

2008

Think Rehab!

Best practice guide on rehabilitation

2nd Edition



FOREWORD

Welcome to the second edition of APIL's best practice guide on rehabilitation. The new edition of this guide is part of APIL's ongoing "Think Rehab" campaign, which aims to raise the profile of rehabilitation amongst our members. Since the first edition was published back in 2004 awareness of rehabilitation has increased, but is not yet universal.

This guide aims to provide guidance and support for APIL members, who we know are committed to ensuring the injured people they act for make the best and quickest possible recovery after an accident.

The guide has been written to be used in conjunction with the 2007 Rehabilitation Code ("the Code"), which can be found on the APIL website. The Code aims to "promote the use of rehabilitation and early intervention in the compensation process so that the injured person makes the best and quickest possible medical, social and psychological recovery" and is designed to apply whatever the severity of the injury sustained by the injured client.

The 2007 version is a revision of a code that was first introduced in 1999, and like that first code was developed jointly between insurers and claimant solicitors under the auspices of a working party set up by the International Underwriting Association. The Code provides a framework supported by all the main associations for insurers and personal injury lawyers in the UK, but is neither compulsory nor the only way to approach rehabilitation. The Code promotes a spirit of co-operation and rehabilitation, and the objectives of the Code will be met whenever parties co-operate to assess and then provide for the injured client's rehabilitation needs.

To help locate a rehabilitation provider, APIL also publishes a "Rehab directory". Whilst APIL does not endorse any particular provider, the directory can be a valuable resource and contains contact details of many providers.

In addition, there is now a dedicated rehabilitation area on our members' website. You can access useful documents, check relevant developments and access the rehabilitation area of the members' forum to discuss issues with other practitioners.

A financial award can never fully compensate an injured person for pain, suffering and other losses. We therefore hope that our members find this guide useful and that it assists in promoting the use of rehabilitation in the claims process where this will be of benefit to the injured person.

Amanda Stevens

APIL Vice-President

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INTRODUCTION

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

As long ago as 1880, in *Livingstone v Rawyards Coal Company* [1880] 5 Appeal Cases 25, Lord Blackburn said the purpose of damages was to “put the party who has been injured... in the same position as he would have been if he had not sustained the wrong for which he is now getting his compensation.” This statement had been reinforced in more recent cases, such as *Wells v Wells* [1996] EWCA Civ 784 and *Flora v Wakom* [2006] EWCA Civ 1103.

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

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

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

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

Whilst decisions regarding rehabilitation should always be made with the involvement of proper medical or other professional input, APIL hopes this guide reminds members to think, in each and every case, “what can I do to make my client better?”

REHABILITATION AND LITIGATION – KEY CONSIDERATIONS

Key activities

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

Pro-active involvement

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

Identifying appropriate actions

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

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

Communicating at an early stage

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

Considering an early independent needs assessment ("INA")

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

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

The assessment should be carried out by an appropriately qualified person. The most appropriate person for such an independent assessment is likely to be an occupational therapist, some specialist nurses 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.

FUNDING OPTIONS

NHS medical rehabilitation

It is vital that there is effective liaison between NHS care and privately funded rehabilitation. This is especially important in cases where there are catastrophic injuries, as the NHS will almost certainly provide some rehabilitation, possibly in a specialist centre. APIL members should therefore attempt to establish a co-operative relationship with the NHS provider and provide feedback to the insurer. This is particularly important during the transition from NHS to insurer funded care. The approach recommended by APIL is that contained in the British Society of Rehabilitation Medicine's best practice guide.

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 located and their use considered. It is important to remember that many private healthcare providers insist on a refund of rehabilitation services if damages are subsequently awarded.

Defendant liability insurance

As soon as practicable, APIL members should communicate any identified rehabilitation needs to the defendant's insurer, in accordance with the Code. Establishing a working relationship with insurers by providing information about the injured client's condition should also help to establish early and appropriate rehabilitative treatment. Trying to establish early contact with insurers will not, however, always mean that an agreement will be reached with regard to interim payments. Be prepared to apply to court for interim payments, if these are not provided voluntarily.

