

# Rehabilitation

## A PRACTITIONER'S GUIDE

(Third Edition – June 2008)

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# 1. Introduction

This is the third edition of this Guide which was first published in 1999 to help practitioners (claim handlers on both sides of the fence) apply the principles of the Rehabilitation Code, which is also now in its third edition.

The Rehabilitation Code has no monopoly on the “right way” and regular participants build up other understandings and arrangements which can also deliver mutual benefit. What the Code provides is a set of useful principles and a very practical starting point.

An essential object of the Code, and, we suggest, any sound approach to the subject, is to establish separate, albeit intermingling, streams of activity and attention for the two aspects of personal injury claims –

1. Rehabilitation
2. Liability and Damages

The first focus (“Rehabilitation”, the one addressed in this Guide) is for the parties to collaborate on their shared interest in the achievement of the best physiological, psychological and social outcome for the claimant. Along the route there are many judgement calls for the practitioner as to what is appropriate, what will be most beneficial and how best to proceed. This Guide is written on the premise that collaboration delivers the best chance of favourable outcome and describes the disciplines most commonly involved, setting out the Why? When? Who? What to expect? and How much? for each.

The second focus (liability and damages) concerns the parties’ conflicting interest in the question of damages for residual injury and loss. Guidance for the practitioner on these issues is abundant elsewhere and is beyond the scope of this text. Nevertheless, we have thought it prudent at certain points to draw attention to factors of special complexity which the practitioner should bear in mind, such as the Roberts –v- Johnstone method of assessing damages where the purchase of premises is involved. Similarly, there are features in some of the appendices which necessarily involve aspects of the law on quantum.

The two aspects – rehabilitation and legal liability to compensate – cannot be isolated from each other. All practitioners need to make a clear distinction between the identities and roles of advisers and expert witnesses.

Whichever disciplines are involved in a case, the factors relevant to them may be profoundly influenced by psychological aspects. Adverse psychological factors can lead to disability outcomes that are disproportionate to the physiological consequences of injury, as described in Chapter 3 and Appendix G.

In connection with the assessment of an injured person, the Code makes specific references to “the overall picture of the claimant’s needs” and “any other medical conditions not arising from the accident”. Whilst a compensator has no obligation to deal with problems not caused by the relevant tort/s, it may be to everyone’s advantage to address them on an economic basis.

There are other tools available to the practitioner today that did not exist in 1999, such as the generic Quality Standards for Rehabilitation Providers, the pilot Mediation Scheme for Rehabilitation issues, the model Agreement for those wishing to work more effectively within the Code, and the Registers for solicitors and insurers who support the principles of the Code. All of these are annexed to this Guide and can be found at [www.bicma.org.uk](http://www.bicma.org.uk)

We have endeavoured to ensure that the specific information provided here is accurate at the time of going to press. Things change and we all need constantly to keep up with developments in this highly dynamic field.

## 2. Immediate Needs Assessment (Serious Injuries)

The Rehabilitation Code identifies that an injured claimant is entitled to receive appropriate rehabilitation at the earliest practical moment and such rehabilitation applies to all types of injury, although clearly, to commission an immediate needs assessment for what appears to be a minor soft tissue injury would be neither appropriate nor cost effective.

The defendant's insurer should usually fund reasonable recommendations by way of an interim payment (see section 7 of the Code).

### Liability

Only a complete denial of liability should prevent a defendant's insurer from considering an immediate needs assessment (but also consider an assessment via Social Services).

If the dispute is confined to contributory negligence, the comparatively low cost of an assessment may well be justified.

### MINOR INJURY

#### What is meant by Minor Injury?

An injury that causes pain, restriction of movement and/or, may cause incapacity and in respect of which, some rehabilitation or treatment will likely hasten recovery.

#### Telephone Triage

This service would be appropriate in respect of all matters where the nature and extent of the injury either does not fall into the bracket of catastrophic or moderate injury, where the nature and extent of the injury is unknown and/or where continued discomfort or disability is being experienced. This would include musculoskeletal injuries, such as whiplash, where the victim continues to suffer pain, discomfort and possibly lack of mobility.

#### Purpose

To provide a prompt snapshot as to the nature and extent of the injury sustained and to identify as to whether prompt intervention or treatment would aid recovery.

#### By Whom?

An appropriate person to conduct telephone triage would be someone with a medical qualification such as a nurse, physiotherapist or GP who has received appropriate guidance or induction, both as to the process and the purpose. A member of one of the case management organisations would likely have the appropriate skills.

