Think Rehab!

Best Practice Guide on Rehabilitation

3rd Edition

Updated November 2015

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FOREWORD

APIL practitioners are dedicated to achieving the best possible outcome for their injured clients. Whilst the law recognises the benefits of monetary compensation, very many injured people crave a sense of normality as much as financial compensation.

Since 1999 there has been widespread recognition of the benefit of rehabilitation across all sections of the personal injury world. 2015 will see the third version of the Rehabilitation Code, which will be an expanded work but one that still embraces the basic principles of striving for a collaborative approach to getting injured people back on the road to all aspects of recovery if at all possible.

The code provides a framework by which personal injury practitioners can start to make a difference for their injured clients and their families from the outset of the post-injury period. APIL's guide is designed to expand on that basic framework and to provide the understanding and support to enable practitioners to make the most of the opportunities provided by the code itself.

The guide is intended to have practical application, and includes case studies and process maps. It anticipates a new era in which personal injury lawyers will take the lead in a proactive manner to instigate rehabilitation wherever this is possible.

There is still much to do to educate both sides of the personal injury divide about rehabilitation, but the time has come for there to be a joining of forces to make this work. The Government and the National Health Service also need to come to appreciate the benefits that can be achieved by a collaborative approach between personal injury lawyers and the insurance industry.

Rehabilitation, the code and this guide are a real opportunity for personal injury lawyers to demonstrate the importance of the work that we do. I commend this guide to you – please read it and use it to best advantage.

Neil Sugarman

APIL Vice-President

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INTRODUCTION

It has been said that the purpose of rehabilitation is to restore an injured person to as productive and as independent a lifestyle as possible through the use of medical, functional and vocational intervention. So, how does this fit with personal injury law and procedure?

As long ago as 1880, in *Livingstone v Rawyards Coal Company* [1880] 5 Appeal Cases 25, Lord Blackburn said the purpose of damages was to "put the party who has been injured… in the same position as he would have been if he had not sustained the wrong for which he is now getting his compensation." This statement had been reinforced many times. A recent example is *Helmot v Simon* (2012) in which the Privy Council mentioned no less than 18 times the injured person's right to full compensation.

Research has shown that in many cases rehabilitation can help injured people recover more quickly, have a better quality of life and return to work sooner. Thus rehabilitation can be the key to returning the injured client to the same position that they would have been in were it not for the negligence of the defendant. The only remedy in court cases involving personal injury is money, but in most instances rehabilitation must be paid for, and so the cost of this can be recoverable as a head of special damage. As with all other special damages, the court will allow the cost of rehabilitation to be recovered as long as it can be shown to be reasonable.

In *Sowden v Lodge* [2004] EWCA Civ 1370 the Court of Appeal confirmed that an injured client is not merely to be provided with the cheapest rehabilitation and care provision possible, but is entitled to have what he reasonably needs to enhance his lifestyle, in an attempt to try to restore it, as much as possible, to how it was prior to suffering his injuries.

Given the potential benefits to clients, APIL members should now be considering whether rehabilitation is appropriate in every case. Furthermore, the pre-action protocol for personal injury claims and the Rehabilitation Code place obligations on personal injury lawyers to do just this.

The holistic approach to personal injury litigation - considering rehabilitation as well as compensation - can only be of benefit to members' injured clients. This guide aims to assist APIL members throughout the process of arranging rehabilitation and seeks to emphasise the range of rehabilitation services available, the benefits of a collaborative approach with insurers, the options if this does not work and the importance of choosing the right provider.

Much skill and knowledge is required when considering issues concerning rehabilitation. The APIL accreditation scheme ensures that those with the relevant accreditation will have the necessary experience in dealing with rehabilitation matters. It is particularly important when dealing with spinal injury and traumatic brain injury cases, that an accredited person conducts these. Alternatively, the lawyer involved should have supervision from such an accredited individual. It cannot be stressed too much how important it is to consider rehabilitation in every case. This is very much the policy of APIL. We are trying to succeed in achieving the best possible outcome for injured people and this is the best approach to achieving this.

REHABILITATION CODE 2015

The 2015 version of the Rehabilitation Code[1] replaces the earlier 1999 and 2007 versions. It remains a voluntary arrangement, but is recognised by the Personal Injury Pre Action Protocols and the portals in applicable cases.

In comparison with earlier versions, the Code differentiates between lower value and medium, severe and catastrophic injuries. It expresses the aims of putting the claimant at the centre of the process and encouraging collaboration between the claimant's lawyer and the compensator, with early notification and exchange of information being objectives.

Rehabilitation needs are stated as a priority, with time frames being specified and an anticipation of early assessments by suitably qualified professionals in a manner appropriate to the type and complexity of the injury. In the case of lower value injuries this is envisaged as being by way of a triage report, although provision is made for there to be assessment and discharge reports in suitable cases. The reporting is outside the litigation process. It is recognised that even injuries that might have a lower value in monetary terms can still be life changing.

Although joint instruction of an assessor might be considered it is clear that the claimant has the ultimate choice, and is not obliged to undergo treatment that is considered unreasonable.

There is an expectation that Case Managers will seek to engage and co-operate with treating NHS clinicians.

Compensators are expected to agree to pay for agreed, assessed rehabilitation needs and are to justify any refusal to follow recommendations. When rehabilitation is provided under the Code the compensator will not later seek to recover the cost if a claim is unsuccessful, other than in the event of fundamental dishonesty.

In this version of the Code, whilst it still tends to concentrate on the early stages post-accident, there is an expressed intention that the parties should adopt the principles beyond an Immediate Needs Assessment and throughout the life of the rehabilitation process.

The Code has sections which describe the role of the Code itself and the roles of the claimant's solicitor and the compensator. Apart from identifying the different categories of injury, the Code outlines what is expected in the assessment process and an Immediate Needs Assessment. It describes ten "markers" to be taken into account when assessing rehabilitation needs.

There is a separate Guide for Case Managers and those who commission them, which is not part of the Code itself, but is intended to be looked at in conjunction with the Code.

Helpfully, the Code encourages compensators to consider from the outset whether liability is a possibility or whether there is some likelihood of even a partial admission so that the Code might come into play. It is also made clear that an Immediate Needs Assessment is to

[1] Hereon after referred to as "the Code"

assess the claimant's medical and social needs and not to provide information to settle the claim.