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 2007 Rehabilitation 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.

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. The DEA will work closely with your client to assess his abilities and the type of work he might do.

Social Services Provision

There are a vast number of statutes, regulations and guidance notes which may be relevant when considering the potential provision of rehabilitation by Social Services. Some provisions incorporate specific duties to provide services which can be relied upon whilst others merely provide targets for general aspiration. 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 47 of the NHS & Community Care Act 1990 obliges a local authority to make an assessment of needs of apparently disabled persons. The purpose of this assessment is to ensure the right of disabled people to access state provision.

Section 21 of the National Assistance Act 1948 relates to the provision of residential accommodation and obliges local authorities to make arrangements to provide residential accommodation for people over 18 "who by reason of age, illness, disability or any other circumstances are in need of care and attention which is not otherwise available to them". This can include local authority homes and other premises for which the local authority makes a direct payment. Section 22 of the Act gives the authority power to charge for section 21 services.

Section 29 of the National Assistance Act 1948 relates to domiciliary care and the provision of services to the injured client in their own home. Similar considerations apply as under section 21. A local authority may use its discretion to charge for assistance provided under section 29, by virtue of section 17 of Health and Social Services and Social Security Adjudications Act 1983.

Section 117 of the Mental Health Act 1983 sets out the obligations on health authorities to provide care and accommodation for mental health patients.

Section 17 of the Children Act 1989 sets out the statutory obligation imposed on local authorities to provide social services for children.

Local authorities also have discretion to provide services under:

Section 45 Health, Services & Public Health Act 1945 (meals, recreational services and travel assistance provided to elderly people)

Section 22 of the Chronically Sick & Disabled Persons Act 1970 (practical assistance in the home and recreational facilities outside the home)

Supporting People Grants (Local Government) Act 2000, section 93

Supporting People (England Directions) 2005

Independent Living Fund (Disability Grants) Act 1993.

INSURER FUNDED REHABILITATION

If the cost of providing rehabilitation is reasonable, then it should form part of the damages award and will be recoverable. APIL members should liaise with the insurers to try and reach agreement concerning rehabilitation at the earliest opportunity. There is no need to await a decision on liability. If a rehabilitation plan is agreed, then any argument relating to the reasonableness of the rehabilitation provision should be disposed of. Under the 2007 Rehabilitation Code, even a later argument on contributory negligence should not result in a subsequent claw back of rehabilitation costs.

Building a firm but non-confrontational relationship with defendants or their insurers should help the client to receive early interim payments which can be used to fund rehabilitation or the insurer may pay the provider direct. If agreement is not reached, 'without prejudice' immediate needs assessments can often be sought to identify the injured client's needs. Alternatively, assessments and treatment can be paid for in the short term by obtaining early interim payments from the court.

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

MODERATE INJURIES

Process

Moderate injuries are traditionally those that are likely to resolve, in medical terms, relatively quickly, but can still cause distress, inconvenience and possibly financial losses to the injured client. Musculo-skeletal injuries, such as many lower back and most whiplash injuries are examples of moderate injuries.

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

arrange to gain access to therapies as quickly as possible;

look seriously at what the defendant insurer is offering, but should be satisfied about the independence, quality and appropriateness of the rehabilitation provider;

not need to involve a case manager.

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

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

Case study

Individual A has a road traffic accident resulting in a whiplash injury. The injury is sufficiently serious to put A off work for three weeks, to be unable to drive and carry out some basic household tasks which might include cooking and shopping. After returning to work, at an office based job, A continues to suffer with whiplash injury symptoms. Ordinarily, in this example, it would be a year before the symptoms would finally subside. Early rehabilitative intervention could include private physiotherapy that might result in only six to nine months, rather than twelve months, of suffering. It might also include provision being made for some initial household domestic assistance, and help with transport such as the establishment of a taxi account. The possibility of a very early interim payment for uncontroversial items of special damage such as a motor policy excess and loss of earnings should be considered in order to alleviate any immediate hardship, and this can, in turn, boost A's morale.

