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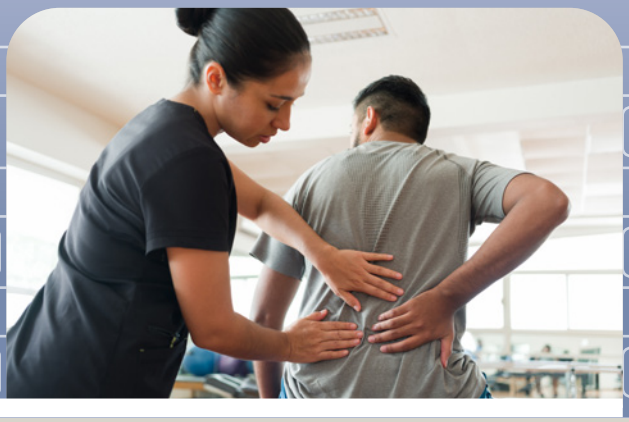
Building a Brighter Future
for Injured People

Best Practice Guide on Rehabilitation

4th Edition Updated May 2024

FOREWORD



As a Lay EC member and victim of personal injury, I want to thank you for the work you are doing to make sure injured people get access to rehabilitation, and impress upon you how vital it is that the best care is made available at the earliest opportunity for injured people. You will know of course that the Rehabilitation Code of Practice is designed for this purpose, and this Guide aims to provide practical advice and support on its application.

In 2014 I was crushed by a skip lorry whilst cycling to work. I very nearly died, and was left with life-changing injuries including having to have my left leg amputated. Whilst I received world class care at the roadside and at the trauma hospital, unfortunately the insurer did not adhere to the Rehabilitation Code of Practice. It was not until over a year after my collision, once the driver was convicted, that any access to private treatment was possible. The impact was that for over two years I was walking with an NHS issued prosthetic which did not have a microprocessor knee, causing me to have frequent falls and impacting my mobility. I fear as well that a lack of early intervention on the nerve damage I sustained has left me with life-long impairment which could have been avoided were I to have received specialist therapies sooner.

Countless other people, who suffer devastating injuries through no fault of their own, find themselves in the position that I did. The very least they should expect is the best treatment possible to help them cope and recover, and get their lives back on track. Written by APIL members for APIL members, this Guide has been designed to help you to do just that. The Guide includes a number of updated case studies to help demonstrate what should be considered in terms of rehabilitation depending on the individual case, and provides a wealth of information on selecting the right case manager. It encourages putting the needs of injured individuals and their families at the forefront of the process, and highlights the importance of early engagement and a collaborative approach from all parties involved in the rehabilitation process. This 2024 version of the Guide is also designed to be more easily accessible and navigated than previous versions. Thank you for taking the time to read it, and for your commitment to improving the lives of injured people.

Victoria Lebrec
APIL Lay EC Member

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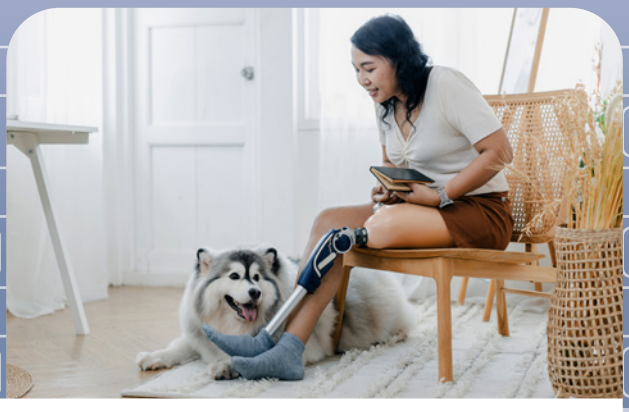
INTRODUCTION



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?

The purpose of damages is 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'[1] . This statement has been reinforced many times. A recent example is *Swift v Carpenter*[2] – Lady Justice Davies stated at paragraph 212: 'At the core of the determination of this court is the principle of law that a claimant is entitled to full and fair compensation for injury sustained as a result of the defendant's tort. The principle provides the legal basis for an individual's right to claim and to be awarded damages, the purpose of which is to place that claimant, as far as is reasonably possible, in the position he or she would have been absent the injury.' Rehabilitation is a key tool to help injured people recover more quickly, have a better quality of life and return to work sooner. It is key to returning the injured client to the same position they would have been in were it not for the negligence of the defendant, as far as is possible.

Rehabilitation costs can be recoverable as a head of special damage, as long as the costs can be shown to be reasonable. In *Sowden v Lodge*[3] 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 they reasonably need to enhance their lifestyle, in an attempt to try to restore it, as much as possible, to how it was prior to suffering their injuries.

APIL practitioners are dedicated to achieving the best possible outcome for their injured clients. Given the potential benefits to clients and their families, APIL members should take a holistic approach to personal injury litigation, considering whether rehabilitation is appropriate in every case. This is the best approach to achieving the best possible outcome for injured people.

Furthermore, the pre-action protocol for personal injury claims and the Rehabilitation Code place obligations on personal injury lawyers to do just this.

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.

This Guide is intended to build on, and should be read in conjunction with, the Rehabilitation Code 2015. The Code embraces the basic principles of striving for a collaborative approach to getting injured people back on the road to all aspects of recovery, if possible. It 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. More detail on the Code can be found in Appendix A.

APIL's Guide expands on the basic framework of the Code, providing support and practical guidance to enable practitioners to make the most out of the opportunities provided by the framework. It is aimed at all claimant practitioners, whatever level of practice they are at and whichever areas of personal injury law they practice in.

