

## **A Guide for Case Managers and those who Commission them**

### **1. Introduction**

This Guide is designed to supplement, but not replace, the Rehabilitation Code in relation to claims for personal injury. It is intended primarily for the use of Case Managers but will also be of value to rehabilitation providers in addition to those who refer clients to them, such as lawyers and insurance claims handlers.

In the context of the medico legal claims process, rehabilitation and Case Management can be a highly complex and contentious issue, but also extremely productive. There are many factors that will determine whether rehabilitation, in the broad sense of the term, is successful. Included among these are the motivation of the injured person and the extent to which they wish or are able to engage with the process, as well as trust – trust between the injured person and Case Manager, and trust between the insurance claims handler and the lawyer acting for the injured person. Where that trust is lacking, rehabilitation outcomes may be affected.

Good communication between the parties and speedy decision-making are essential to good rehabilitation outcomes.

At all times, Case Managers who are registered with a professional body, e.g. nursing or occupational therapy, must abide by the standards and guidance set by those bodies. Case Managers and others will also find it useful to refer to the Code of Ethics set by BABICM and CMSUK, and also to BABICM's 'Competencies and standards for case management practice' and CMSUK's 'Standards and Best Practice Guidelines'.

Where the term rehabilitation is used in this Guide, it is intended to include all aspects of rehabilitation including case management unless stated otherwise.

### **2. Purpose of Rehabilitation**

The intention of the Rehabilitation Code is to put the injured claimant at the heart of the process. Rehabilitation must look to put the claimant back, in so far as is possible, to the same physical, mental and financial condition that they enjoyed before the accident. Where the severity of their injuries means that this will not be possible, rehabilitation must be aimed to reasonably maximise the **independence** and quality of life of the injured person, and not create **dependence**. Rehabilitation should also be regarded as a comprehensive exercise for the benefit of the injured claimant, taking account of the impact of the accident on those also affected, such as the claimant's family, and in addition on the claimant's possible inability to work. As such, sometimes, particularly on larger claims, it will be necessary to work with the claimant's family so that they are better equipped to help the claimant; this can be especially so in cases involving brain injury to a family member, especially children. Similarly, counselling can help a family

member come to terms with what has happened to a loved one and this in turn can help the rehabilitation process.

Cases where the effects of an injury overlap or exacerbate a pre-existing condition or work/domestic issue can be problematic. Although the purpose of rehabilitation is to put the claimant back to the same physical, mental and financial condition that they were in before the accident, sometimes this can only be achieved by addressing the pre-existing health condition or domestic/work issue. How far this is done will depend on the facts of the case and complexity of the injury. However, in such circumstances, the Case Manager should identify pre-existing barriers to successful rehabilitation and, if it is important that these are addressed, should spell out why that is the case and the possible consequences of not addressing them. Sometimes, the pre-existing medical condition or issue may be so intractable that the cost of endeavouring to address the problem far outweighs the financial and non-financial benefit that might accrue.

Rehabilitation outcomes and objectives need to reflect the reasonable pre-accident situation and aspirations of the claimant, and should not be used as a means to maximise damages in the claim prior to settlement.

### **3. Rehabilitation and the Law**

The purpose of damages is to put the injured person in the same position they would have been in if they had not sustained their injury. These damages can be reduced if the injured person was partly at fault for their own injury. *Sowden v Lodge*<sup>1</sup> emphasises that an injured claimant is entitled to have not merely the cheapest rehabilitation they need, but rather the rehabilitation they **reasonably** need to enhance their lifestyle with a view to restoring it, as much as possible, to how it was prior to the accident.

Rehabilitation costs are treated as damages by the Court. In simple terms, this means that where there is a single referral by the claimant (*or their lawyer on their behalf*), with the costs of case management and rehabilitation funded by way of interim payments made by the insurer, unless liability is agreed in full, the costs of rehabilitation are capable of reduction by the extent of any contributory negligence on the part of the injured person. Rehabilitation funded under the Code sits outside of the litigation process and thus the costs of agreed rehabilitation are paid in full by the insurer and are not at risk of reduction for contributory negligence.

The provision and funding of rehabilitation has to be viewed against this backdrop.

The Pre Action *Protocol*, which forms part of the Court Civil Procedure Rules, places on the claimant's solicitor and defendant's insurer an ongoing duty to consider rehabilitation. If, subject to some liability attaching to the defendant, and thus their insurers, rehabilitation would help put the injured person back into the position they were in before the accident, it should not be refused. Nevertheless, rehabilitation should be proportionate to the injury and should not be refused unless what is being proposed is unreasonable.