MAJOR INJURIES AND THE INA

Process

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

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

the defendant/insurer, voluntarily or
early proceedings and interim payments.

This type of injury may not always need a case manager, although this is something that is likely to be dependent on the facts of the case. It will be dictated by both the capability of the injured client and his family and social circumstances. Clients suffering from major injuries will normally need an INA. Case management is more likely to be needed for psychiatric or psychological injury.

Immediate Needs Assessment

A face to face INA will be most appropriate for injured clients who have sustained injuries likely to cause incapacity for several months or longer. Ideally 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. Early anticipation and engagement with the insurer is crucial.

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

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

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

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

It should be possible to put recommendations into immediate effect at a proportionate cost.

An INA should not be confused with long term care needs and costing, which will be addressed by appropriate experts in the claim.

In terms of cost, the INA should be paid for by the insurers, with any reasonable recommendations being funded by them under the terms of the Code.

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 relative low cost.

Case study

Major injuries are the type of cases where an individual has an injury that, in a working context, means that he is no longer capable of returning to his own pre-accident job but is capable of some work.

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

He can no longer use his leg to operate the accelerator or brake. In some other aspects, however, he remains able bodied and simply requires retraining. Further physiotherapy could help to improve movement of the injured limb. Similarly, B needs help with activities of daily living, domestic chores and transport. He may need further and early medical treatment (manipulation procedures, bone grafting, removal of metalwork etc) that can be funded privately and may have 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.

CATASTROPHIC INJURIES AND THE CASE MANAGER

Process

These are traditionally injuries which can be seen as life-changing, for example, traumatic brain injury or spinal cord injury, resulting in virtually no chance of returning to work. 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. These claims will almost always need a case manager.

Case managers

A case manager should not be viewed as a medical expert. This position was affirmed by the court in *Wright v Sullivan* [2005] EWCA Civ 656. A case manager's role is to assess, plan, implement, co-ordinate, monitor and evaluate options and services to meet the injured person's health needs, and to promote the restoration to their pre-accident standard of life as far as is possible.

A case manager's primary duty is to the injured client, regardless of who is paying for the rehabilitation. The case manager's client is the injured person, and not the insurer or a lawyer.

When considering the appointment of a case manager, as with choosing a person to conduct an independent assessment, APIL members should ensure potential case managers are suitably qualified. See the later section in this guide about choosing a provider for more information. A copy of the case manager's CV should always be obtained and examined, and it is almost always useful to speak to someone who can give a personal reference for the case manager.

Ultimately it will be for the client to choose and appoint the case manager with the help and advice of their legal representative. It is worthwhile being cautious about using the same case manager, or case management firm, who or which carried out the INA. In some circumstances the independence of the case manager may be compromised. Under the Code, any rehabilitation provider should disclose any business interests they have so that relationships are transparent before a choice is made. Rates should be agreed beforehand and the terms of engagement checked. For example, a large number of rehabilitative interventions may be proposed under the INA with the assumption that the same case manager making the suggestions will then be appointed to deliver the rehabilitative care. It could therefore be in the unscrupulous case manager's interest to increase the amount of rehabilitation provisions suggested.

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

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

Once the original plan of action has been completed, a further plan should be prepared and costed. This arrangement should continue for as long as it is necessary to retain a case manager.

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.