In higher value cases, this Guide should also be read alongside the Guide to the Conduct of Cases Involving Serious Injury (the Serious Injury Guide).

In Hadley v Przybylo[4], the Court of Appeal give strong encouragement for the collaborative approach envisaged under the Code and Serious Injury Guide and recognise the important role of members in supporting access to rehabilitation.

This 4th edition of the Guide includes a focus on extended fixed costs, as well as updated information on choosing a case manager, and updates relating to social care provision.

[1] Livingstone v Rawyards Coal Company [1880] 5 Appeal Cases 25

[2] [2020] EWCA Civ 1295

[3] [2004] EWCA Civ 1370

[4] [2024] EWCA 250, at [57]-[58].

> 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

REHABILITATION AND LITIGATION – KEY CONSIDERATIONS

"Early rehabilitation is key to helping our clients achieve their best possible outcome following injury. I believe this is a key priority of any solicitor representing those who have been affected by injury. It includes ensuring specialist support is in place from day one for both the injured party and their family. I have seen personally how working collaboratively with other professionals equally committed to early rehabilitation can have a significant impact on our client's recovery."

Michelle Cresswell,
Partner, CFG Law

Proactive 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.

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

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;
- consider the needs of the client's family, in addition to the needs of the client themselves.

Communicating at an early stage

"At LV=/Allianz we passionately believe that we should place the injured individual at the heart of the process and work collaboratively with all parties to make sure effective rehabilitation is proactively utilised to maximise their potential recovery and quality of life. We are signatories to the Serious Injury Guide and see this as the gold standard for collaboration between the parties to the benefit of the injured individual."

Ben Hibbs, Head of Technical Claims, LV=

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 Serious Injury Guide. This provides further information about on-going dialogue and disclosure of documents. It is important to note that the Serious Injury 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. Parties are also encouraged to follow the Serious Injury Guide's process in cases valued below £250,000, but with an element of future continuing loss, where they agree to do so.

The Serious Injury 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 Serious Injury 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 Serious Injury Guide also requires a willingness to make early and continuing interim payments where appropriate.

The claimant's representative is required 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 programme.

"I have spent most of my career trying to introduce and then improve collaboration between the parties dealing with serious injury compensation cases. That does not mean that we always have to agree but rather that we will agree where we can and work through differences in a constructive and professional way. The people and families at the heart of these claims have had their worlds turned upside down. We owe it to them to maximise the impact of rehabilitation and to remove conflict and friction wherever possible. The Serious Injury Guide provides the ideal framework to facilitate that, and I encourage all to embrace it at every opportunity."

Andrew Hibbert, Partner, Clyde & Co

Considering an early immediate needs assessment ("INA")

The purpose of an immediate needs assessment is to ascertain the most appropriate form(s) and extent of rehabilitation for the injured person. The form that the immediate 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 significant and major injury cases, an immediate needs assessment at home or in hospital would probably be most appropriate;
- in the fourth 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 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.

> Research shows that in many cases, [rehabilitation] will help injured people recover more quickly, have a better quality of life and return to work sooner

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 their 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 Rehabilitation 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 should be 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 overall benefits 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, members will be putting injured clients' best interests first by discussing rehabilitation initiatives with them.

"Timely and proactive rehabilitation should always lie at the heart of what experienced solicitors and insurers strive for right from the earliest stages of a personal injury claim. It helps claimants not just with maximising their recovery, but also to understand from the outset that focussing on the positive aspects of good quality rehabilitation and case management will invariably lead to better outcomes."

Ben Posford, Partner and Head of Catastrophic Injury, Osbornes Law

FUNDING OPTIONS

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. There is no need to await a decision on liability. 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. 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 that guide. If an agreement to fund rehabilitation 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 an insurer is unwilling to do this, assessments and treatment can be paid for in the short term by making an application to the court for an early interim payment, although each practitioner will have to advise their client about the ultimate recoverability of the costs involved.

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. Under the Code, even a later argument on contributory negligence should not result in a subsequent claw back of rehabilitation costs. 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.

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

NHS medical rehabilitation

As a result of the Covid-19 pandemic and industrial action within the NHS, waiting times for healthcare services have increased, and this includes NHS-funded rehabilitation. APIL members should advise their clients on likely waiting times and discuss options for the most efficient and effective way of obtaining treatment.

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 into 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.

Case managers play an important role in liaising with hospitals, NHS staff and treating teams to help them understand rehabilitation needs. Case managers will work with treating teams to assess and understand the claimant's rehabilitation needs. They will also play a role in helping with discharge and supporting and reassuring families through the process.

It is recognised that in claims for clinical negligence, the claimant may not wish to have further treatment provided by an 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 NHSR 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. The Integrated Care Board (ICB) among other functions, fulfils the role previously held by clinical commissioning groups (CCGs) and is responsible for the provision of relevant NHS services, including continuing healthcare assessments. Assessments are carried out by a multi-disciplinary team from the patient's local ICB using 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 ICB 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 his or 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.

"Early rehabilitation is essential to every case and should be at the forefront of the litigation process from the outset. On every case we want to give the injured party the best chance of recovery by putting the injured party at the centre of what is a very difficult and challenging journey for the injured person and their loved ones. Collaborative working with your opponent and the NHS treating team is essential to get the help and support they deserve and should receive for the best outcome, and I have found collaborative working with my opponent achieves that goal. Working together we can make a positive difference."

Ann Allister, Technical Director, Carpenters

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.

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 their 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

The social care system changed significantly from 1 April 2015, when the Care Act 2014 came into force bringing with it one single system for obtaining social care provision for adults and their carers. New regulations and statutory guidance came into force at the same time. The Care Act does not apply in Wales but the Social Services and Wellbeing Act came into force on 6 April 2016, and contains similar (but not identical) provisions.