REHABILITATION AND LITIGATION – KEY CONSIDERATIONS

Key activities

- Pro-active involvement
- Identifying appropriate actions
- Communicating at an early stage
- Considering early independent assessment

Pro-active involvement

At the earliest practicable stage, APIL members should, in consultation with the client and/or the client's family, consider whether early intervention, rehabilitation or medical treatment would improve the present or long term situation. In other words, focus on the client's needs. The duty to consider rehabilitation is included in the pre action-protocol for personal injury claims.

Identifying appropriate actions

In many personal injury claims, the injured person's medical situation and quality of life may be improved by early intervention. APIL members should:

- consider early intervention/rehabilitation treatment which could improve the present and/or long term physical or mental wellbeing of their clients;
- consider and investigate the immediate need for other services, aids or adaptations that will assist their client.

Communicating at an early stage

APIL members should communicate as soon as possible with the insurer about their clients. Involving the insurer to try to agree the best way forward at an early stage can be beneficial in helping and contributing to early recovery and resolution; and can establish an element of mutual trust.

This communication should be on-going to ensure that the insurer or appointed solicitor is kept up to date.

In the more complex and higher value cases, regular updates on the progress of rehabilitation should be provided as part of case planning.

In higher value cases, members should refer to the *Guide to the Conduct of Cases Involving Serious Injury* (the "*Serious Injury Guide*"). This provides further information about on-going dialogue and disclosure of documents. APIL considers that the guide represents best practice for dealing with these higher value cases. It is important to note that the guide is

intended to help parties involved in multi-track claims resolve any issues, whilst putting the claimant at the centre of the process. It puts in place a system that meets the reasonable needs of the injured claimant whilst ensuring the parties work together to resolve the case by co-operating and narrowing the issues.

It is considered that such an approach is one that is going to be in the best interests of the claimant. The guide has a number of objectives. These include early notification of the claim, engaging in case planning with the defendants and resolving liability at the earliest possible stage. With regard to rehabilitation, the guide provides that there should be:-

“Discussion at the earliest opportunity by all parties to consider effective rehabilitation where reasonably required. An independent clinical case manager instructed by the claimant will be appointed or subject to the claimant’s agreement, on a joint basis.”

The guide also requires a willingness to make early and continuing interim payments where appropriate. The guide makes reference to APIL’s Best Practice Guide on Rehabilitation.

The guide also requires the claimant’s representative to keep the defendant’s representative up to date with the progress that the claimant is making under any rehabilitation plan, and provide notes and records in relation to that program.

Considering an early independent needs assessment (“INA”)

The purpose of an independent assessment is to ascertain the most appropriate form(s) and extent of rehabilitation for the injured person. The form that the independent assessment will take will depend on the extent of the injury. As a guide:

- in moderate injury cases, you probably only need a telephone assessment leading to a triage report.
- in major injury cases, an independent needs assessment at home or in hospital would probably be most appropriate.
- in the third type, catastrophic cases, you would probably instruct a case manager to act on behalf of the injured client at the outset. The case manager would report regularly on progress.

The assessment should be carried out by an appropriately qualified person. The most appropriate person for such an independent assessment is likely to be an occupational therapist, a specialist nurse, or someone who has a rehabilitation qualification or relevant experience pertaining to the injury, in rehabilitation. Regardless of professional title, the assessor must be appropriately qualified.

DEALING WITH CLIENT EXPECTATIONS

Tell the client what rehabilitation is

Rehabilitation is designed to help the injured person regain the closest possible level of mental, physical and social ability which the person possessed prior to being injured. Research shows in many cases this will help injured people recover more quickly, have a

better quality of life and return to work sooner. Rehabilitation may take the form of provision of equipment, physical therapy, treatment, nursing care, accommodation adjustments or psychological care. It should reflect the client's changing needs.

The process of planning rehabilitation should be undertaken in conjunction with treating doctors but will not be limited to the services that the state can provide. Rehabilitation can be put in place even before the insurer has admitted liability and there are time limits for requesting and responding to rehabilitation requests.

Discuss with the client how rehabilitation will help

APIL members should talk to the injured client about his or her quality of life. Issues for consideration include:

- Would early intervention assist with day to day living?
- Are home adaptations needed to make life easier?
- Is support or counselling needed due to trauma?
- Are transport needs problematical?
- What are the pressures on other family members and would respite support help to alleviate them?
- Is retraining needed to get back to work?
- Is the injured client facing social isolation?

By using the Code, or other negotiated arrangements, these needs can be assessed and delivered outside the clams handling or litigation process.

Explain the process and how rehabilitation is paid for

The injured client's needs are assessed by an independent expert and costed. The insurer is then required to consider whether to pay to implement the expert's recommendations. It may be challenged. Once agreed funding is in place, treatment can start immediately. The cost of rehabilitation will be paid for as part of the damages the injured client is awarded. The initial funds needed for rehabilitation will either come directly from the insurer to the rehabilitation provider, or by early interim payments. If rehabilitation is paid for under the terms of the Code, insurers cannot later contest the cost. Alternatively, the court will allow the cost of rehabilitation to be recovered as part of the damages award, as long as the cost is established as being reasonable.

Detail the consequences of rehabilitation

The 'holistic' approach to personal injury litigation helps injured clients recover physically, psychologically and emotionally from their injury. By receiving rehabilitation and, as a consequence, getting better faster, the overall level of damages may be reduced. Rehabilitation can therefore help injured clients mitigate their losses. APIL members should advise accordingly but as rehabilitation can offer injured clients the opportunity to

get better, have less pain and have a better quality of life, you will be putting injured clients' best interests first by discussing rehabilitation initiatives with them.

FUNDING OPTIONS

NHS medical rehabilitation

It is vital that there is effective liaison between NHS care and privately funded rehabilitation. This is especially important in cases where there are catastrophic injuries, as the NHS will almost certainly provide some rehabilitation for some conditions, but possibly not for others and this may be in a specialist centre. APIL members should therefore attempt to establish a co-operative relationship with the NHS provider, encouraging the NHS workers involved to understand where they fit in to the rehabilitation process. APIL members should also provide feedback to the insurer. This is particularly important during the transition from NHS to insurer funded care. The approach recommended by APIL is that contained in the British Society of Rehabilitation Medicine's best practice guide. The guide seeks to ensure that the parties involved in the medico-legal process, their legal representatives and the treating specialist in the NHS all work with the common objective to act at all times in the best interest of the injured claimant. It aims to encourage the proper use of the NHS rehabilitation services which are available, and to ensure that, where additional services are acquired they are properly integrated with any NHS provision.