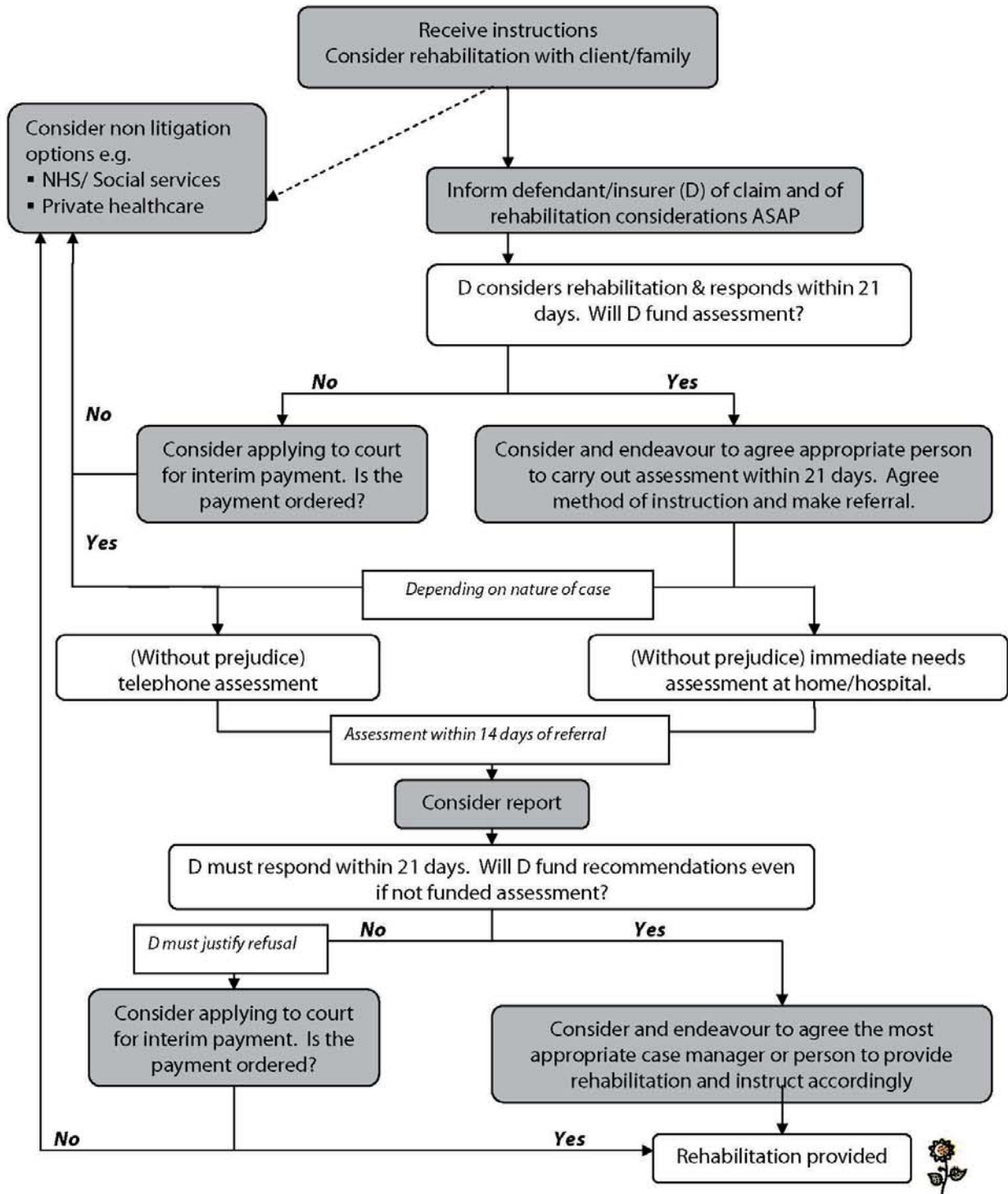
Case study

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

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

A combination of some of these behaviours together may well render C unemployable. They will create problems trying to live an independent life. Rehabilitation should be provided that will teach new skills and coping strategies. It might also be worthwhile to recruit a "buddy" who has suffered a similar injury but who is on the road to recovery to encourage and inspire C. Finally, family and friends of C will need help in adapting to their "new" loved one and assisting with her maximal rehabilitation.

PRACTICE MAP



CHOOSING A REHABILITATION PROVIDER

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

There are increasing numbers of 'rehabilitation providers' in the UK. This term has come to encompass both individuals who offer specific services as well as firms who can provide and arrange treatment and assistance from across a range of disciplines. 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.

In order to identify a suitable provider, APIL members should scrutinise the curriculum vitae of the provider. 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.

Personal recommendations from those with experience of rehabilitation providers can be invaluable. APIL members are reminded that they can use the members' area of the website to contact other practitioners.