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<sup>1</sup> *Sowden v Lodge* [2004] EWCA Civ 370

#### 4. Selecting a Rehabilitation Provider or Case Manager

A good Case Manager or rehabilitation provider is worth their weight in gold. Appointing a poor Case Manager or rehabilitation provider can be an impediment and end up costing more money and failing to deliver quality outcomes for the injured person and the parties to the claim. So, investing time and effort at the outset to choose an appropriate Case Manager or provider can pay dividends.

This applies equally to insurers who have preferred providers; the Case Manager who is to be commissioned MUST have the appropriate knowledge and skills to address the injury in question.

Things that those who commission Case Managers should look for, and that the Case Manager or rehabilitation provider should be prepared to provide, might include:<sup>2</sup>

- Does the Case Manager or therapist to be commissioned have the relevant professional qualifications? For example, some people who carry out telephone assessments may not be medically qualified, though Case Managers who come from a social-work background and are CQSW or similarly qualified can be highly effective.
- Do they have relevant knowledge and experience of working in the required field either as a Case Manager/therapist or in the NHS? Beware of superficial CVs; don't be afraid to ask questions!
- Do they have evidence of relevant CPD?
- What evidence is there of clinical governance or supervision? Who supervises the sole practitioner? They may have a peer group, but you need to ask.
- Do they have external accreditation with a recognised body such as CARF, or can they evidence compliance to PAS150?
- Do they have full and adequate professional indemnity insurance? This is particularly relevant after *Loughlin v Singh*.<sup>3</sup>
- Does the Case Manager live or work close enough to the client, depending on how regularly they may need to visit? Normally, one hour's travelling time is considered the maximum.
- Can you take up a reference from somebody whose opinion you value?

It is also necessary to consider the charging structure and fees. Do the fees charged reflect market rates? Is it a set fee or an hourly rate? What is the charging unit and how does that compare with competitors?

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<sup>2</sup> Taken from APIL's '2008 Think Rehab! Best practice guide on rehabilitation'

<sup>3</sup> *Loughlin v Singh & Ors* [2013] EWHC 1641 (QB)

## **5. Duties of a Provider and Those Who Commission Them**

*To foster trust, the claimant's lawyer and insurer should declare any financial or ownership relationship, direct or indirect, that they have with any Case Manager or provider, but so too should the Case Manager and provider declare any relationship they have with the insurer or claimant lawyer.*

### **Case Manager/provider**

First and foremost, the duty of a Case Manager/provider is to the injured person. The nature of the relationship with the injured person is therapeutic and they are not part of the litigation team.

Irrespective of how the Case Manager/provider receives the referral, whether jointly from the claimant and insurer or solely from the claimant (*or their solicitor on their behalf*), they must preserve their independence and the nature of the therapeutic relationship at all costs.

They must adhere to their own professional standards and not be influenced by commercial considerations.

A Case Manager/provider should only accept a referral if it is within their field of expertise and they are able to help the injured person. Case Managers/providers should not be afraid to decline referrals if they don't have the expertise or capacity to do the job. To do so may earn the Case Manager/provider greater professional respect than accepting the job and failing to deliver. The Case Manager should also consider whether they are capable of providing a suitable service from a geographical perspective. Do they live or work close enough to the client, depending on how regularly they may need to visit?

### **Insurer**

The insurer should not refuse rehabilitation unreasonably. If a recommendation is being made and the insurer does not understand why it is being made, they should ask for more information.

Insurers should deal with communication and funding requests, etc. in a timely fashion. Not doing so and delaying can have a negative impact on rehabilitation outcomes and build cost. Insurers should also be mindful that often rehabilitation recommendations are interlocking and that to pick and choose some recommendations and not others can prejudice outcomes. If this is a route the insurer wishes to go down, the Case Manager/provider will find it useful to be given an explanation *as to the rationale behind the decision*. Similarly, where the Case Manager/provider makes interlocking recommendations, they should make it clear that one recommendation cannot succeed without the other.

### **Solicitor**

A solicitor has a duty to act in the best interests of their client. This does not always equate to maximising damages; maximising life chances for the injured person is more important.

It should be the aim of the solicitor to act in a holistic manner, balancing their duty to obtain full and fair compensation with their duty to do everything possible to facilitate their client's optimum recovery. This should include working with a Case Manager and other relevant professionals in a

collaborative manner. The solicitor should agree service level standards or other terms and conditions with the Case Manager and should also agree a regularity of contact and exchange of information which are appropriate to the individual case.

