in line with attendance at the Club and shared with appropriate Medical Staff as necessary to manage.
- Clubs may consider screening for STI's via referral at a local clinic.

PERSONAL HYGIENE

- Encourage all to undertake good personal hygiene at home and within Rugby League environments.
- Regular focus on hand hygiene, particularly following use of the bathroom and around food and drink.
- All team sites must have a supply of hand sanitisers available where handwashing facilities are not readily accessible.
- Soap dispensers must be checked regularly to ensure they are fit for use.
- Do not share towels.
- 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 contact or touch the nozzle of squeeze bottles. **WARNING:** The potentially life-threatening meningococcal disease can be transmitted by sharing drink containers.
- Reporting of and management of bleeding wounds immediately, limiting contact with others.
- Advising players to have good mouthguard hygiene, particularly where this is handled by others such as the iMGs. Handwashing after handling mouth guards.
- Discourage spitting.

PPE

- Correct and appropriate level of PPE use (and disposal) when there is a possibility of encountering bodily fluids.
- Consideration of face mask use for the mitigation of airborne disease spread particularly in indoor environments and shared spaces.

CLEANING PROCESSES

- Medical rooms must operate with a clean surface policy and kept to high clinical standards.
- Gymnasium, wrestle room etc flooring should be of an impervious material with a sealed surface that is easily cleaned. Carpet or artificial turf type are

not allowed within gymnasium environments. Clubs must specifically consider the risk of ringworm and its transmission and manage environments accordingly, particularly wrestling and wrestle rooms.

- Shared surfaces must be maintained clean including gyms and offices , with Clubs conducting regular deep cleaning of areas and equipment. Regular touch points should be frequently cleaned.
- Players must have clean shoes and clothing for each gym session.
- Appropriate laundering of player kit (match day and training if managed by the club) substitute jackets, interchange bibs.
- Where food is provided on site ensure the site meets FSA guidelines and all Hazard Analysis and Critical Control Point (HACCP) regulations are followed by catering staff, the venue has a high-level certification in place and sharing of cutlery etc is prohibited.

Useful information can be found here Preventing and controlling infections - GOV.UK (www.gov.uk)

MITIGATIONS IN THE EVENT OF SQUAD ILLNESS

- If there is a cluster of similar illness within a club, a risk assessment should be conducted to mitigate further spread. The following may form part of your risk assessment process:
- Identifying patterns or sources of transmission.
- Testing for specific pathogens of concern
- Discussion with UKHSA / local health protection teams where relevant.
- Cohorting of individuals to limit transmission, including training, travel and overnight accommodation.
- Consider isolation away from the squad where necessary or appropriate. Consider the effect on player health with continuing to exercise. Hydration status management is likely to be of greater significance.
- Consider any high-risk or immunocompromised individuals within your environment for additional prevention measures.
- Limit shared indoors spaces if airborne concerns, if indoor contact is needed maximise ventilation, consider mask wearing, increase room size or decrease numbers within.
- Limit shared surfaces if fomite transmission of concern- regular disinfecting of touch points, sporting / gym equipment, no sharing of clothing such as bibs. Consider deep cleaning by an external provider.
- Prevent sharing of drinks containers, dispose of open unlabelled bottles.
- Consider nature of training, can training be modified or changed to minimise physical or face to face interactions.
- Limit unnecessary interactions with others including wider stakeholders (e.g., mascots Match Officials, Media, corporate guests etc) to ensure infection does not transmit to wider population, external to the Club.
- Consideration of duty of candour to the opposition team preceding and following identification of squad or significant illness.

APPENDIX 1 – IMMOFP & i-IMMOFP

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

New Doctors or Physiotherapists have three months to successfully complete an IMMOFP or equivalent course, or until the first available course if there are no courses available within this time frame. **NB** This is not applicable to Sports Therapists, Sports Rehabilitators, ANP's or Paramedics.

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

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

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

PAYMENT & CANCELLATION

For staff currently employed by a Rugby League club, payment will be made via a deduction from the clubs Central Distributions upon enrolment to the course, as agreed in writing by responsible Club personnel.