#### What to Expect

A telephone triage should provide the purchaser with a snapshot of the injured persons situation as voiced by them. It should cover:-

- The nature and extent of the injury.
- What GP or hospital attendance.
- Any diagnosis that has been provided.
- What medication and/or treatment has been prescribed and whether effective.
- The client's social situation.
- Whether there are mobility issues.
- The extent of any incapacity.
- Whether off work.
- Identification of bio-psychosocial obstacles to recovery.
- Any recommendations likely to aid recovery and return to work.

Telephone triage should identify the likelihood of any support or treatment being available on the NHS and/or identify any perceived psychological issues.

#### Timescales

Within 7 days, subject to the availability of the client.

#### Cost

This will depend on the quality both of the provider and of the content of the report. Expect to pay anything between £50 and £100.

### MODERATE INJURY

Most practitioners now recognise the benefits of providing early intervention and support to those who have suffered serious injuries and the moderate or mid-range injury can often be overlooked. Quite often rehabilitation can be dismissed because of the anticipated cost implications.

## What is meant by Moderate Injury?

For the purpose of this Guide we are looking at any injury that is incapacitating and where the client is likely to achieve a full or near full recovery and return to work. Broken Limbs, Pelvis etc. , an injured hand or even a long term incapacitating whiplash – these are all injuries likely to be incapacitating and yet, subject to the age of the client, likely to result in a full recovery.

### Assessment

Effective rehabilitation can produce remarkable outcomes and injuries at this level do not always require a full domiciliary assessment. An in-depth discussion with the client and their family at the telephone can often suffice (a telephone assessment of immediate needs). As with a full immediate needs assessment, the case manager/assessor will:

- Contact the existing healthcare team as to present and future treatment needs.
- Access private treatment and obtain timescales and costs where appropriate.
- Source solutions for mobility, social and domestic issues.
- Establish and maintain contact with the client's employer, advising them of progress and anticipated return to work.

### What can be gained?

- a. A detailed snapshot of the client's circumstances.
- b. Social support and mobility assistance.
- c. Access to treatment.
- d. Reduced waiting times.
- e. Employment liaison

Effective case management at this level is likely to result in less dependency, earlier recovery and an earlier return to work.

### Cost

Generally speaking an assessment at this level can be conducted effectively at the telephone. The case manager will identify any matter where it is considered that a full domiciliary visit would be more appropriate. It follows that the cost should be substantially less than a full immediate needs assessment, but charged on the basis of time spent.

## SERIOUS AND CATASTROPHIC INJURIES

### Why?

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.

Those persons who have sustained serious or maximum severity injuries will have a myriad of immediate needs that may prove to be both wide-ranging and involve considerable expense. Funding will be required from the Insurer and the Case Manager/Assessor appointed will need to identify and co-ordinate these needs.

There is likely to be a considerable overlap between the rehabilitation process and the claims process. Such claims will probably be handled by senior staff with experience of major claims.

### At What Level?

As a rule of thumb, an immediate needs assessment is applicable to claimants who have sustained injuries likely to cause incapacity for several months or longer.

### When?

The assessment should be done as soon as possible, even before discharge from hospital, with a view to ensuring the home environment to which the claimant will be discharged is suitable at least for the basic needs of the claimant and his/her family. However, an assessment undertaken years after the event of the injury can still help.

### What to Expect

The report should provide preliminary background information about the claimant's circumstances, including the following:

- a. The nature and extent of the injury;
- b. Any relevant medical background;
- c. Family circumstances;
- d. Immediate home adaptation needs;
- e. Steps to improve the claimant's quality of life and support for family carers;
- f. How, and at what cost, recommendations can be implemented.

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

Recommendations should be capable of being put into immediate effect and at proportionate, reasonable cost. Do not confuse an immediate needs assessment with long-term care needs and costs, which will be addressed by appropriate experts in the claim.

**By Whom?**

A case manager trained and committed to the standards laid down by the Case Management Society of the UK (CMSUK) or of the British Association of Brain Injury Case Managers (BABICM) is the most obvious choice.

An occupational therapist or anyone with a social care background, for example, a community care nurse, a social worker or a general practitioner, may similarly be able to conduct the assessment provided that they have been appropriately trained.

There is no effective regulation of rehabilitation providers at the present time. This is likely to be addressed in the not too far distant future, but in the meantime it is recommended that you ensure that the person or organisation entrusted to this task adheres to the BICMA Quality Standards for Providers of Rehabilitation (as annexed).

**Cost**

The Rehabilitation Code requires that the insurer be responsible for the cost.

The fee will depend upon the complexity of the report and travel expenses, but expect to pay between £1,000 and £1,750.

### 3. Psychological Assessment and Support

#### Why?

Anyone who has suffered a serious injury has experienced a major life event. The injured person, his/her family and close friends will be totally unprepared for either the injury or what follows.