## **6. The Rehabilitation Process**

### **Referral**

This can be a joint referral or sole referral by either party with the agreement of the other. It is for the injured person and their legal advisers to choose. *The parties are encouraged to agree the selection of an appropriately qualified Case Manager best suited to the Claimant's needs.*

Where the insurer and claimant solicitor are working collaboratively and there is trust, joint referral can work. However, the insurer cannot insist on joint referral and, indeed, the law makes it clear that it is the claimant (*or their solicitor on their behalf*) who should commission the Case Manager.<sup>4</sup> Where this occurs, the case of *Wright v Sullivan* does nonetheless encourage collaboration between the different parties.

An insurer should not commission a Case Manager or provider without any dialogue or contact with the claimant's solicitor and then expect the Case Manager to obtain the claimant's solicitor's agreement that they should be commissioned.

The referral should make it clear who will be paying the fees of the Case Manager/provider and any limits or constraints on funding.

The Case Manager/provider being commissioned may also find it useful to understand the position in respect of liability; the purpose of this is to assist them in managing the injured person's expectations.

### **The INA or Assessment**

This is usually the starting point of the rehabilitation process. However, some injured people may be so badly injured or traumatised by the event giving rise to their injury that psychologically they are not ready or able to engage with the process fully. It does not necessarily mean that the injured person is looking to enhance their claim in an inappropriate way; it can simply be that they need help to understand and engage with the rehabilitation process, and that they are overwhelmed with everything that has happened to them. In such instances, counselling or other psychological input before the rehabilitation process itself starts can be helpful if the injured claimant is prepared to engage and it is medically recommended. The Immediate Needs Assessment or initial rehabilitation assessment should focus on the rehabilitation priorities and what is required. Often the recommendations are interlocking; this means that there is a danger that agreeing to one recommendation but not to another could impact on the success of what is to be delivered;

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<sup>4</sup>

*Wright v Sullivan* [2005] EWCA Civ 656

although in some circumstances, only some of the options may be appropriate or attract the willingness of the claimant to engage.

In the more serious cases where liability investigations might be ongoing or where liability might be in dispute, insurers may wish to consider funding some but not all of the recommendations. This can be a useful approach in those cases where there is unlikely to be a full defence and it can assist in building trust and goodwill. In such circumstances, the Case Manager/provider and the claimant's advisors must be made aware of the situation and, where they have not done so already, prioritise and fully cost the rehabilitation requirements.

Where liability attaches and where what has been recommended is proportionate to the benefit to be obtained by the claimant, it is unhelpful for an insurer to refuse funding.

If there is to be a delay in agreeing funding, it can be helpful to explain why to the claimant/claimant's solicitor and Case Manager.

From an insurer perspective, it is very important that, once received, INA reports are prioritised so that early decisions regarding the recommendations and agreement to fund can be made and communicated to both the Case Manager and claimant solicitor. Delay can lead to poor outcomes.

### **Case Management and Delivery of Ongoing Rehabilitation/Therapy**

This is a potentially thorny issue and one where views of all involved in the process may be different.

Some will argue that to avoid conflicts of potential interest, there should be a clear dividing line between the assessment process and the provision of case management and other therapeutic relationships; different professionals should be involved in each aspect. However, continuity between assessment and delivery works, but the tensions and conflicts that can emerge are something that practitioners, whether Case Manager, insurer or claimant's solicitor, need to be mindful of. It is the therapeutic process that should be paramount. Continuity that builds on the therapeutic relationship established in the assessment process through to delivery of recommendations is regarded by many clinical practitioners as being best practice and, for instance, is emphasised in the CMSUK's Best Practice Guidelines.

### **Goal Setting**

Goal setting is integral to the rehabilitation process. Goals should be those of the injured person or client. They should be agreed at the outset between the injured person and Case Manager/therapist, and there might be a need for a negotiation phase with the injured person so as to ensure 'buy in'.

This emphasises the importance of the INA assessment and continuity of the therapeutic relationship. Goals should be SMART:

Specific/Subjective, e.g. to be able to walk the dog to the shop to get a paper, or return to work.

Measurable, e.g. by date XX/YY/ZZ, or to lose 3 kilos in weight.

Agreed/Achievable, e.g. they should be the client's goals and thus be agreed with them. What they MUST NOT be is a list of Case Manager actions.

Realistic, e.g. at the most absurd, being able to walk to the shop will not be realistic for a paraplegic.

Time-bound/Timely, e.g. to be achieved by a certain date.

Goals may be supported by Case Manager actions, but tasks or actions to be carried out by the Case Manager are not goals and should be challenged.

The injured person's goals might be very long-term or even aspirational; provided that there are shorter-term, measurable goals leading to the achievement of the longer-term aim, that is valid.

Claims handlers and fee earners should be alert to instances where there is no progress towards some or all goals from one period to the next, especially so when there may be several months between *updates*. This should prompt questions as to why there has been no progress as there may be legitimate reasons. It may also require dialogue with treating medical and associated professionals. In some circumstances, it might be appropriate for the Case Manager to attend multi-disciplinary meetings.