It is recognised that in claims for clinical negligence, the claimant may not wish to have further treatment provided by a NHS organisation where they are the defendant in the claim. APIL members should advise the client that they are entitled to seek rehabilitation, and notify defendants of best practice. The parties should be sympathetic to the breakdown of the trusting relationship with the medical provider and consider alternatives in order to provide the rehabilitation they need. There are also difficulties with getting the NHSLA to agree to provide rehabilitation until liability has been resolved. There is a need to recognise these difficulties and to be aware of other options available. Some services may be accessible through charities, and help may be available to optimise the use of available benefits.

If a person is deemed to have a 'primary health need' they will be eligible for continuing healthcare in the community. Continuing healthcare, unlike social care provided by the local authority, is free of charge.

If a person appears to have a primary health need, they should be referred for a continuing healthcare assessment. This will be carried out by a multi-disciplinary team from their local Clinical Commissioning Group ("CCG"). The assessment will be carried out with reference to a 'decision support tool.' The assessor will consider 12 domains of need: behaviour, cognition (understanding), communication, psychological/emotional needs, mobility, nutrition (food and drink), continence, skin (including wounds and ulcers), breathing, symptom control through drug therapies and medication, altered states of consciousness and any other significant needs specific to the person. The assessor will also consider the complexity, intensity and severity of the needs. If the person has at least one priority need, or severe needs in at least two areas, they should be eligible for NHS continuing healthcare. They may also be eligible if they have a severe need in one area plus a number of other needs, or a

number of high or moderate needs, depending on their nature, intensity, complexity or unpredictability.

Since April 2014, those eligible for continuing healthcare have had a 'right to ask' for a personal health budget. The CCG must provide reasons if they refuse a request. If provided, the personal health budget operates in much the same way as personal budgets for social care. The personal budget is effectively a sum of money which can be provided to the person as a direct payment, allowing her the choice and control to spend that money flexibly in order to meet her care needs.

Funding for rehabilitation through the NHS is often inadequate. Much depends on the nature of the injury and the area where the incident has happened as to the level of provision that is likely to be offered. Alternative funding options must often, therefore, be explored.

Private health insurance

Private or work provided health insurance, if available, may be able to fund some rehabilitative treatment, and so any policies should be identified and their use considered. It is important to remember that many private healthcare providers have a contractual right to subrogation and a refund of the cost of rehabilitation services if damages are subsequently awarded. It must be borne in mind that the rehabilitation offered through private health insurance is often limited.

Defendant liability insurance

As soon as practicable, APIL members should communicate any identified rehabilitation needs to the defendant's insurer, in accordance with the Code. Establishing a working relationship with insurers by providing information about the injured client's condition should also help to establish early and appropriate rehabilitative treatment. Trying to establish early contact with insurers will not, however, always mean that an agreement will be reached with regard to interim payments. Be prepared and alive to the possible need to apply to court for interim payments, if these are not provided voluntarily. If the case is being conducted under the *Serious Injury Guide*, the insurer should be willing to provide early interim payments as part of their commitment under the guide.

APIL members should also remember that while insurers may provide the initial funds for rehabilitation, these funds will be taken into account when the final damages award is received. Where funds have been provided pursuant to the Code, there can be no subsequent challenge to their reasonableness and no deduction from other heads of loss in the final calculation of the compensation award. In cases involving moderate injury, the Code provides that the claimant may start treatment without waiting for the compensator's response to the triage report, but at their own risk as to recovery of costs.

Government based vocational rehabilitation

The Government provides a number of different rehabilitation services and schemes designed to get injured people back to work. These are not detailed here, due to their propensity to change, but the first port of call to accessing services would usually be the client's local Jobcentre Plus.

Each Jobcentre Plus will normally have a Disability Employment Adviser (DEA), whose role is to provide employment services for people with disabilities – including help with finding a job, gaining new skills and indicating disability friendly employers in the local area. The DEA will work closely with your client to assess his abilities and the type of work he might do. The DEA will also advise on the government programmes and grants available to your client that will help them get back into work. These may include interview coaching and techniques to build confidence, and grants to pay costs for, for example, adaptations to work equipment, a support worker or job coach and/or a communicator at a job interview.

Social Services Provision

There are currently a vast number of statutes, regulations and guidance notes which may be relevant when considering the potential provision of rehabilitation by Social Services. From 1 April 2015 the current system will change significantly when the Care Act 2014 comes into force, bringing with it one single system for obtaining social care provision for adults and their carers. New regulations and statutory guidance will come into force at the same time. From 1 April 2016, it is anticipated that further reforms will come into force under the same Act, including reforms to the way that people pay towards the costs of social care provision. This will not apply in Wales.

The following is a guide to the main legislation which members may find relevant at the time of publication. Even if state provision is approved, APIL members must be alive to the possibility that the social services provider may seek subsequent recoupment from the client. APIL members should therefore give consideration to the use of insurer indemnities to ensure the client is not left out of pocket once the damages award has been finalised.

Section 9 of the Care Act 2014 places a duty on a local authority to carry out an assessment of needs where that person appears to be in need of services and support. This is the first step towards obtaining state-funded support. The threshold is purposefully low and should ensure that nearly all people with a disability are entitled to an initial assessment.

Once an assessment has been carried out, the local authority is required to determine which of an individual's needs are 'eligible' for care and support under section 13 of the Care Act and the accompanying regulations. In brief, this is completed with reference to whether the individual is unable to achieve two or more of a long list of possible 'outcomes', and whether the impact of not being able to meet those outcomes is that there is a significant impact on the person's wellbeing.

If it is determined that an individual has eligible needs, the local authority will be under a duty to meet those needs under section 18 of the Act. This means that support will need to be provided to the person, providing that they are ordinarily resident in the local authority's area, that the support is provided free of charge, or that if there is a charge for the service that the person is financially eligible for state funded support or otherwise contributes towards it.