Those who have suffered a serious injury will need to come to terms with what has happened to them. There may also be psychological disorders triggered by the accident, which must be recognised and dealt with. Failure to do so may prevent other treatments from being effective and may hinder a return to work.

Emotional, and in many cases psychological, support needs to be given to help the claimant and those upon whom he/she depends.

#### When?

Support should be offered as soon as possible. Often this will be determined by the willingness of the injured claimant and/or his/her family to accept outside help. Many people are frightened by their feelings or by the idea of sharing them with someone. Proper counselling can also be of great assistance to relatives acting as carers.

An early assessment can in itself help identify problems or potential problems in time to prevent prolonged post-traumatic stress disorder.

An assessment and, where needed, counselling or psychological treatment are best considered soon after the injury and/or return home from hospital (i.e. within the first three months of injury). The need for emotional and psychological support may last much longer than the medical treatment.

#### By Whom?

Clinical psychologists should normally carry out an initial assessment. If there is any suggestion of brain injury, then a neuropsychologist should be used.

It is useful to check first whether the claimant's hospital team has already involved a psychologist to help with rehabilitation or whether there is a facility within the GP's practice.

Arrangements should be made with a clinical psychologist close to the claimant's home. Where necessary, appointments can be arranged at the claimant's home, which is important if the claimant is distressed by travel.

#### Contacts

British Psychological Society (45,000 members) provides contacts with clinical psychologists, occupational psychologists, neuropsychologists, counselling psychologists.

The British Psychological Society, St Andrews House, 48 Princess Road East, Leicester LE1 7DR Phone 0116 254 9568  
[www.bps.org.uk](http://www.bps.org.uk)

British Association of Behavioural and Cognitive Psychotherapies BABCP The Globe Centre PO Box 9 Accrington BB5 0BX  
[www.babcp.com/](http://www.babcp.com/)

#### What to Expect

Most assessments involve some psychological testing. This is necessary to determine what help is needed. Better insight and understanding by the claimant and/or his/her family of what to expect of themselves and their feelings will help to achieve maximum recovery.

#### Cost

At about £125-£175 per hour, a clinical psychologist's assessment and recommendations will cost between £250 and £500. Most face to face assessments will last at least two hours with subsequent treatment sessions most frequently being one hour.

A neuropsychologist's assessment will cost between £750 and £1,750.

Counselling psychologist - between £75 and £150 per session.

For more detailed information see Appendice G. "Emotional and Psychological Care"

## 4. Physiotherapy, Osteopathy and Chiropractic Treatments

### Why?

Early mobilisation following injury is now widely recognised as an important part of recovery and needs to be encouraged. Damaged tissue needs careful handling. Injury victims need to be shown how to regain movement and function as soon as possible. Whilst rationales vary amongst the different professions, these all work towards maximising useful function and can help prevent an injury from becoming a permanent disability.

### When?

In the case of serious injuries, these types of treatment are normally determined by the hospital medical team. After discharge from hospital, it is all too easy to overlook the benefit to be gained from continuing treatment until it no longer serves a useful purpose. Treatment is not just about relieving pain, but equally about achieving the best possible recovery of movement, strength and function. In the case of soft tissue injuries, treatment should be assessed as soon as possible, i.e. within a few weeks, not months, of the injury. In more serious cases, initial treatment should be considered as part of the overall medical management of the patient. After discharge, treatment should be considered as part of the overall nursing plan or by direct referral to a practitioner.

### By Whom?

This type of treatment is provided by chartered physiotherapists, osteopaths or chiropractors. Increasingly, it is possible to find that two or more of these disciplines are offered at the same clinic. There are a number of specialist agencies that will provide and co-ordinate treatment. Details of local practitioners can also be found in the Yellow Pages. Alternatively, information is available from:

- Chartered Society of Physiotherapists    0207 306 6666
- General Council of Osteopaths            0207 357 6655
- British Association of Chiropractic        0118 950 5950

### What to Expect

Make sure the proposed treatment provider is a member of a relevant professional body. All will want to assess the patient before offering treatment. The assessment may involve x-rays as well as a physical examination.

If treatment is offered, a plan should be prepared that identifies the number of sessions and when they are to be given. Often a patient will be taught exercises to help speed up the recovery process.

### Cost

The cost will vary from clinic to clinic. Average costs for an assessment will be in the order of £60 to £90. Treatment is likely to cost in the order of £35 to £50 per session depending upon locality.

## 5. Accommodation

### Why?

- The Claimant needs a living situation which enables him/her to function as normally as possible.