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. An assessment should be detailed and set out all areas of need. There should also be particular reference to the impact on that person's wellbeing.

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 2014 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 that is required to meet the person's 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 2014. The rules differ for non-residential and residential care services. It was originally anticipated that a 'costs cap' of £72,000 would be brought into force in 2020, but implementation of this proposal has met with multiple delays. Advisers must check prevailing rules and guidance, seeking specialist advice where appropriate.

The Care Act 2014 reforms 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. The Care Act 2014 also places a duty on local authorities to promote a 'marketplace' in care services, to ensure people have a choice over their care provision.

Alternative Funding

Alternative funding may be available through deferred payments. Another alternative funding option may be through utilising charities. Some charities will provide funding, and others will assist in obtaining grants for rehabilitation.

> When selecting a case manager, it is important to identify that they are registered with the relevant regulatory body, depending on their profession
>
> You should ensure that the individual who you engage/commission has the necessary capacity, and that their approach, skills and expertise match the needs of your client and their family

CASE MANAGERS

"Accessing local specialist neuro-rehabilitation is of enormous importance for people with acquired brain injury. If the right rehabilitation is provided, long term outcomes can be much improved."

Chloe Hayward, UK Acquired Brain Injury Forum

"CMSUK shares APIL practitioners' passion for achieving the best possible outcomes for their injured clients through rehabilitation. Rehabilitation outcomes are optimised when the right rehabilitation is delivered by the right people at the right time. CMSUK promotes the use of skilled case managers, selected for their expertise within their scope of practice, to assess, plan, implement and support clients through their individual rehabilitation journey. CMSUK leads best practice for case managers in the UK, covering the scope of clients with moderate, major or catastrophic injuries, empowering our members through providing support and education to enhance their expertise."

Sue Ford, Case Management Society UK

Selection of a case manager

In both the Code and the Serious Injury Guide, the parties are expected to discuss who to appoint as the case manager. Ultimately, however, it is the choice of the client. Care should be taken to ensure that a client fully appreciates what the role of a case manager is.

Invariably case managers will be instructed in cases of substantial value. The title of "case manager" is not protected, and so health and social care professionals from a variety of backgrounds can carry out the role. 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 suitable 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?

Regulatory and membership bodies

When selecting a case manager, it is important to identify that they are registered with the relevant regulatory body, depending on their profession. Registers have specific criteria and a registrant can be struck off if they do not comply. A register aims to protect the public. It is also important to consider whether the case manager has membership of a professional body. Membership bodies usually promote best practice and the interests of its members, and are joined according to specialism. The relevant regulatory and membership bodies for different professions can be found at Appendix B to the Guide.

Institute of Registered Case Managers

At the time of writing, there is no regulatory body specifically for case managers. However, the Institute of Registered Case Managers is currently in development, with registration opening in 2024. The IRCM's role will be to safeguard the users of case management services by setting standards for case management practice, developing a public register of those who meet the requirements, and providing a process for the reporting of concerns. IRCM will also develop an accreditation scheme. It will not be mandatory for case managers to become members of IRCM. However, in view of IRCM's safeguarding role, we can see advantages in instructing case managers who are registrants of IRCM, once the institute is established. It is also worth noting that case managers will not have to be registered with another regulatory body in order to be registered with the IRCM. It is important that you check that they are registered with their relevant body according to their profession.

Membership bodies

Case Managers Society UK (CMSUK) is a membership body that represents and supports the practice of case managers. There is also the British Association of Brain Injury Case Managers (BABICM) which represents best practice standards and its members work with brain injury and other complex conditions/cases; and the Vocational Rehabilitation Association (VRA). All these have, to a greater or lesser extent, developed guidelines, standards and, latterly, codes of ethics. Reliance has to be placed upon their registration with the relevant regulatory body assuming that the case manager has the appropriate health and social care/vocational 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. Be aware though, that BABICM is a membership body for brain injury and other complex case management, so there are advanced members with most of their experience in spinal cord injury or cerebral palsy. Use the advanced registered practitioner label as a starting point, and select a case manager with the correct expertise relevant for your case.

Care Quality Commission

The Care Quality Commission, which is the regulatory body for Health and Social Care Services in England, exists to ensure that bodies meet professional standards. These do not address the broad range of activities that fall within the scope of case management. There is no requirement for case managers or their companies to be registered with the Care Quality Commission, unless they employ staff who undertake CQC-regulated activities, or they are directing or controlling staff who do so, and who are directly employed by their client (usually via their deputy). It is up to the case manager or case management company to determine whether they are carrying out regulated activities or directing and controlling these.

The Care Inspectorate Wales has a similar regulatory role for clients living in Wales (CQC registration does not cover clients living in Wales). In Wales, registration depends on how many clients a service has. Care workers themselves must be registered, and the inspections and standards differ to those in England. Case managers operating in Wales should understand their obligation as to whether they need to be registered or not.

The equivalent body in Scotland is the Care Inspectorate, and in Northern Ireland it is the Regulatory and Quality Improvement Authority.

Other considerations

There are other points to bear in mind regarding selection of case managers, apart from registration and membership of the relevant bodies:

- You should ensure that the individual who you engage/commission has the necessary capacity, and that their approach, skills and expertise match the needs of your client and their family. For example, consideration should be given to the client's cultural and language needs. You should also ensure that they are in an appropriate geographical location. Appropriate geographical location is vital, for ease of the client. Case managers in the client's local area will also be familiar with the services available in that area and be able to make the most appropriate recommendations. Choosing a local case manager will also keep travel costs down, and ensure that they are recoverable.