The support to meet the needs should be set out in a detailed care plan. Services provided by the local authority can include residential care, domiciliary care (in the individual's own home), access to respite provision or help accessing the community. All care plans need to include a personal budget (i.e. the cost of meeting the needs), and the individual can either ask the local authority to provide the services directly, or they can ask for a direct payment to arrange the care for themselves.

A local authority has the power to charge people for most (but not all) services, and depending on a person's financial circumstances they may need to pay towards the costs of their care. The rules are heavily prescribed and are set out in regulations accompanying the Care Act. The rules differ for non-residential and residential care services. It is worth noting that from 2016 the financial assessment process will change significantly. It is currently anticipated that a 'costs cap' of £72,000 will be brought into force. This means that once an individual has spent £72,000 towards the costs of their care, the local authority will then take over the care costs for that person going forwards, even if the person has sufficient money to continue paying the costs. This cap on care costs will be set at zero for people who already have care needs upon reaching the age of 18, so for those injured during childhood, there may be other implications which need to be considered.

The Care Act will radically reform some of the issues local authorities will need to consider when meeting a person's needs. Critically, a new 'wellbeing duty' will place local authorities under a duty to place the individual at the heart of all decision making, to consider their wishes and feelings, to make sure the care planning process is 'person centred' and to consider key issues such as the person's dignity, happiness, social life and access to education and training, when making decisions about their care.

Insurer funded rehabilitation

If the cost of providing rehabilitation is reasonable, then it should form part of the damages award and will be recoverable. APIL members should liaise with the insurers to try and reach agreement concerning rehabilitation at the earliest opportunity. There is no need to await a decision on liability. If a rehabilitation plan is agreed, then any argument relating to the reasonableness of the rehabilitation provision should be disposed of. Under the Code, even a later argument on contributory negligence should not result in a subsequent claw back of rehabilitation costs.

Building a firm but non-confrontational relationship with defendants or their insurers should help the client to receive early interim payments which can be used to fund rehabilitation or the insurer may pay the provider direct. If agreement is not reached, insurers can sometimes be persuaded to fund, under the Code, an immediate needs assessment without prejudice to their stance on liability. If the insurer is unwilling to do this, assessments and treatment can be paid for in the short term by obtaining early interim payments from the court, although each practitioner will have to advise their client about the ultimate recoverability of the cost involved.

Alternative funding may also be available through deferred payment, or can be offered by some charities.

An early pro-active approach to rehabilitation may also enable the client and his family to make informed decisions about short and long term rehabilitation strategies and provide them with the opportunity to trial and test possibilities.

CHOOSING A REHABILITATION PROVIDER

Choosing who to instruct to assess a client's rehabilitation needs, or who to provide the necessary treatment or support, can be difficult.

There are increasing numbers of 'rehabilitation providers' in the UK. This term has come to encompass both individuals who offer specific services as well as firms who can provide and arrange treatment and assistance from across a range of disciplines. Rehabilitation providers are therefore distinguished from case managers, as case management can be specifically defined as an intervention to address the overall maintenance of the client's physical and social environment. A case manager's goals include facilitating physical survival, personal growth, encouraging community participation and assisting in recovery from or adapting to a disabling condition.

If a case manager is instructed, they will identify the appropriate rehabilitation provider. If not, when selecting a rehabilitation provider themselves, APIL members should be aware that there are a limited number of rehabilitation qualifications available in the UK, and rehabilitation as a whole is largely unregulated. As such, in order to identify a suitable provider, APIL members should scrutinise the curriculum vitae of the provider to ensure that they have the necessary qualifications and experience. Members should ask questions about the details contained within it such as up to date education, experience and knowledge, area of specialism, capacity and geography. Even if APIL members instruct a firm to assess or meet a client's rehabilitation needs, it is important to ensure that the individual who will be actually carrying out the assessment, or providing the treatment or assistance, is the right person to do the job. References are invaluable, as are personal recommendations from those with experience of rehabilitation providers. APIL members are reminded that they can use the members' area of the website to contact other practitioners.

As it is common for rehabilitation providers to have started their career in another health profession, it is crucial to think about what the client wants to achieve from the rehabilitation process and whether a provider's current scope of practice makes them the right person to help the client accomplish this.

APIL members should also consider whether a rehabilitation provider should be a member of a professional association. Providers may be members of a professional organisation, such as the Royal College of Nursing, but the scope of their rehabilitation practice may take them beyond the standards of this organisation. There are also a number of mainly voluntary organisations for rehabilitation providers, which cover different specialisms, some of which have codes of practice or standards to which their members subscribe.

In the section on case managers below, reference is made to the UK Rehabilitation Council (UKRC) rehabilitation standards and also PAS150 (see page 14 for further details). These standards cover all rehabilitation providers, not just case managers. Accordingly, it is worthwhile reviewing what the standards are. Whilst these standards make reference to rehabilitation companies, it is quite simple to apply the standards to a sole provider of rehabilitation services.

Standard 1

This requires the provider of the service to clearly define the service offered in a **Service Definition Document**.

Standard 2

The provider should have staff with the appropriate skill, knowledge and ability to deliver each of the services offered. This standard relates to competency and is about the qualification, training, experience and on-going learning of the staff delivering the services.

Standard 3

The provider should clearly define the service delivery element of each service offered, including for example, the work practices for referral, assessment and reporting and, where appropriate, charges and rates. The provider should monitor the effectiveness of the working practices compared to the outcomes.

Standard 4

The provider should have clear policies ensuring the protection of users. This is both about preserving the personal safety and rights of the individual user and about protecting the rights and interests of other purchase users.

Standard 5

The provider should have in place business governance and practices ensuring that the business structure and processes support the services offered.

It is recommended, in respect of any case management company, or other rehabilitation provider, that scrutiny of their operation is necessary in order to see whether they comply with these standards.

IMMEDIATE NEEDS ASSESSMENT

A face to face immediate needs assessment (INA) will be most appropriate for injured clients who have sustained injuries likely to cause incapacity for several months or longer. Rehabilitation must be considered from day one, and an assessment should take place as soon as possible, even before discharge from hospital, to ensure that the home environment on discharge is suitable for at least the basic needs of these injured clients and their families. It is never too early to begin to consider rehabilitation. Early anticipation and engagement with the insurer is crucial, and effort should be made to collaborate with the discharging physician to ensure that the client's needs are met.