### When?

- Accommodation assessment should commence as soon as possible, especially when immediate needs exist. Assessment should not be delayed if a claimant remains in hospital, as some steps may have to be taken prior to discharge.
- Short-term needs can sometimes be crucial. Proper attention at this stage can help the claimant recover lost confidence and provide the ability to start beginning a new life. In some cases it can be many months before a final stage of recovery is achieved and short term needs may have to continue throughout. If a period of many months is involved, these short-term needs must be constantly reviewed.
- The need for substantial adaptations to an existing property or moving to an alternative suitable home is often a long-term consideration. Such permanent arrangements are best delayed until long-term needs and requirements are properly established.
- To remain in their existing home is often not in the client's best interests and will sometimes fail to provide a happy social environment. Many seriously injured persons will, wherever possible, prefer to remain in familiar surroundings. Adaptation of the current property or a property constructed to a client's particular needs may be required. It is usually preferable to find a property that is close to required amenities such as shops, schools etc, and also near to the claimant's family and friends.
- Medical evidence, care and nursing reports etc will be required to help assess future accommodation needs. The extent of such evidence will depend upon the nature of the injury.

Bear in mind that the defendant or insurer will not be required to pay for the whole cost of new accommodation (following *Roberts –v- Johnstone*) and the (possibly substantial) funding shortfall will have to be met from the claimant's other resources or damages.

### By whom?

- A case manager or occupational therapist may be able to advise upon minor property alterations, whether they be permanent or short-term. Examples include installation of hand rails by doorways, stairs, bathrooms etc, wheelchair ramps, widening doorways, stair lift, internal layout of the home.
- If major alterations are needed to an existing property or the construction of a new purpose-built home an accommodation professional will need to be consulted (preferably on a joint instruction basis). Usually a surveyor or architect who will assist and provide experience of designing or adapting accommodation according to the needs of the claimant.
- The professional should be familiar with the framework surrounding local government grants and local authority statutory obligations (though the latter is subject to availability in terms of budgetary restrictions, available properties and waiting lists). This is particularly important for claimants whose Damages are reduced due to contributory negligence.

### What to expect?

- Following consideration of such medical evidence as may be available the professional will attend at the property and consider what, if any, adaptations or alterations may be appropriate to enable the claimant to function as normally as possible.
- For the more serious long-term injuries there are numerous aspects to take into account, such as the possible need for a live-in nurse or carer. In these cases, the property may need to be larger to allow additional and private living space or may be deemed to be inadequate and an alternative domicile might need to be sought.
- Having considered all of the above a report will be prepared and costings provided and the professional will then be able to project-manage delivery.

### Cost

The cost of an accommodation professional will depend on what is involved although the initial cost is likely to exceed £1,000

## 6. Nursing and Care

### Why?

Where there is a need, the objective will be to establish the most beneficial regime, aimed at ensuring the health and welfare of the injured person, and optimising independence and self-esteem by the most cost-effective means.

### When?

It is important to establish what arrangements will be beneficial at each stage of the recovery process. It is then vital that the case manager, or those reporting, are fully aware of the current medical prognosis, including any anticipated changes.

### By Whom?

The appointed case manager is likely to be the best choice, as they often possess all the relevant experience and information. The person chosen must have an understanding of the medical physical and psychosocial needs of the claimant, and how to provide for them. Separate advice may be needed from an occupational therapist as to aids and equipment.

### What to Expect

All existing reports will need to be considered and it may be beneficial to confer with the different disciplines involved.

There will need to be consultation with the claimant and his/her family and carers as well as those responsible for medical treatment. The report should address:

- The injured person's capacity for coping with the challenges of his/her injury and impairment;
- Existing care, by whom and in what environment;
- External features impacting on the situation, e.g. accommodation, social contact, locality and family dynamics;
- The level of nursing care required;
- Vulnerabilities – health and safety issues for the claimant and his/her carers at present and in the future;
- The need for an enabler (to provide unqualified but personal support);
- The need for domestic assistance;
- Details of equipment needed;
- Detailed cost of recommendations and suggested providers;
- Overall objectives, intermediate objectives and their timescales.

In cases of very serious injury, it should be remembered that the local authority may have a statutory responsibility for the clients care.

### Cost

This will depend upon the circumstances and the complexity of each case. Reports will cost from £1,000. Hourly charging rates are likely to range from to £90/100 per hour, but could possibly be higher.

## 7. Mobility

### Why?

Restricted mobility emphasises impairment and threatens independence.

Better mobility enhances independence

### When?

Immediate thought should be given to any impairment of mobility whether within the home or ability to travel.

Mobility within the home is often greatly improved by simple steps such as providing ramps and widening doorways for wheelchair users.

Longer-term projects, such as specialised wheelchairs or appropriate motor vehicles, may have to await some measure of medical recovery.