When considering providers, APIL members should be aware that there are a limited number of rehabilitation qualifications available in the UK and rehabilitation as a whole is largely unregulated. As a result, most rehabilitation providers are self styled, their professional qualifications lying elsewhere such as in the field of nursing or occupational therapy. Expertise in a particular field of rehabilitation therefore tends to accrue from experience rather than formal education.

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

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

Minimum standards for rehabilitation providers

There are plans underway by those involved in the rehabilitation industry to formulate standards to which all rehabilitation providers can subscribe. Until these standards become available, APIL members are advised to consider the following as minimum standards for rehabilitation providers.

Qualifications and experience

Rehabilitation providers must have a relevant professional qualification;

Rehabilitation providers must be able to demonstrate that they:

- * have experience of working in the required field;
- * have current and relevant knowledge in the required field;
- * pursue continuing professional development appropriate to their field;
- * have professional indemnity insurance.

Client care

Rehabilitation providers must agree to:

- * comply with the timings set out in the 2007 Rehabilitation Code;
- * provide the client with clear details of the recommended treatment and the intended outcomes;
- * not share confidential information without the client's consent;
- * reporting standards (including method and frequency), in writing, in advance of being instructed;
- * provide costed plans for treatment.

Independence

Rehabilitation providers must put the interests of the injured person first and in this regard must:

- * disclose the nature of their ownership, and any business relationships or agreements they have with others
- * have a system of work in place which will enable it to show what work has been completed and why.

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 and physical 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, nursing care, accommodation adjustments or psychological care. It should reflect the client's changing needs.

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

Discuss with the client how rehabilitation will help

APIL members should talk to the injured client about his quality of life. Would early intervention assist with day to day living? Are home adaptations needed to make life easier? Is counselling needed due to trauma? Is retraining needed to get back to work? By using the Code, or other negotiated arrangements, these needs can be assessed and delivered outside the claims handling or litigation process.

Explain the process and how rehabilitation is paid for

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

Detail the consequences of rehabilitation

The 'holistic' approach to personal injury litigation helps injured clients recover physically, psychologically and emotionally from their injury. By receiving rehabilitation and, as a consequence, getting better faster, the overall level of damages may be reduced. Rehabilitation can therefore help injured clients mitigate their losses. APIL members should advise accordingly but as rehabilitation can offer injured clients the opportunity to get better, have less pain and have a better quality of life, you will be putting injured clients' best interests first by discussing rehabilitation initiatives with them.

COUNSEL'S ROLE

Understandably counsel may not be as familiar as solicitors with the workings of the Rehabilitation Code. They are rarely involved at the outset of a claim when rehabilitation should first be considered. It is important, however, that counsel are aware of the Rehabilitation Code and precisely where it is meant to fit into a personal injury claim.

Counsel should primarily be aware of how rehabilitation can benefit the injured client but also need to understand which aspects of the Code should be within or entirely outside the litigation process. It is also important to understand how the process works generally, and what has been done in each individual case to assess the needs of the injured client, in order to be able to argue the reasonableness of rehabilitation if this is in dispute.

Serious claims will always benefit from the early inclusion of counsel on the legal team, and a working knowledge of the Code is fundamental to the planning of the injured client's case.

OVERCOMING PROBLEMS

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

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

You may find that you are facing delay in receiving a response to correspondence 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 2007 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. 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.

- 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.

- Check the APIL website and ask other APIL members

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

DETAILS OF CHARITABLE ORGANISATIONS

APIL wishes to thank the following charitable organisations for their support for this guide



ASPIRE works with people with spinal cord injury to create opportunity, choice and independence for disabled people in society.
info@aspire.org.uk www.aspire.org.uk
Tel: 020 8954 5759



A national charity that helps people manage and prevent back pain by providing information and support, promoting self help, encouraging debate and funding research into better back care.
Helpline: 0845 130 2704 www.backcare.org.uk
Tel: 020 8977 5474



The Back-Up Trust runs a variety of services for adults and young people that encourage self-confidence, independence and motivation following a spinal cord injury. www.backuptrust.org.uk
Tel: 020 8875 1805