Rehabilitation in the long term will be more difficult, if not impossible, if short term needs are overlooked. "First aid" support is essential to overcome the immediate aftermath of an injury and to provide a platform on which to build long term rehabilitation.

An INA report should provide a preliminary background of the injured client's circumstances, including the following:

- the nature and extent of the injury;

- any relevant medical background;
- family and social circumstances;
- immediate home adaptation needs and equipment;
- steps needed to improve the injured client's quality of life and support for family carers;
- how, and at what cost, recommendations can be implemented.

Relatively simple and inexpensive measures can make a big difference. For example, the installation of stair handrails, ramps for wheelchair access, raised toilet seats, widened doorways and lowered light switches or doorknobs.

It should be possible to put recommendations into immediate effect at a proportionate cost. An INA should not be confused with long term care needs and costing, which will be addressed by appropriate experts in the claim.

In terms of cost, the INA should be paid for by the insurers, with any reasonable recommendations being funded by them under the terms of the Code. Be prepared to have to discuss and argue for what is reasonable.

In respect of liability, ideally only a complete denial of liability should prevent a defendant's insurer from considering an INA. Even in the case of contributory negligence, an INA should be justified due to its relatively low cost.

CASE MANAGERS

Selection of a case manager

Invariably case managers will be instructed in cases of substantial value. A case manager has no professional status and working with clients following complex injuries rests upon their existing qualifications in other health fields. There is difficulty in defining what a case manager is required to do. The Case Management Society UK (CMSUK) defines case management as: "A collaborative process which assesses plans, implements, co-ordinates, monitors and evaluates the options and services required to meet an individual's health, care, educational and employment needs using communication and available resources to promote quality, cost effective outcomes".

The appointment of a case manager is critical. A case manager with the necessary skills can offer services that are likely to result in managing the difficulties of clients very effectively, maximising improvements in their condition, resulting in significant improvement in quality of life. The question is how to identify the skilled case manager?

There is no accreditation system for case managers. Reference has already been made to CMSUK which is a membership body that represents and supports the practice of case managers. There is also the British Association of Brain Injury Case Managers and the Vocational Rehabilitation Association. All of these have, to a greater or lesser extent, developed guidelines, standards and, latterly, codes of ethics. However, there is no regulatory body with which the case manager can officially register or to whom they are accountable as a case manager. Reliance has to be placed upon their registration with the relevant regulatory body assuming that the case manager has the appropriate medical qualification.

In respect of cases involving traumatic brain injury, serious consideration should be given to instructing a case manager who is an Advanced Registered Practitioner with BABICM. Such a person is likely to have not only significant case management experience but such experience will mainly be in assisting those with a serious brain injury.

It is recommended that the case manager instructed is an associate of or employed by a company that has appropriate structures in place which will offer good clinical governance. It is much more likely that this will be achieved in a corporate setting. With regards to case managers who work on their own, they have to be asked what arrangements they have in place to ensure that their work is quality checked and that they have adequate cover for illness, holiday and busy periods.

There are no accreditation systems that relate specifically to case managers or case management companies. Nevertheless, the UKRC published their rehabilitation standards in 2009 aimed at educating commissioners and service users in helping them to choose an appropriate rehabilitation service. These standards form the basis for the British PAS150 Code of Practice for Rehabilitation Services. Although these set out good practice for rehabilitation services, neither of these are regulatory standards, specific to the practice of case management.

There is a Commission on Accreditation for Rehabilitation Facilities (CARF) an accreditation body with an extensive and growing international remit. The standards match the functions of a case management company more closely than PAS150 in that they focus on clinical and rehabilitation activities in addition to solid business practices.

PAS150 is a joint report prepared by UKRC and ISO9001 which means that they are concerned with the excellence of business practices. The Care Quality Commission, which is the regulatory body for Health & Social Care Services in England, exists to ensure that bodies meet prescribed standards. These do not address the broad range of activities that fall within the scope of case management. Therefore, the preferred framework for case management companies in the UK may be CARF accreditation. There are only two case management companies that have this certification.

There are other points to bear in mind regarding selection of case managers, apart from accreditation.

- Any case manager should have rigorous training regarding all legal issues that are likely to relate to a personal injury case.

- It is best if individual case managers have either medical qualifications, for example, nursing or occupational therapy, or Social Services or other relevant backgrounds. It is important that the selected case manager has the necessary experience.
- They should appreciate that their client is, in fact, the injured person and not the lawyer who represents them.
- You should ensure that the individual who you engage/commission has the necessary expertise, capacity and they are in an appropriate geographical location.
- You should ensure that the case manager is adequately insured, should anything go wrong, and it is your on-going responsibility to ensure that the case manager is being proactive.
- A case manager will always prepare a full needs report. The report will set out goals and how those goals are to be achieved. There will be regular reports regarding progress towards achieving goals along with an annual report. Regular reporting is essential.

In both the Code and the *Guide to the Conduct of Cases Involving Serious Injury*, the parties are expected to discuss who to appoint as the case manager. Ultimately, however, it is the choice of the client. Care should also be taken to ensure that a client fully appreciates what the role of a case manager is. They should also be given the opportunity of interviewing potential candidates.

There is a separate Guide for Case Managers and those who commission them, which is not part of the Code itself, but is intended to be looked at in conjunction with the Code.

Process

The chosen case manager should be asked to provide a summary of the work to be carried out. This summary should include:

- an estimate of the time needed;
- justification for the work being proposed;
- an estimate of the costs.

Once the original plan of action has been completed, a further plan should be prepared and costed. This arrangement should continue for as long as it is necessary to retain a case manager. The case manager should continually measure the attainment of goals that have been set, keeping track of the client's measurable progress, as insurers are likely to wish to see on-going justification for the input.

If the insurer wants to be involved with the case manager's activities, an agreement should be reached on how the case manager should report and on what issues. It is worth remembering that the case manager's records will be disclosable.