### By Whom?

Personal mobility can be assessed by an occupational therapist.

Disabled Living Centres exhibit and assist in identifying appropriate aids, including wheelchairs and prosthetic appliances.

Driving Assessment Centres or Mobility Centres can identify and address any barriers to independent driving ability, and can identify aids, adaptations or controls which might assist. A driving assessment will determine the right choice of vehicle.

Disabled living experts, usually architects, can advise on property alterations to ensure ease of access.(see section 5 "Accommodation")

### What to Expect

A report from any or all of the foregoing making recommendations and providing costings.

It may be proposed that the claimant or his/her family apply to the DSS for a Mobility Allowance (see s8). Help and/or payment under the Motability Scheme may defray the cost of a vehicle or adaptation for the injured person either as driver or passenger – see <http://www.motability.co.uk/main.cfm>

### Cost

Will depend on the professional instructed

A driving assessment may be free or could cost £50 to £100 or more, at a mobility centre.

The Disabled Living Centres provide advice and recommendations on equipment at no cost.

## 8. Vocational

### Why?

A return to work is more likely to raise a claimant's self-esteem than anything else. It provides independence and self-respect.

### When?

Subject to the views of the existing healthcare team, a claimant should be helped to return to work as soon as possible

It will be necessary to:

- a. Take early steps to consider, with the involvement of the employer, the preservation of the claimant's pre-accident job, by adapting the workplace or duties in accordance with the Disability Discrimination Act 1997; (Insurers may be willing to fund the necessary steps to achieve these goals.)
- b. Identify whether the claimant is able to undertake preparatory activities. For example, it may be possible to return to light duties, or perhaps voluntary work, or work placement, which could assist to build up physical stamina and maintain a focus on employment
- c. Investigate alternative avenues if remaining with the pre-accident employer is not possible, or the client is not employed at the time of the assessment.

### By Whom?

A vocational or employment rehabilitation professional should assess in association with the claimant, the medical team, the employers, and the unions, the claimant's suitability to return to work and his/her requirements.

A vocational report should not be confused with the reports commonly commissioned from employment consultants. The latter are generally designed to assist in the quantification of loss, whereas the former is intended to identify the injured person's potential and motivation for employment, and to recommend how to achieve a return to suitable work. The professional instructed should preferably know the local area and sympathetic employers, whilst having a good working relationship with the Disability Employment Advisor.

### What to Expect

A detailed interview should be undertaken to identify the claimant's former work experience abilities and qualifications, his/her aspirations, and a general assessment of his/her current physical and mental ability, focussing on transferable skills and any perceived barriers to employment.

The next stage should, ideally, be a discussion between the vocational professional and the previous employer with a view to identifying whether re-employment is possible, either in full or reduced capacity; whether other placements may be available; and/or whether adaptations to the work place may be necessary to facilitate such employment.

The vocational consultant should be able to advise the employer on accessing funding for any required adaptations from programmes such as the Access to Work Scheme.

If employment with the pre-accident employer is not possible for whatever reason, then consideration will be given to other suitable local job opportunities.

Clients with complex injuries or where functional capacity and/or transferable skills are difficult to assess may require more in-depth functional assessment

There are numerous facilities nationwide where such assessments can take place either on a day or residential basis. Assessments take place in a working environment and measure dexterity, co-ordination, ability, communication skills, confidence and motivation. Speed, ability and quality of work is recorded, assessed and reported upon.

Following assessment, recommendations may include finding a work placement properly suited to the claimant's skills and abilities or sending the claimant on a training scheme to learn new skills. Another possibility is for the claimant to be supported by a trainer or friend, who would work alongside him/her in a work placement until confidence is gained in employment skills.

A return to some form of remunerative employment is the most effective way an injured person can regain his/her self-esteem and achieve an improved quality of life.

### Cost

This will vary depending upon the type of assessment and the time it takes. Expect charges to range from £500 to £1,500 for a vocational interview and report. More detailed assessments will cost more. A residential five-day assessment is likely to cost more than £2,500.

## 9. Case Management

One of the first decisions to make is who will manage the rehabilitative process. The various specialist disciplines are outlined above. The task of organising so many disciplines may seem daunting, but help can be found.

One way is to use a case manager to act as case co-ordinator.

(In minor cases the appointment of a case manager would likely be inappropriate although an early assessment of the injury and treatment options will be required.)

The appointment of a Case Manager at an early stage in the claim will need to be discussed and preferably agreed with the claimant and the insurer. The Case Manager's first responsibility is to the injured person. Remember the guidance given by the courts in *Wright -v- Sullivan* that such an appointment should be made by the claimant's solicitor, funded by the insurer. The notion of "joint appointment" was not considered appropriate. BICMA's view is that best outcomes are obtained for all where there is agreement including both the commitment and the entitlement to participate constructively in the development of the rehab plan.