- Any case manager should have received training on the litigation process, should have an understanding of their duty as per *Wright v Sullivan*[4] in particular and, where they are inexperienced, should have ongoing supervision from an experienced case manager.

- It is important to match the experience of a case manager with the complexity of the case. Those involved in more complex cases should have substantial post-graduate experience in the field in which they are specialist, and as a case manager. However, those with less experience should not be ruled out. Where the best fit for the client in terms of clinical and geographical requirements and engagement is a case manager with less experience, you should ensure that there is robust supervision in place.

- They should appreciate that their client is, in fact, the injured person and not the lawyer who represents them.

- Check your firm's due diligence procedure. This will usually require you to ensure that the case manager is up to date in relation to continuous professional development, that they have passed any necessary disclosure and barring service checks, and that they are adequately insured, should anything go wrong. You should also ask about the complaints process.

- 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. This is likely to be achieved in a corporate setting. Smaller services can maintain good standards of practice too, however. Where case managers are working on their own, you must check their oversight, supervision, complaints and training structures, and be satisfied that they have adequate cover for illness, holidays and busy periods.

[4] [2006] 1 WLR 172

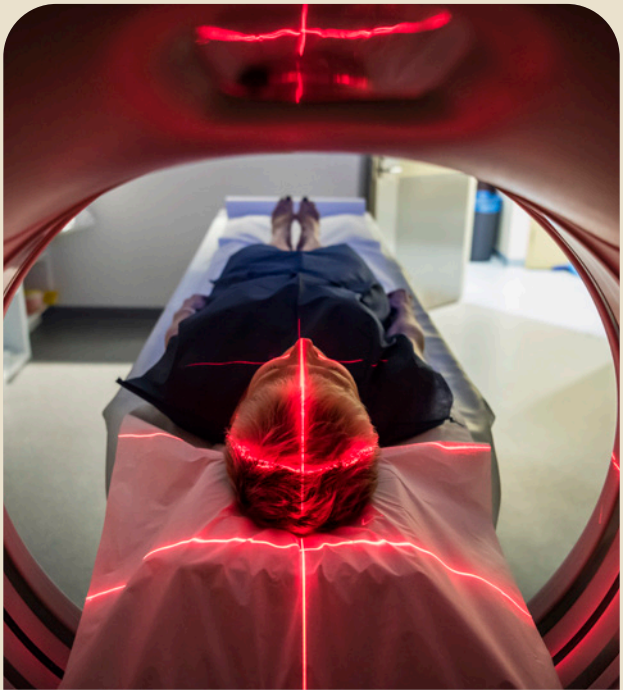
There are a number of ways that solicitors can help their clients to choose the correct case manager. Clients and their families should be given the opportunity of interviewing potential candidates – 'meet and greets' can be arranged, if this would help the client and their family to determine whether a particular case manager is the right fit. Do not be afraid to reach out to a number of case managers that you and your client are considering, to have a discussion with them about how they would meet your client's needs if instructed. This could be done via email or over the phone, and can help you to ascertain whether the goals of the client and the case manager are aligned.

Given that the choice of case manager will depend on multiple factors, as indicated above, it is a good idea to consider needs and facts as a whole when identifying the best fit. Below are a number of examples where a case manager has been a good fit for the client.

Case 1

Client: A young male, with spinal cord injury and complex circumstances.

Case Manager: Chosen based on their availability and experience in spinal cord injury and a systemic approach to complexity. They also had local knowledge and were male, at the request of the client.



Case 2

Client: Orthopaedic injuries, no cognitive difficulties and aiming to return to work.

Case Manager: Not local but skilled in accessing the right services, and they have condition knowledge.

Case 3

Client: Birth Injury with multiple complex disabilities.

Case Manager: Has knowledge of education, health and care plans, housing, equipment, and disability support. They are local to the family. They are new to case management, but working with robust mentoring and support.

Case 4

Client: Has an acquired brain injury and is part of a strict Muslim family.

Case Manager: Has knowledge of the Muslim culture and is a skilled communicator. They are local to the client. They are less experienced in brain injury but have robust support and supervision.

Unilateral or joint instruction

As stated above, the choice of case manager is ultimately the claimant's. As set out in *Wright v Sullivan*[5], the case manager owes a duty to the claimant alone, not to the claimant solicitor or defendant representatives. The relationship is therapeutic in nature and it is often not appropriate for the defendant to have such direct access to such a relationship, through joint instruction. Considering the points highlighted above, and being able to demonstrate to the defendant why a particular case manager meets the needs of your client, can be helpful in establishing unilateral instruction.

There are cases where joint instruction may be appropriate, for example in cases where there is a high proportion of contributory negligence, or where there are difficult arguments around liability. Even in cases where there is joint instruction, the choice of case manager should still be the claimant's. Careful consideration of the factors set out above will help to demonstrate to the defendant why the particular case manager that has been chosen is the right fit for the claimant.

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. It is helpful to establish a timeline for when the insurer will be updated/involved, to avoid unnecessary delays to the claimant's treatment.

Process

A case manager will usually prepare an immediate needs assessment. The report will identify needs and recommendations made to meet those needs. Some goals may be established, but in complex cases especially, the client will not yet be at a stage where they can engage in those.

The regularity of reports is often determined by the referrer. You should set out to the case manager what is required of them, if it is different from the service's usual practice.

Where funds are extremely limited, or where one case manager is taking over from another case manager, a shorter report (sometimes referred to as a progress report) will be provided.