MODERATE INJURIES (CASES LIKELY TO BE VALUED UP TO £25,000)

Process

Moderate injuries are traditionally those that are likely to resolve, in medical terms, relatively quickly, but can still cause distress, inconvenience and possibly financial losses to the injured client. Musculo-skeletal injuries, such as many lower back and most soft tissue and whiplash injuries are examples of moderate injuries.
The vast majority of these cases will be commenced within the portal. It is therefore key that any rehabilitation needs are identified before the Claim Notification Form is submitted. Within this form, you should then detail whether any rehabilitation has been recommended or if you have identified any rehabilitation needs on behalf of your client. Be alive to the possibility that there will be little insurer appetite for rehabilitation in such cases. Nevertheless be prepared to pursue it where realistic to do so.

In dealing with claims for these types of injuries, APIL members should ideally:

- arrange to gain access to therapies as quickly as possible;
- look seriously at what the defendant insurer is offering, but should be satisfied about the independence, quality and appropriateness of the rehabilitation provider;
- not need to involve a case manager.

Due to the relatively modest nature of these claims, a formal INA may prove unwieldy and disproportionate for such injuries. A telephone filtering system, or basic telephone triage, should be able to identify necessary rehabilitative needs. Formal assessment should not, however, be ruled out.

It is essential that, regardless of the initial perceptions of the claim and the rehabilitative measures taken thereafter, the focus of any treatment is the client. In some cases it may at first appear that the injuries are moderate but subsequently they develop into something more serious. In those circumstances there may need to be a change in approach more in tune with the ‘major injuries’ or even ‘catastrophic injuries’ sections of this guide.

Case study – Moderate injury

Individual A has a road traffic accident resulting in a soft tissue injury. The injury is sufficiently serious to put A off work for three weeks, to be unable to drive and carry out some basic household tasks which might include cooking and shopping. After returning to work, at an office based job, A continues to suffer with whiplash injury symptoms.

Ordinarily, in this example, it would be a year before the symptoms would finally subside. Early rehabilitative intervention could include private physiotherapy that might result in only six to nine months, rather than twelve months, of suffering. It might also include provision being made for some initial household domestic assistance, and help with transport such as the establishment of a taxi account. The possibility of a very early interim payment for uncontroversial items of special damage such as a motor policy excess and loss of earnings should be considered in order to alleviate any immediate hardship, and this can, in turn, boost A’s morale. In portal cases, there is no automatic right to any special damages without medical evidence. If the case is not capable of settlement upon receipt of the medical report then an interim settlement pack can be submitted, whereby the third party insurers are obliged to make a general interim payment of £1000 plus any special damages which have been incurred or can be evidenced at that stage in the claim.

MAJOR INJURIES (CASES LIKELY TO BE VALUED BETWEEN £25,000 and £250,000)

Process

These are the types of injuries where there is a definite need for some immediate rehabilitative attention, but also an element of waiting to see how the injury develops, possibly with some further rehabilitative treatment. Compound fractures and other orthopaedic injuries are examples of major injuries. It could also include psychological or psychiatric injury.

In order to help the injured person back into a normal routine as quickly as possible it is essential to obtain the necessary funds. This money should come via:

- the defendant/insurer, voluntarily or
- early proceedings and interim payments. Alternative statutory funding should be sought if this is not possible and all else fails.

The category of “major injuries” is varied, and each type of injury will come with different consequences and challenges for the injured person and their family.

Case study – Major Injury

Where an individual has suffered a major injury, this will mean that, in a working context, he is no longer capable of returning to his own pre-accident job but is capable of some work.

B is a lorry driver. He has a very serious fracture to his leg.

He can no longer use his leg to operate the accelerator or brake. In some other aspects, however, he remains able bodied and simply requires retraining. Further physiotherapy could help to improve movement of the injured limb. Similarly, B needs help with activities of daily living, domestic chores and transport. He may need further and early medical treatment (manipulation procedures, bone grafting, removal of metalwork etc) that can be funded privately and may have on-going transport needs. It is also likely that there would be a need for vocational rehabilitation intervention at an early stage. Vocational case managers would help B to find the most appropriate type of work and also identify courses for him to retrain in the necessary skills. In addition, they will assist in teaching B interview techniques and how to write CVs and so on.

CATASTROPHIC INJURIES (CASES LIKELY TO BE VALUED OVER £250,000)

Process

These cases traditionally involve injuries which can be seen as life-changing, for example, traumatic brain injury, spinal cord injury, or a loss of limbs. It is essential that a full needs analysis is conducted for catastrophic injuries as there will often be a need to adapt the person's accommodation, as well as provide long term medical assistance. In many cases, employment should be seen as a key outcome of successful rehabilitation. These claims will almost always need a case manager – see above.

Initial steps

The *Serious Injury Guide* is designed to assist members in conducting cases involving complex injuries. The guide suggests a process for conducting these cases in a collaborative way. More detail on the guide is found at page 6, above.

Case study – Catastrophic Injury

C is involved in a head-on collision in a road traffic accident. She suffers multiple fractures, loss of spleen and a traumatic brain injury (TBI), necessitating months of in-patient care. A TBI does not mean that she will be hospitalised for ever. A typical TBI can include difficulties in the following areas:

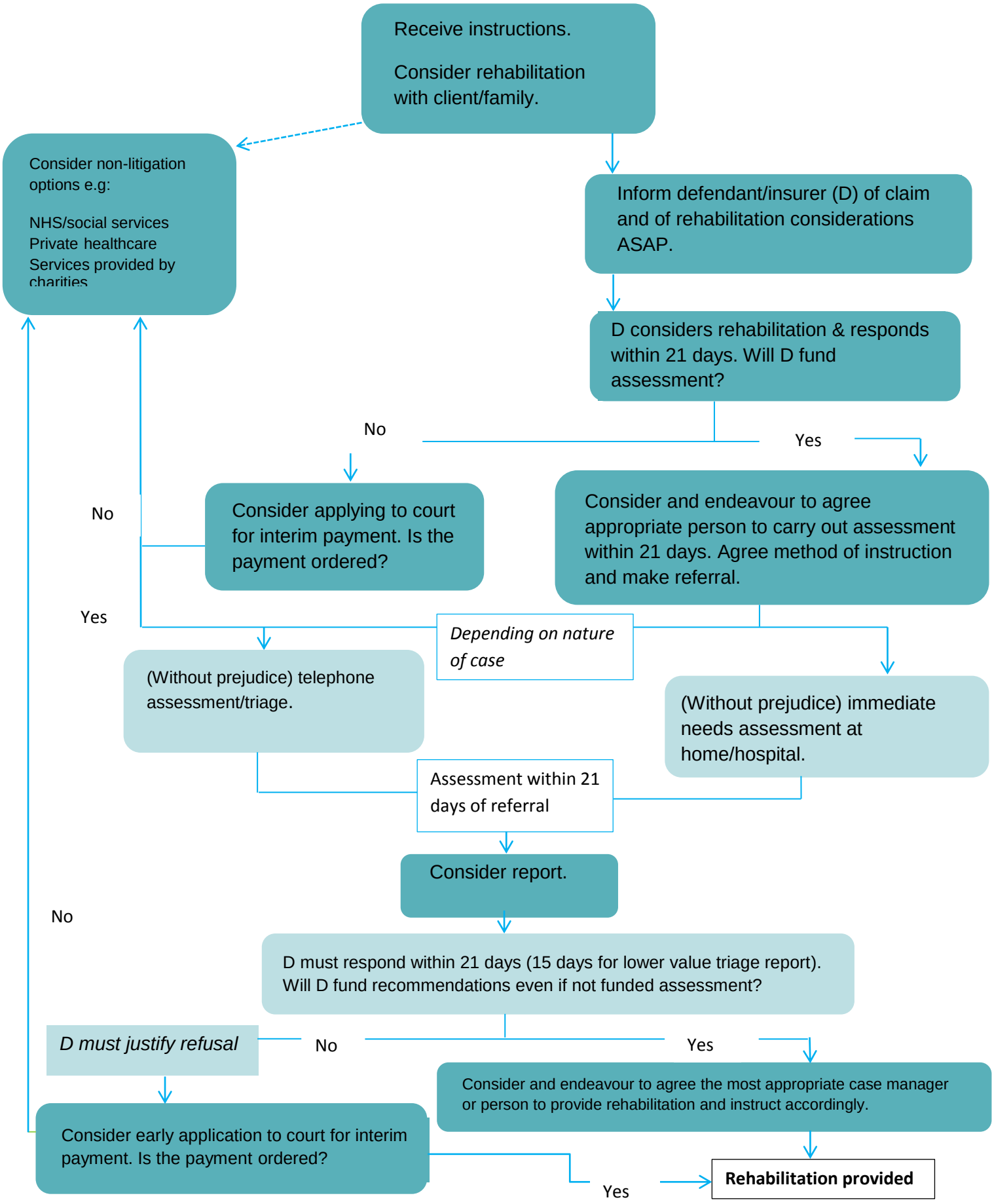
- Headaches
- Nausea
- Concentration levels
- Anger and aggression
- Communication of feelings
- Lethargy/tiredness
- Motivation/ambition
- Indecisiveness
- Panic attacks
- Reduced libido
- Visual problems
- Confidence
- Mood swings
- Fears and anxieties
- Language difficulties
- Memory
- Ability to cope with pressure
- Intrusive thoughts of accident
- Depression

A combination of some of these behaviours together may well mean that C will find it very difficult to get back to work. They will create problems trying to live an independent life. A case manager should be appointed. He/she will prepare an immediate needs assessment. This assessment will identify issues that will help to teach new skills and coping strategies. Investigation will be carried out in order to see whether or not improvement can be made in areas such as speech, psychology and activity. Inevitably, this will involve recruiting a:

- Neuropsychologist
- Neuropsychiatrist
- Speech and language therapist
- Physiotherapist
- Occupational therapist.

The claimant may also benefit from a support worker who will be able to encourage and motivate her to carry out various tasks. The aim of rehabilitation is to ensure that the individual's independence is maximised and that their quality of life is enhanced.

PRACTICE MAP



OVERCOMING PROBLEMS

Ensuring your client gets the full benefit from rehabilitation involves getting an early assessment of his needs, finding the right person to provide the right treatment and assistance, and ensuring he receives this at the time it is most beneficial to him.

The code is designed to be a process through which parties can endeavour to agree on the needs of the injured client, but this does not mean that parties will actually reach an agreement.

You may find that you are facing delay in receiving a response regarding rehabilitation, or are faced with insistence from an insurer that you must instruct a case manager from a certain company.

So, how can you overcome these problems?

- Refer to the Rehabilitation Code

Look at the code and see if it includes reference to the issue you are facing. The code includes, for example, a specific obligation on insurers to consider rehabilitation and requires them to justify a refusal to assist with the implementation of an assessment. It also includes time scales for each stage of the process.

Some claims handlers may be more familiar with the code than others – specific references to the code may make them reconsider their position.

- Referral to more senior staff

Ask for the case to be referred to a more senior claims handler and/or ask if the insurer has an area rehabilitation manager whom you could be referred to. Some insurers have people with special responsibility for rehabilitation. You will need to explain to the claims handler, and the person you are referred to, the reason for your request and to emphasise the importance of getting rehabilitation right for the injured client, and also for the insurer.

- Guide to the Conduct of Cases Involving Serious Injury

When dealing with cases in excess of £250,000, reference should be made to the APIL/FOIL *Guide to the Conduct of Cases Involving Serious Injury*.

- Application to the court for interim payments

Remember the place that the code has in the overall process of personal injury litigation. The emphasis in the code is on prompt responses and prompt implementation of rehabilitation. If insurers block this in any way, you will need to revert to traditional court procedures.

Unfortunately, in claims for clinical negligence it is almost always necessary to make an application to the court for an interim payment, even after liability has been resolved, both

where the defendant is represented by the NHS Litigation Authority and by private medical insurers.

In some cases, liability can remain disputed for some time and it may be 1-2 years until it is resolved by negotiation or the Court. Where liability is disputed and/or the defendant is unwilling to make an interim payment, recourse should be made to other sources of help for the claimant. Assistance with benefits assessments and applications can be provided by private companies, or can be sought directly from Jobcentre Plus. Counselling services, emotional support and information can be provided free of charge by charities. Solicitors may have an arrangement with companies who offer state benefits assessments and/or rehabilitation services on a deferred payment basis.

- Check the APIL website and ask other APIL members

The APIL members' website is updated with relevant case law and other documents which may assist. Remember that you can also ask other members questions about rehabilitation using the members' forum. Other APIL members may have experienced the same difficulties with rehabilitation issues as you, and may have come up with a way to resolve such problems.