Independent candidates must pay for the course in full via BACS within 7 days of date of invoice which will be generated once a place has been confirmed by the RFL. We reserve the right to offer your place to another candidate if payment is not received within this time frame. Clubs are discouraged from 'block booking' multiple spaces for the same candidate. Please note that payment will be taken for all bookings and only refunded should the place(s) be filled 5 weeks in advance of the course date. Cancellations will only be accepted up to 5 weeks prior to the course start date thereafter without refund and payment deducted from central distributions for club staff.

Those who withdraw from the course within the 5 week period of the applicable course evidence of the reasons for cancellation must be provided for the CMO's consideration. The CMO will determine dispensation for the Medical Staff to still provide on field game cover until such time as the member of staff attends the next available course. The CMO may recommend after a period of invalid qualification that the member of staff is required to attend a two-day reaccreditation course. A medical note must be provided for cancellation due to illness for a refund or course transfer.

For course dates and fees for 2024 follow this link: https://www.rugby-league.com/governance/medical/immediate-medical-management

The IMMOFP course costs are (excluding VAT):

COURSE	CLUB STAFF	INDEPENDENT CANDIDATE
1-DAY	£375	£405
2-DAY	£675	£765

The i-IMMOFP course costs are (excluding VAT):

COURSE	CLUB STAFF	INDEPENDENT CANDIDATE
2-DAY	£415	£465

Venue: As determined by the RFL.

RE-ACCREDITATION & RE-CERTIFICATION

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

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

Please note, where a candidate holds PHICIS Level 3, they must attend IMMOFP refreshers in line with the annual cycles set out above.

EXAMINATION AND IMMOFP PROCEDURES

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

The two-day course manual and course lectures will be shared by email only on receipt of payment in full.

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

COURSE ELEMENTS

IMMOFP 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.

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

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

The assessment will compromise the following:

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

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

iIMMOFP

- Successful completion of the pre-course element is a mandatory requirement for attending the face-to-face element of the course.
- The on-course skill stations will be Competent or Not Yet Competent (C or NYC).
- The two assessments end of day 2 will then be C or NYC.
- Resits allowed assuming Competency is achieved in all skill stations and a pass on the assessments on day 2.
- If there is an outstanding NYC in any skill stations (with the exception of the practice scenarios) or in one of the assessments that is an unsuccessful completion of the course.
- If 2 NYCs are achieved in the practical assessments that is an unsuccessful completion of the course.
- Where an unsuccessful completion of the course is the outcome, learners are required to repeat the course, in full, at a later date at their own cost.

GAMEDAY COVER & CLUB ARRANGEMENTS

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

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

Candidates, who fail the course, will not be able to enter the field of play until such time as a pass is achieved. These individuals may provide assistance with stretcher bearing and off-field. It is the responsibility of the candidate to inform their Club of the failure immediately after the course. The RFL will notify the individual and the member of Club Staff who countersigned the individuals application for any individual who was not successful in achieving a the overall pass score, on the day immediately following the course.

IMMOFP RE-SIT PROCEDURES

Any candidate who does not achieve the overall required mark across all elements will be deemed to have been unsuccessful in achieving the required standard of the course. In this instance, they will no longer be able to run on the field of play with immediate effect, until such time as they have attended and passed another IMMOFP course. This is in line with industry best-practice, where any medical course that has elements of ongoing assessment is deemed not to be suitable for re-sit opportunities for individual elements of the course. For clarity, individuals may still provide medical support to a team/Club however must not enter the field of play or act outside of their scope of qualification.

APPENDIX 2

EDUCATION

MEDICAL STAFF CPD PROGRAMME – BEST PRACTICE/MANDATORY

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

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. It is Best Practice for Women's Super League, Championship and League 1 Clubs to send at least one representative to CPD sessions.

UKAD EDUCATION COURSES

It is Mandatory for Club Doctor , physios and conditioners to have completed UKAD's online Introduction to Clean Sport course (or alternative as made available by UKAD) to ensure that they are up to date with regards to the current anti-doping rules. There are no entry requirements for this programme. Training is via an on-line e-learning programme with an assessment at the end. Advisors remain accredited until the UKAD advised expiry date. If you are already registered, you may log in with your current username and password. The course and registration portal is hosted on About the | UK Anti-Doping (ukad.org.uk) This qualification is valid for 2 years.

QUALIFICATIONS

Safeguarding
Concussion Module
Anti-Doping Module