Case managers should always provide their own recommendations and costs – even if reported briefly – and should not simply follow recommendations made by an expert. Case managers have their own duty of care to the client, where the expert does not.

Immediate Needs Assessment

An immediate needs assessment (INA) is an evaluation of the effects of the injuries sustained on all aspects of an individual's daily life. It should be an objective and evidence-based assessment, which identifies immediate needs, rehabilitation goals and expected outcomes. The INA allows the case manager to understand the client's life prior to their injury. A face-to-face immediate needs assessment 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. Early rehabilitation 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;
- employment status;
- 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.

It is useful if the recommendations in the INA are evidence based.

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.

[5] [2005] EWCA Civ 656

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 management update reports

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. Costings within the INA may be for a three-month period, or so, but once the treating team is settled in place, a longer time frame for costings would usually be provided, i.e. for six to twelve months. This will be of benefit to both the claimant – as it allows for a longer plan of action for treatment – and also provides certainty for the insurer. If anything changes which will affect the costings, this can be included in any update reports and costings revisited.

Issues with case managers

It is your ongoing responsibility to ensure that the case manager is being proactive. If there are issues with the case manager and they are not delivering as expected, the first step will be to speak with your client, their family and the case manager to raise concerns and discuss whether they can be addressed. This will include setting out key requirements that you and your client, and their family expect to be delivered, and the timeframe for delivery. If, after the set timeframe, there is not the expected progress, you should speak to the case manager and establish there is a common understanding of needs and expectations, and the reasons why something is not as expected. If this does not resolve matters, you should escalate the issues to a senior supervisor. One option would be to have the supervisor sit in on some meetings, or oversee their work for a set period. If a concern cannot be resolved quickly, a provider ought to have a formal complaints process which can be followed.

If there is still little to no improvement, or you simply feel that the case manager is no longer the right fit for your client and their family (for example, the case manager specialises in children, and your client is now an adult), you should decide whether another case manager within the same company, or a different case manager, should take over. You should try to take steps to make the transition period between case managers as efficient as possible. This will include having another case manager in mind – and checking that they have the capacity to take on your client - before deciding to end the relationship with the current case manager. All the relevant requests, records and authorities should also be in place to enable the new case manager to get started as quickly as possible. The previous case manager should be professional in supporting a smooth transition.

"Within Bush & Co, and case management overall, we see evidence of the beneficial impact of early rehabilitation on recovery times. We are able to support the clinical research and guidance that highlights that early intervention, both clinical and psychological, following a traumatic event, such as injury, leads to improved client engagement in the rehabilitation process, better clinical gains towards recovery and a higher success rate of returning client to their pre incident state, whether that be education or employment. We see this evidenced with clients who we are able to assess and support within the first two years post incident, compared to the clients who are not referred into us until after that date. The NICE guidelines (Rehabilitation after traumatic injury) *supports early intervention, with clear rehabilitation goals, collaborative coordination of discharge from hospital to community settings, through to implementing physical, cognitive and psychological rehabilitation. Case management works within the principles of early intervention, clear assessment and therapy coordination, resulting in improved recovery times."*

Fiona Kenny, Bush & Co

Case study – issues with case manager

The case involved a male who sustained a moderate traumatic brain injury following an incident at work. The client had the benefit of a reasonable support package from statutory services however it became increasingly apparent that there was an over-reliance being placed on these services and the case manager was not exploring ways in which the private rehabilitation could supplement the statutory services. General communication was also poor, with the case manager often taking weeks to respond to both the client and solicitors. The client raised concerns about this. A meeting with the case manager was arranged to discuss concerns and the outcome of that meeting was that agreements were put into place regarding recommendations for the rehabilitation moving forward and the level and frequency of communication expected. The client's mother was notified of the outcome of the meeting and asked to keep the solicitor updated in terms of improvements.

Unfortunately, there were not any significant improvements and so a further meeting was arranged with the case manager's supervisor. Concerns were again raised, and specific examples were given. As the case involved a company that had the benefit of several alternative suitable case managers being available, the solicitor felt it would minimise disruption to change case managers to one within the same business and selected a new case manager on this basis. The client was notified of the change in case manager, although he had been kept fully updated and was anticipating this. A handover meeting was arranged between the old and new case managers. The new case manager then arranged to visit the client and an updated progress report was drafted, with fresh recommendations, following this visit.

Further information

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.

Deputies/Trustees

Particularly in brain injury cases, a solicitor should always think tabout whether the client has mental capacity and if a deputy/trustee may be required for cases involving children receiving compensation. This paragraph refers to deputies but where there is a child injury client who is likely to achieve capacity upon adulthood such that a deputy will not be required, their finances can be managed by way of a trust deed.

Once it is determined a client lacks capacity, a deputy should be appointed by the Court of Protection to manage that client's financial affairs. The role of the deputy is to make decisions which are in the best interests of the client.

A deputy can be a friend or family member, known as a lay deputy, but it can also be a solicitor, known as a professional deputy. A professional deputy will usually be recommended for high value cases. A professional deputy is typically a specialist solicitor experienced in Court of Protection work, who is appointed to manage the property and financial affairs of someone who lacks the mental capacity to make their own decisions.

Professional deputies are best placed to manage the affairs of someone in more complex situations and ease the burden on their family and/or close friends.

It's less common for a solicitor to be appointed as a personal welfare deputy as this is usually the natural remit of close family.

There are two types of deputy (a client may need a deputy for both):

- Personal welfare – The deputy has the authority to make decisions about the medical treatment and health decisions and how they are looked after.
- Property and financial affairs – The deputy has the authority to pay bills and deal with other financial matters, such as pensions and benefits.