Child Brain Injury Trust (CBIT) is a UK wide charity offering support and information on acquired brain injury in children. It supports children, parents, siblings, relatives and professionals.
Helpline: 0845 601 4939 www.cbituk.org
Tel: 01869 341075



the brain injury association

Headway works on a national and local basis to promote understanding of all aspects of brain injury and its effects, as well as providing information, support and services to help brain injury survivors and their families.
Helpline: 0808 800 224 www.headway.org.uk
Tel: 0115 924 0800



The Spinal Injuries Association is a national, user led charity which offers support to individuals who become spinal cord injured and their families, from the moment the injury or illness occurs, and for the rest of their lives.
Helpline: 0800 9800 501 www.spinal.co.uk
Tel: 0845 678 6633

THE APIL WEBSITE - www.apil.org.uk

On the APIL website, you will find

Useful documents such as the 2007 Rehabilitation Code

Links to useful websites such as those of rehabilitation providers' voluntary organisations

Relevant news

A link to the rehabilitation area of the members' forum

APPENDIX - "REHAB LITE"

A summary of the 2007 Rehabilitation Code - Making a real difference to injured people

The Rehabilitation Code provides an approved framework for injury claims within which claimant representatives and compensators can work together. Whilst the Code is voluntary, the court Pre-action Protocol provides that its use should be considered for all types of personal injury claims. The objective is to ensure that injured people receive the rehabilitation treatment they need to restore quality of life and earning capacity as soon as possible and for as long as the parties believe it is appropriate.

The important features of the Code are:

- 1 the claimant is put at the centre of the process
- 2 the claimant's lawyer and the compensator work on a collaborative basis to address the claimant's needs, from first early notification of the claim and through early exchange of information
- 3 the need for rehabilitation is addressed as a priority and sometimes before agreement on liability. Fixed time-frames support the Code's framework
- 4 rehabilitation needs are assessed by those who have the appropriate qualification, skills and experience
- 5 the choice of rehabilitation assessor and provider should, wherever possible, be agreed by the claimant lawyer and the compensator
- 6 initial rehabilitation assessments can be conducted by telephone or personal interview, according to case type and the resulting report should deal with matters specified in the Code.
- 7 the claimant is not obliged to undergo treatment or intervention that is considered unreasonable.
- 8 the compensator will pay for any agreed assessment of rehabilitation needs and must justify a refusal to follow any of the rehabilitation recommendations
- 9 the initial rehabilitation assessment process is outside the litigation process
- 10 where rehabilitation has been provided under the Code, the compensator will not seek to recoup its cost, if the claim later fails in whole or part.

Time Scales

Claimant Solicitor

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

Give earliest possible notification to compensator of the claim and need for rehabilitation

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

Compensator

Shall equally consider and communicate at earliest practicable stage whether the claimant will benefit from rehabilitation

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

Parties

Consider choice of assessor and object to any suggested assessor within 21 days of nomination

Immediate Needs Assessor

Assessment to occur within 14 days of referral letter

Provide report simultaneously to parties

Compensator

Pay for report within 28 days of receipt

Respond substantively to recommendations to claimant solicitor within 21 days of receipt of report

The new 2007 Code simplifies the original version, first published in 1999, at the same time as underlining the important principles. It has the support of all the important stakeholders in the claims process including the ABI, IUA, APIL, FOIL, MASS, the Civil Justice Council and major insurers.

This document is a summarised version. To read in full, go to www.iua.co.uk/rehabilitationcode

For enquiries, please email deborah.finch@iua.co.uk

The Rehabilitation Code is endorsed by many organisations, including:

Association of British Insurers
Association of Personal Injury Lawyers
Bodily Injury Claims Management Association
Case Management Society of the UK
Forum of Insurance Lawyers
International Underwriting Association
Motor Accident Solicitors' Society.



The Association of Personal Injury Lawyers

11 Castle Quay, Nottingham , NG7 1FW, Tel: 0115 958 0585

Fax: 0115 958 0885, Email: mail@apil.org.uk Web: www.apil.org.uk