A case manager must have the time available to deal with the claimant and preferably be based close to the claimant. Close contact will be required with both the claimant and his/her family.

Case managers can come from a variety of disciplines, but look for someone trained and committed to the standards laid down by the Case Management Society of the UK (CMSUK), The British Association of Brain Injury Case Managers (BABICM) or the Vocational Rehabilitation Association (VRA). It would also be beneficial to ensure that your case manager adheres to the BICMA Quality Standards as annexed to this Guide.

There are a number of specialist case management organisations in the UK, although the number of claimants is likely to outweigh the availability of specialists for some time to come.

A case manager will co-ordinate all of the available services and should be required as appropriate to:

- Engage the claimant in consensual, fully informed, goal setting and planning;
- Assess the personal circumstances and needs of the claimant and his/her family;
- Monitor medical rehabilitation and, if necessary, provide for multi-disciplinary assessment;
- Monitor psychosocial rehabilitation and, if necessary, provide for assessments and interventions;
- Liaise with the Benefits Agency and claim appropriate benefits;
- Liaise with the local authority for interim support prior to a statutory assessment (currently Community Care Act 1990); review such assessment and negotiate the provision of services and financial assistance from the local authority;
- Arrange for therapies;
- Monitor the needs of the claimant's family and arrange for respite care, if necessary;
- Assist the claimant in obtaining training and monitoring carers;
- Facilitate employment rehabilitation;
- Arrange appropriate accommodation;
- Review personal transport arrangements;
- Consider mobility issues;
- Consider funding arrangements for rehabilitation.

### Cost

Following an initial assessment, case management will normally be charged on an hourly basis (expect to pay between £85 and £105 per hour). Input by a case manager should reduce once rehabilitation needs have been addressed.

## 10. Appendices and additional reading

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### Further reading:-

- "Work & Health" published by TSO – contact 0870 600 5522 quote ISBN 9999072399
- "Helping staff back to work – Guidance for line managers" Airmic and CBI – download at [http://www.airmic.com/en/other/document\\_summary.cfm/docid/189B32EO-4A72-A1A56BAE8722DAB](http://www.airmic.com/en/other/document_summary.cfm/docid/189B32EO-4A72-A1A56BAE8722DAB)
- "Helping staff back to work – Guidance for senior executives" Airmic and CBI - download at [http://www.airmic.com/en/document\\_summary.cfm/docid/BC4557E1-B99E-4B14-8232BE888EC44A80](http://www.airmic.com/en/document_summary.cfm/docid/BC4557E1-B99E-4B14-8232BE888EC44A80)
- "The Rehabilitation Code" – download at [http://www.bicma.org.uk/The\\_2007\\_Rehabilitation\\_Code.pdf](http://www.bicma.org.uk/The_2007_Rehabilitation_Code.pdf)

## Quality Standards for Providers of Rehabilitation

### Purpose

The provision of rehabilitation involves many disciplines of which most are already regulated by their own professional bodies. To provide one individual body capable of regulating all of these disciplines will prove difficult, if not impossible, but in the meantime, there is a need to provide purchasers with an assurance as to the quality and/or standard of service that they can expect from their chosen provider. With this in mind, BICMA proposes a generic document setting out minimum standards to be expected from practitioners involved in the rehabilitation process to include all disciplines, both medical and other.

### Agreement to these standards would constitute a commitment that:

a  
any person involved in providing the service shall be appropriately qualified, shall be a member of their appropriate professional body and shall act in accordance with the standards of practice of that professional body.

b  
there shall be, in respect of any such service as is provided, appropriate and proper professional indemnity and liability insurance.

c  
the duty of the provider of any service is to the injured party, who is at all times the client, and that duty shall be independent of any claim or litigation.

d  
the services and/or recommendations provided shall be appropriate, timely, reasonable and not influenced by the source of instruction..

e  
in the provision of any services, account will be taken of the availability of such services within the National Health Service and/or the relevant Statutory Services provisions.

f  
Terms of business and transactions, including any credit arrangements, will be open and available to inspection by any legitimate interest.

By adhering to these quality standards and conditions, the provider demonstrates both independence and the commitment to deliver a quality service and, despite no provision for regulation, should the provider be found to be in breach then he would in effect be in breach of the terms of his contract with the instructing party.

It is not intended that these standards should go in place of any eventual regulation that may be considered necessary and/or appropriate, but that they provide some assurances of the quality of provision of services in the shorter term.