If the client satisfies the legal requirements, then an application should be made to the Court of Protection. Once the application is submitted, there is a two-week period for others to object to the appointment. If the application is approved, the deputy will formally be appointed. The Office of the Public Guardian (OPG) will supervise the deputy and a deputy is strictly accountable to the OPG. The supervision tends to be more extensive where compensation is in excess of £21,000.

Clients and their families are often unaware about the need for a financial deputy. It is best practice, as a solicitor with conduct of any associated injury case, to advise them of this possibility and to keep the need for a deputy under review, particularly where it is likely that damages will be received whether by an interim or final payment because a deputy will need to be in place to manage and receive the client's damages. The appointment of a deputy can be protracted, sometimes taking between six to nine months or longer for the Court of Protection to issue the order. For that reason, it is good practice to avoid deferring making enquiries to identify a deputy and to instruct them to make the application.

Another practical issue to consider is preparing the COP3. This is a form required by the Court of Protection in support of the application seeking appointment of a deputy. The signatory of the COP 3 needs to confirm the client lacks and is unlikely to achieve capacity and that will need to be signed by someone with appropriate qualifications, often following an assessment.

Below is a non-exhaustive list of a financial deputy's most usual tasks:

1. Prepare annual accounts/reports for the OPG.
2. Pay an annual security bond which is a form of insurance that protects the assets of the person whose finances the deputy is managing.
3. Prepare tax returns and pay any tax owed to HMRC.
4. Consider and action requests for larger purchases such as a specialist vehicle, significant surgery, equipment or a house.
5. Complete tax returns and make payment to the HM Revenue & Customs as necessary.
6. Budget and arrange for payments to be made.
7. Invest the compensation appropriately with advice from an IFA for larger sums of money.
8. Make decisions and monitor carer staff with an eye to considering how employment law impacts on these arrangements. It is often worth employing an HR agency to deal with the employee's NI and tax deductions.
9. Monitor therapies including the costs.
10. Assist client with any EHCP needs and liaising with professionals in educational law and other professionals to assist with preparation of an EHCP.
11. Work closely with the litigating solicitor, case manager, and family to ensure decisions made are in the 'best interests' and in a compensation claim context, verify recoverability.
12. Advise on eligibility for benefits.
13. Prepare costs projections for the deputy's fees and submit costings to the Court of Protection annually.
14. Buying and renting housing with regular reviews on how this suits their needs, whether it is appropriately insured, and handling practicalities relating to adaptations, lease renewals, deposit and any leasehold requirements that need to be complied with.
15. Consider carefully the final settlement terms in an injury claim including the split between a capital lump sum and a PPO.

> **It is crucial to think about what the client and their family want 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**

CHOOSING A REHABILITATION PROVIDER

In cases where a case manager is instructed, they will choose the rehabilitation provider. This section looks at cases where a case manager is not instructed and how to select a rehabilitation provider. APIL members should not recommend any treatment to the client themselves, but can signpost to appropriate qualified support. Only a clinician should make recommendations on the client's rehabilitation needs.

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.

APIL members should be aware that there are a limited number of rehabilitation qualifications available in the UK. 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.

A NICE guide providing guidance on commissioning rehabilitation can be found here. Anyone commissioning a service can look online at Care Quality Commission/ Ofsted reports, check a professional's registration, and can ask for DBS, insurance and complaints process information.

It is crucial to think about what the client and their family want 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.

As with case managers, all providers of rehabilitation should be registered health and social care professionals, and they should also be members of their professional association. A table of professions along with their regulatory and membership bodies can be found in Appendix B.

It would also be useful to instruct a rehabilitation provider who is familiar with the litigation process, and the specific note-taking procedures etc that will need to be satisfied as part of that process.

It may also be useful to consider the rehabilitation providers regularly instructed by case managers and whether they are appropriate in your particular case.

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 and their family. 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 and their family.

Rehabilitation is referred to in all the personal injury pre-action protocols. Under the pre-action protocols for both low value RTA and employers/public liability claims, there is a requirement for the parties to consider the Rehabilitation Code at all stages of the claim. There is no reference to the Rehabilitation Code in the pre-action protocol for RTA claims falling below the small claims track although the claimant must advise on the claim form whether they have been advised to seek further medical treatment such as physiotherapy. This is so that the defendant can decide whether to offer the claimant access to, or funding for, further treatment or therapy.

Be alive to the possibility that there will often be little insurer appetite for rehabilitation in such cases. Nevertheless, be prepared to pursue it where realistic to do so and refer to the Rehabilitation Code where appropriate.

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 'significant', 'major' or even 'catastrophic injuries' sections of this Guide.

Case study – moderate injury

Individual A has a road traffic collision 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 12 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 £1,000 plus any special damages which have been incurred or can be evidenced at that stage in the claim.

SIGNIFICANT INJURIES (CASES LIKELY TO BE VALUED BETWEEN £25,000 and £100,000)

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.

Cases within this bracket will largely fall within the extended fixed costs regime from October 2023. There is no mention of rehabilitation in the rules relating to the extension of fixed costs. There should be nothing that waters down the obligations on parties to consider rehabilitation. There should be no dilution of responsibility relating to rehabilitation in cases where extended fixed recoverable costs apply.

In order to help the injured person back into a normal routine as quickly as possible it is essential to obtain the necessary funds, for example for early access to physiotherapy, or cognitive behavioural therapy. This money should come via:

- the defendant/insurer, voluntarily or
- early proceedings and interim payments.
- Alternatively, grants from charities or statutory funding should be considered if funds are not forthcoming from the defendant.