Case study – Denial of liability

D suspects that he has been diagnosed late with multiple myeloma, a cancer affecting the bone marrow, and contacts a solicitor. He is suffering with an advanced stage of the disease, and it is clear that he and his family need extra support.

An early notification letter to the defendant NHS Trust leads to a request by the NHSLA for a letter of claim with full allegations of breach of duty and causation, pending which no funding will be provided further to the Code. At this early stage expert evidence has yet to be obtained, and whilst the allegations of breach of duty appear clear, the effect of the consequent delay in diagnosis is not, and an expert haematologist will need to advise on the difference the breach of duty has had on the claimant's condition.

An immediate needs assessment is carried out which identifies care needs, and that some aids and equipment are required. This is disclosed to the NHSLA, who refuse to provide funding whilst liability remains outstanding. Whilst it is not possible to obtain an interim payment, the claimant's solicitors and their agents will provide the claimant with specialist advice to ensure he is receiving all state benefits to which he and his family are entitled, and work with the local authority to arrange for aids and equipment to be fitted around their home. Contact is made with local Macmillan nurses who provide regular visits and telephone calls with the claimant and his family, and the claimant is put in touch with a specialist charity, Myeloma UK through which he joins a support group.

Supportive evidence is obtained from experts on both breach of duty and causation, taking approximately 5 months. This says that as a result of the negligent delay his condition is more advanced, and he suffers increased symptoms and has a reduced quality of life than he would otherwise have had. His life expectancy has also been reduced by 10 years.

Once the expert evidence is received, a full letter of claim is sent to the NHSLA, including a further request for funding for care and aids. The letter of response is provided after 4 months, accepting breach of duty but disputing causation, alleging that the breach of duty has made no difference to the claimant's condition. On this basis, an interim payment for his extra care needs is refused. Without prejudice disclosure of the claimant's expert evidence does not change the defendant's view.

Court proceedings are issued, and the defendant's position remains unchanged in the defence. Further expert evidence is obtained which recommends a care package to include palliative nursing care. Approximately 12 months later after proceeding through court directions, the claim settles without prejudice at a joint settlement meeting, without the defendant making a concession on causation. On payment of damages, the claimant is able to fund the private care package recommended by the experts.

REHABILITATION CODE TIME SCALES

Claimant Solicitor

It is the duty of every claimant solicitor to consider from the earliest practicable stage in consultation with the claimant/their family and if appropriate treating physicians the need for rehabilitation.

The claimant solicitor should give earliest possible notification to the compensator of the claim and need for rehabilitation. In Portal cases this will be via the Claim Notification Form.

Where the need for rehabilitation is identified by the compensator, the claimant solicitor shall consider this immediately with the claimant and/or the claimant's family.

Compensator

The compensator shall equally consider and communicate at earliest practicable stage whether the claimant will benefit from rehabilitation.

Where the need for rehabilitation is notified to the compensator by the claimant solicitor, the compensator will respond within 21 days.

Parties

The parties should consider the choice of assessor and object to any suggested assessor within 21 days of nomination.

Immediate Needs Assessor

The assessment is to occur within 21 days of the referral letter.

The assessor should provide the report (including the triage report in lower value injuries) simultaneously to parties.

Compensator

The compensator should pay for the report within 28 days of receipt.

Lower value injuries: in the interests of speeding up the process, there will sometimes be a medical need for the claimant and/or their solicitor to arrange treatment before the compensator has had time to approve it. In these circumstances, the compensator is not obliged to pay for treatment that is unnecessary, disproportionate or unduly expensive.

The compensator should respond substantively to recommendations to the claimant solicitor within 21 days of receipt of the report. For lower value injuries, the compensator should respond to the triage report within 15 working days.

DETAILS OF CHARITABLE ORGANISATIONS

APIL works closely with charities and other support organisations to help ensure injured people get the help they need to get their lives back on track. APIL would like to thank the below organisations for offering their support to the guide. These charities can offer emotional and other support and assistance for injured people and their families.

ASPIRE

ASPIRE is a national charity that provides practical help to people who have been paralysed by Spinal Cord Injury, supporting them from injury to independence.

Web: http://www.aspire.org.uk/

Tel: 020 8954 5759

Back Up

Back Up is for everyone affected by spinal cord injury in the UK, providing services that transform lives and rebuild confidence and independence.

Web: www.backuptrust.org.uk

Tel: 020 8875 1805

Brain Injury Rehabilitation Trust

BIRT is part of the Disabilities Trust, which is a leading national charity providing innovative care, rehabilitation and support solutions for people with profound physical impairments, acquired brain injury and learning disabilities

Web: http://www.thedtgroup.org/brain-injury/

Brake

Brake is a UK-wide road safety charity providing emotional support, procedural information and practical help to people seriously injured or bereaved in road crashes, and professionals and carers working with them, through an accredited helpline and support literature.

helpline@brake.org.uk

www.brake.org.uk/support

Helpline: 0808 8000 401

Child Brain Injury Trust

The Child Brain Injury Trust is the leading voluntary sector organisation and registered charity providing non-medical services to families affected by childhood acquired brain injury across the UK. The charity supports children, young people, their families and professionals and helps them come to terms with what has happened and how to deal with the uncertainty that the future may hold.

Website: **www.childbraininjurytrust.org.uk**

Tel: 01869 341075 Helpline Tel: 0303 303 2248

Email: **info@cbituk.org** **helpline@cbituk.org**

RoadPeace

RoadPeace is the national charity for road crash victims and is a membership organisation. Members include those who have been bereaved or injured in road crashes and also those who are concerned about road danger. RoadPeace provides emotional and practical support to those bereaved or injured in a road crash

Web: http://www.roadpeace.org/

Tel: 020 7733 1603

Spinal Injuries Association

The Spinal Injuries Association is a national, user led charity which offers support to the individuals who become spinal cord injured and their families, from the moment the injury or illness occurs, and for the rest of their lives.

Web: www.spinal.co.uk

Tel: 01908 604191

Helpline: 0800 9800 501

The United Kingdom Acquired Brain Injury Forum

The United Kingdom Acquired Brain Injury Forum (UKABIF) aims to promote better understanding of all aspects of ABI; to educate, inform and provide networking opportunities for professionals, service providers, planners and policy makers and to campaign for better services in the UK.

Web: http://ukabif.org.uk/

Tel: 0845 608 0788