Providers wishing to publicly adhere to these services should be provided with the opportunity of signing an appropriate document to be held by BICMA, who would undertake to provide a register of those providers willing to adhere to these standards on its website and the providers would be invited to declare themselves as signatories on their letterhead and/or marketing material.

# Mediation Scheme for Rehabilitation Disputes



### CMC/BICMA/NMH SCHEME

1. It is widely recognised that since the introduction of The Rehabilitation Code in personal injury claims, many thousands of people who would otherwise have had little or no immediate rehabilitation have benefited from expert care and assistance. This has been of clear importance to the injured person and it is also of significant benefit to the insurer in promoting the best outcome as well as to the State in reducing the dependency upon NHS provision.
2. BICMA, the Bodily Injury Claims Management Association which draws representatives from all sides of the personal injury world together and instigated the principle of immediate needs assessment in personal injury claims so as to allow an injured person early access to appropriate rehabilitation is pleased that it remains a vital piece of the compensation jigsaw. BICMA is therefore a strong supporter of The Rehabilitation Code. Unfortunately, disputes can arise between the parties as to the direction that such rehabilitation should take and, on occasions, the choice of individual providers. This creates inappropriate delay.
3. To avoid this slough of inaction, BICMA is promoting proportionate resolution of such disputes through telephone mediation. It believes that the provider of the service should be neutral and national, offering readily accessible mediation at an affordable fee.
4. Following discussions with the MOJ, HMCS, and the Civil Mediation Council (CMC), BICMA is to fund a pilot scheme under the National Mediation Helpline (NMH)'s auspices to see whether telephone mediation would offer a viable and reasonably successful option for the resolution of rehabilitation disputes.
5. BICMA is funding and promoting the pilot scheme across the industry. It will also monitor on an anonymised basis the use of the pilot.
6. BICMA is working closely with the MOJ, HMCS, and NMH, as well as liaising with the CMC, during the establishment and life of the pilot. It is entrusting the running of the pilot to the NMH and its service provider and will not seek to interfere with operational matters, but will provide such support and assistance as is reasonably necessary. BICMA will publicise this scheme with the MOJ and CMC.
7. The pilot scheme was announced on 26th April 2007.
8. The life of the pilot is for 25 funded telephone mediations. It is anticipated that the scheme will run for 12 months.

#### Outline of the operation of the Scheme

9. The scheme is intended to allow parties to resolve disputes concerning rehabilitation to refer them to a mediator appointed from a panel coordinated by the National Mediation Helpline (NMH).
10. One, or both, parties may contact the NMH and ask for a referral under the NMH BICMA Scheme. The process thereafter is similar to that of any other NMH request with the main difference being that the panel for use in the pilot scheme is defined in

advance (see below) and instead of a referral on a regional/ rota basis to a provider, the NMH operator will refer to the next BICMA panel member.

11. The NMH operator will contact the next BICMA panel member and ensure that there is no conflict. Assuming that there is no conflict, the NMH operator will then confirm the appointment to the parties and the address to which the dispute summary should be sent.
12. The parties will then send a one page summary of their view on the dispute to the mediator. Once the mediator has received the summaries she/he will contact the parties by email to propose a date and time for the telephone mediation.
13. Once the date and time have been agreed, the insurer/defendant will arrange the telephone legal call with its chosen provider.
14. At the same time, the mediator will notify the NMH of the date and time for the hearing.
15. The mediator will then conduct the hearing and, on completion, notify the NMH of the outcome. The mediator will also complete such research forms as may reasonably be required by Dr Auty.
16. The NMH will notify the Treasurer of BICMA who will despatch a cheque made payable to the mediator.
17. The NMH will keep a record of the number of mediations undertaken under the pilot scheme. When this has reached 25, the NMH will notify the Secretary of the CMC and an urgent meeting will be arranged to look at future arrangements for the scheme.

#### Monitoring of panel

18. Dr Andrew Auty, an Oxford academic and a member of BICMA, has agreed to monitor the work of the panel as indicated above. He will be given necessary access to anonymous NMH records and will collate and present the results of his research of the pilot scheme to BICMA after 25 mediations. This research will be passed to the MOJ and CMC.

#### The BICMA Scheme pilot panel

19. Five carefully selected volunteers are accepting mediations under the scheme so that they can report back with the advantage of five mediations each. They are:

Paul Randolph	RPSPC	London	(ii)
David Cook	LADR	London	
Judith Kelbie	LDDR	Leeds	
Steven C Jones	SOUTHERNHAY	Exeter	
John Gunner	InterResolve	London	
20. Jonathan Dingle as BICMA's representative is being kept informed of progress and is acting as a referee for appointments. In the unlikely event that none of the five are available a contingency plan exists.
21. Contact details for the five volunteers for the pilot scheme are held by the NMH. These include mobile telephone numbers and emails.