The category of 'significant injuries' is varied, and each type of injury will come with different consequences and challenges for the injured person and their family. Ongoing case management should be considered but, should be reviewed as appropriate on a case-by-case basis.

It is important to bear in mind that the claims which fall to the higher end of a significant injury could easily fall into the major injury category, if the claimant's recovery is prolonged or if they incur significant loss of earnings or private medical costs.

Case study – significant injury

Where an individual has suffered a significant injury, this will mean that, in a working context, he is no longer capable of returning to his own pre-injury 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 ongoing 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.

Case study – significant injury

M is a student. Following a road traffic collision she sustained serious fractures to her arm and leg, which required surgical intervention.

Following an inpatient stay in hospital, she was discharged and provided some access to physiotherapy via the NHS.

Further private physiotherapy could help to improve movement and functionality of the injured limbs. Occupational therapist input and equipment recommendations are likely to assist her with accessing her home and the community during her rehabilitation period. She may need psychological intervention.

M needs help with activities of daily living, domestic chores and transport.

M may need further and early medical treatment that can be funded privately and may have ongoing transport needs and require assistance with continuing to access her studies. She may require assistance from the case manager to assist her with arranging medical appointments and liaising with the university but this may not be required. Should a postponement on her course be required, there may be a need for vocational rehabilitation intervention.

MAJOR INJURIES (CASES LIKELY TO BE VALUED BETWEEN £100,000 - £250,000)

These are the types of injuries where there is a definite need for some immediate rehabilitative attention. There is also likely to be ongoing medical treatment and continuing rehabilitative treatment over the next year to 18 months.

Open fractures, complex orthopaedic injuries and mild brain injuries are examples of major injuries. It is likely to 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.
- Alternatively, charitable grants or statutory funding should be considered if this is not possible and all else fails.

Ongoing case management should be considered, especially if complex injuries have resulted in numerous therapies or ongoing medical treatment. As with significant injuries, 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

N works part time in a school and looks after her two children. She was hit by a car whilst crossing at a pelican crossing. She sustained internal injuries and a pelvis fracture which required surgical intervention.

Following an inpatient stay in hospital, she was discharged home but was unable to climb the stairs and so had to sleep downstairs.

Private physiotherapy could help to improve movement and functionality. Occupational therapist input and equipment recommendations are likely to assist her with accessing her home and the community during her rehabilitation period. Hydro/aquatic therapy should also be considered to improve N's strength and gait.

N needs help with activities of daily living, domestic chores and transport. N suffers with anxiety and psychological distress following the collision and finds it difficult to cross roads. Her anxiety prevents her from driving. Early access to a private psychologist would assist her to help manage her anxiety and psychological difficulties. Ongoing case management support should be considered to assist arranging numerous therapies

Once N becomes more mobile, she may also require access to a personal trainer, gym or pool for ongoing strength training in the longer term. She may also need further and early medical treatment that can be funded privately. Ongoing daily living and transport needs need to be assessed and considered. Once physically and psychologically able to, N may need driving assessment or lessons to build confidence.

Assistance with her reintegration back into work needs to be considered and vocational rehabilitation may be required.

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.

Initial steps

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

Case study – catastrophic injury

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

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

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 her quality of life is enhanced.

Case study – catastrophic injury

Negligent errors were made by the midwives and obstetrician during the delivery of E. He suffered a hypoxic injury and has been diagnosed with quadriplegic spastic cerebral palsy (CP) which is a serious and permanent condition. CP varies enormously from patient to patient. Some patients require 24-hour care and have no independent function and limited cognition. Others may have mobility issues and require extensive lifelong support, but can go on to live independent lives with opportunities to work, have a family, and live independently.

Typical CP patients will suffer from some or all of the following difficulties:

- Impairment of motor skills
- Mobility limitations
- Orthopaedic health issues requiring support from spinal consultants and with hip revision surgery often required.
- Visual and hearing problems
- Difficulties with speech and language
- Impaired cognition
- Seizures
- Dietary difficulties relating to nutritional intake and administering feeds
- Educational challenges
- Psychological symptoms

Suffering from any or all of the above limitations and injuries may mean that E will never be able to work or live independently. It is essential to appoint a case manager to support the family by way of assessment and arranging a complete package of care and rehabilitation. The case manager will typically hire a team of therapists including a physiotherapist, speech and language therapist, a clinical psychologist. and occupational therapist. More specialist therapies should also be explored such as music therapy, play therapy and input from an advisor in assistive technology.

The transition to adulthood, demands of adolescence, and E's future life as an adult need careful consideration and assessment by a large team of medico-legal experts in multiple disciplines. An important issue in projecting E's future, including likely financial needs, will be that of life expectancy. An opinion from a paediatric neurologist will be required to advise accordingly.

The more long-term objective will be, once prognosis is certain and liability is resolved, to purchase permanent accommodation for the family, set up a care package with a view to increasing care needs as E moves into adolescence and adulthood, and whatever other costs are anticipated to improve the prospects of a bright and comfortable future for E and his family.

A deputy was appointed to manage interim and final settlement payments. Prior to final settlement, the advice of an independent financial adviser will be required, to advise on suitable periodical payment orders, split appropriately to ensure that E's financial future is sensibly catered for.

> The [Rehabilitation] Code includes a specific obligation on insurers to consider rehabilitation

OVERCOMING PROBLEMS

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

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 a case is being conducted under the Serious Injury Guide, please refer to the escalation contact list here, for details of the correct person to escalate your issue to.