The Case Manager or therapist themselves should remember the therapeutic nature of their involvement, and if they are having no impact, they should question their own continued involvement, irrespective of the loss of possible fee income.

### **Records**

Case Managers should keep comprehensive records. They should remember at all times that their relationship with the claimant is a clinical and therapeutic one. There is no specific, required format for keeping the records, but Case Managers should be aware that the records may be the subject of scrutiny by other medical professionals, lawyers, insurers and the Court. They should therefore be clear, legible and a comprehensive, true and accurate record of their involvement with the claimant.

At all times, records must comply with the relevant professional standards of the Case Manager/therapist.

### **Communication and Disclosure**

Where there is unilateral referral by the claimant solicitor as opposed to joint referral, in accordance with the principles outlined in *Wright v Sullivan*, documentary records of the involvement of a Case Manager are subject to disclosure to third parties as outlined above and do not, apart from in certain specific circumstances, attract legal professional privilege. It is not for the Case Manager to decide what is or is not subject to privilege. The claimant solicitor should decide what is privileged and redact as appropriate, and should then send the records to the defendant insurer/solicitor.

### **Involvement in the Legal Process**

A Case Manager is not an expert witness but can be a witness as to fact (*Wright v Sullivan*). They can voluntarily provide witness statements but are not compelled to do so. However, they are not immune from being called to give evidence. They can also choose whether they wish to participate

in providing information within the legal process, e.g. attending a conference with legal advisers. A Case Manager should remember that their overriding duty is to their client in all circumstances and to act in their best interests. Again, as emphasised in the CMSUK's Best Practice Guidelines, 'The case manager is part of, if not leading, the rehabilitation process and is not a member of the litigation team'. Their primary focus is the therapeutic needs of their client and they should use their professional judgement and **evidence base** to determine whether any suggested action is appropriate. It is recognised that a Case Manager, when attending a meeting with the client's legal team, may find it difficult to remove themselves from the meeting. However, they should not allow themselves to be open to undue influence.

## **Funding**

It is sensible for a Case Manager to undertake full and regular accounting, and to ensure that they are working within agreed budgets. Case Managers should be alive to the fact that obtaining funding or decisions about funding is not always a speedy process, and they should try to anticipate this by planning ahead, wherever possible. However, insurers should also be aware of the need for consistency and to avoid disruption in the rehabilitation process, and should respond and react to requests from Case Managers promptly. Case Managers and insurers should work together to establish smooth pathways to payment, so as to avoid lack of continuity. The insurer should be transparent if there are issues with regards to future funding and they should discuss these in a timely fashion with the claimant solicitor. The Case Manager should not be used as 'piggy in the middle' with regards to any disputes and these should be resolved between claimant solicitor and insurer. If the decision is made to withdraw funding, a phased withdrawal, as opposed to a sudden cut-off, can assist all parties.

## **7. Vocational Rehab**

Vocational rehabilitation will, for many injured claimants, be exceedingly important to their physical and mental wellbeing. Getting back to work in some form or other is a benefit to all; to the injured claimant, the paying insurer, and to the government and society in general. Case Managers should recognise that this is not an objective for all injured people, but it is for many in their attempts to resume some form of normality. Case Managers should consider the possibility of vocational rehabilitation at the earliest appropriate moment. This may involve them in dialogue with employers, and Case Managers should be aware of some of the mythical barriers to a return to work. However, vocational rehabilitation is a specialist area and if a Case Manager does not have the relevant experience or expertise, this should be recognised and a referral to somebody more suitable should be made.

## **8. Case Manager Dos and Do Nots**

The case of *Loughlin v Singh*<sup>5</sup> reinforced the responsibilities of a Case Manager. It is imperative that Case Managers are therefore aware of the need to be alert to changing clinical and social needs and circumstances. Failure to do so can now lead not just to poorer outcomes for their clients, but also to financial penalties for the Case Manager or provider. If in doubt, Case Managers should liaise

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<sup>5</sup> Loughlin v Singh & Ors [2013] EWHC 1641 (QB)

closely with treating professionals, family members and, subject to confidentiality, with third parties. It is imperative that Case Managers do not fall into a 'comfort zone' once a regime has been established and that they have systems to carry out regular reviews which will enable them to be alert to medical and other recommendations, and new needs arising.

### **9. Problems and What To Do When They Arise**

Case Managers should be aware that, in many cases, there will be emergencies or crises that are likely to arise, depending on the type and extent of the injury and the family dynamics. They should risk-assess this possibility so far as they are able and make contingency plans or have these available.