- 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, particularly maximum severity cases, there is often a protracted period of time in the preparation work to feed into formulating a breach and causation case and therefore to draft and serve the letter of claim. This is due to the length of time it can take to obtain records and the liability experts' waiting times. Following service of the letter of claim, the defendants usually request an extension of time for service of the letter of response which can be up to 12 months or longer in some cases, particularly brain injury cases. For that reason, the agreement to make an interim payment is likely to be delayed while each party prepares their case and response on liability. Following liability investigations, however, if breach and causation are admitted, interim payment requests are rarely resisted by the defendants in clinical negligence cases. They are likely to argue about the quantum of the interim payment, however, and in such circumstances an application to the court may be required.

In some cases, liability can remain disputed for some time and it may be one to two years until it is resolved by negotiation or the court. Far more often than not, NHSR defends cases which go on to settle and a casualty of this is that the claimant is unable to pursue an interim damages request or application. Rarely would a defendant in a clinical negligence case voluntarily make payment for interim damages if liability is not yet admitted or denied. 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

Remember that you can 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 NHSR 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 NHSR, which refuses 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 five 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 NHSR, including a further request for funding for care and aids. The letter of response is provided after four 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 twelve 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.

DETAILS OF CHARITABLE AND OTHER RELEVANT 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 and other organisations 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.

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

Tel: 020 8954 5759

Brainkind

Brainkind is the UK's leading charity helping people to thrive after a brain injury. It provides innovative rehabilitation and ongoing support to ensure life after brain injury (and with neurological conditions) can be a life well lived.

Website: https://brainkind.org

Email: info@brainkind.org

Burning Nights

Burning Nights CRPS Support is a national charity working to improve life for anyone affected by complex regional pain syndrome (CRPS) a debilitating rare condition, providing advice & information by way of various a number of services supporting adults, children, healthcare and legal organisations.

Website: https://www.burningnightscrps.org

Helpline Tel: 01663 795055

Email: support@buningnightscrps.org

BABICM

The leading membership organisation for professionals in brain injury and complex case management, supporting best practice through research and high-quality evidence-based training.

Website: https://www.babicm.org/

Tel: 0161 762 6443

Brake

Brake is a UK-wide road safety charity established in 1995 and provides specialist road victim support across the UK via our National Road Victim Service (NRVS). The NRVS cares for and supports road victim families whose loved ones have been killed or have suffered catastrophic injury (life changing or life threatening). The service operates from day one of the crash, providing accredited trauma-informed care, which can be accessed across the UK either by police referral, third party referral or self-referrals. The NRVS deploys professional caseworkers to victim families to provide practical and emotional support and can advocate on their behalf. The NRVS can also provide support to professionals and carers working with families.

Website: www.brake.org.uk

NRVS support line: 0808 8000 401

Help and support email: help@brake.org.uk

Calvert Kielder

Calvert Kielder is a registered charity providing activity holidays for disabled people and their families in either our fully accessible main centre or self-catering chalets. In addition, we operate a CQC registered adult respite care service providing 24-hour care to individual guests enabling them to holiday independently of their families and home care network. We pride ourselves on helping both children and adults to achieve their potential and rebuild their self-confidence through the medium of adventurous outdoor activities.

Website: www.calvertkielder.org.uk

Telephone: 01434 250232

Email: enquiries@calvert-kielder.com

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.

Website: www.backuptrust.org.uk

Tel: 020 8875 1805

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

Case Management Society UK

Case Management Society UK (CMSUK) is a non-profit association of registered case managers and registered charity. We promote quality case management provision and support the individual and collective development of case management throughout the United Kingdom

Website: https://www.cmsuk.org/

Tel: 01329 446959

Email: info@cmsuk.org

Frenkel Topping Charitable Foundation

The Charitable Foundation was founded by Frenkel Topping in 2015 and is a saving grace for individuals and their families who have experienced a life-changing injury but were unable to secure financial support following the incident. The foundation supports a great many individuals and charities each year, providing financial support and funding to improve the lives of those who need it most.

Website: ftcharitablefoundation.co.uk/

Tel: 0161 886 8042

Email:
enquiries@ftcharitablefoundation.co.uk

Headway

Headway works to improve life after brain injury, helping people to relearn lost skills and regain independence. They also support families and carers recognising that brain injury affects more than just the individual. Support is through a range of services including a nurse led helpline, an award-winning range of free to access publications and a network of over 120 groups and branches.

Website: www.headway.org.uk

Tel: 0115 924 0800
Helpline tel: 0808 800 2244

Email: enquiries@headway.org.uk

Helpline email:
helpline@headway.org.uk

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

Email: helpline@roadpeace.org

Steel Bones

Steel Bones helps amputee families overcome the trauma of amputation through peer mentoring.

Web: Home - Steel Bones

Tel: 01223734000

Email: hello@steelbonesuk.co.uk

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

APPENDICES

APPENDIX A

An overview of the Rehabilitation Code 2015

The 2015 version of the Rehabilitation Code 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-incident, 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 assess the claimant's medical and social needs and not to provide information to settle the claim.

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.

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 programme.

APPENDIX B Table of Regulatory and Membership Bodies

Profession	Regulatory body	Relevant membership bodies
Social worker	Social Work England (in England) Scottish Social Services Council (in Scotland) Social Care Wales (in Wales) Northern Ireland Social Care Council (Northern Ireland)	British Association of Social Workers
Physiotherapist	Healthcare Professionals Council	Chartered Society of Physiotherapy
Occupational therapist		Royal College of Occupational Therapists
Speech and language therapist		Royal College of Speech and Language Therapists
Psychologist		British Psychological Society
Psychotherapist	UK Council for Psychotherapy	British Association of Counsellors and Psychotherapists
Nurse	Nursing and Midwifery Council	Royal College of Nursing

APPENDIX C
Process map