### Summary Rehabilitation Code August 2007 ("Rehab Lite")

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

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Claimant Solicitor	<ul style="list-style-type: none"><li>● 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</li><li>● Give earliest possible notification to compensator of the claim and need for rehabilitation</li><li>● 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</li></ul>
Compensator	<ul style="list-style-type: none"><li>● Shall equally consider and communicate at earliest practicable stage whether the claimant will benefit from rehabilitation</li><li>● Where the need for rehabilitation is notified to the compensator by the claimant solicitor, the compensator will respond within 21 days</li></ul>
Parties	<ul style="list-style-type: none"><li>● Consider choice of assessor and object to any suggested assessor within 21 days of nomination</li></ul>
Immediate Needs Assessor	<ul style="list-style-type: none"><li>● Assessment to occur within 14 days of referral letter</li><li>● Provide report simultaneously to parties</li></ul>
Compensator	<ul style="list-style-type: none"><li>● Pay for report within 28 days of receipt</li><li>● Respond substantively to recommendations to claimant solicitor within 21 days of receipt of report</li></ul>

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## Agreement for Immediate Needs Assessment (INA)

1. The Claimant is making a Claim for compensation for Personal Injury against the Defendant.  
The Insurer is handling the claim on behalf of the Defendant.
2. The Claimant and the Insurer wish to identify the immediate needs of the Claimant so as to help the Claimant's recovery and rehabilitation.
3. The Insurer will pay the cost of the INA and where reasonable and necessary fund its implementation.
4. The Claimant and Insurer jointly appoint the Assessor to investigate the Claimant's immediate needs and provide an Immediate Needs Assessment (INA) in accordance with the Rehabilitation Code.
5. The Assessor shall in the INA identify the Claimant's immediate needs and offer practical suggestions as to how to those needs can be met together with details of possible providers, availability and cost. (See Appendix for further details.)
6. The Claimant and the Insurer will:
  - i) co-operate with each other and the Assessor; and
  - ii) within 28 days of receipt of the INA give notice to the other and the Assessor that they accept reject or make alternative proposals to those set out in the INA but failing such notice shall be deemed to have accepted the INA
7. Any such notice will give reasons for rejecting or varying those parts of the INA that have not been accepted.
8. The Claimant and the Insurer agree that the purpose of the INA is to assist with the rehabilitation of the Claimant and is not intended for use in legal proceedings concerning the Claim. However if either party refuses to implement the INA or fails to give good reason as at 6. above, the other party may refer to the INA in any proceedings.
9. The Insurer agrees that it will not challenge on grounds of cost or necessity any special damages claim subsequently made in proceedings by the Claimant for the cost of meeting the Claimants immediate needs as recommended by the INA save for those recommendations which the Insurer notified to the Claimant it did not accept.

SIGNED For and on behalf of the Claimant

Date...../...../200.....

SIGNED For and on behalf of the Defendant

Date...../...../200.....

### APPENDIX

#### **THE ROLE OF THE ASSESSOR/CASE MANAGER**

in preparing an Immediate Needs Assessment

The purpose of assessment as described within the Rehabilitation Code is to identify the immediate rehabilitation needs of an injured person. The Code specifically excludes consideration of causation, liability or quantum and reference to any long-term care needs within the INA.(Clause 5.3)

The report should identify the immediate needs and offer practical and timely solutions together with details of providers, availability and cost.(Clause 5.2 )

In practice the Immediate Needs Assessment report should not make recommendations for e.g. a course of treatment/rehabilitation or adaptations to property. Recommendations can properly be made to the appropriate experts in these disciplines who in turn will assess and advise.

The sole purpose of the report is to identify the injured person's disability and circumstances and to make recommendations as to those needs that will immediately aid their recovery, rehabilitation and quality of life.

The need for further or subsequent assessment or treatment shall be agreed between the parties (Clause 6.5)

See Bodily Injury Claims Management Association website for a copy of the code and the practitioners guide -

## Appendix E

### Social Security Benefits

#### Aim

To maximise benefits and to preserve the right to means-tested benefits.

#### NON MEANS-TESTED BENEFITS

There are four main groups of non means-tested benefits that are payable as a consequence of disability:

1. **Incapacity for Work**
  - Incapacity Benefit
  - Statutory Sick Pay
2. **Care and Supervision**
  - Disability Living Allowance
  - Care Component
  - Attendance Allowance (for those aged over 65)
  - Carers allowance
3. **Mobility**
  - DLA Mobility Component
4. **Degree of Disablement**
  - Severe Disablement Allowance
  - Industrial Disablement Benefit

Receipt of the Disability Living Allowance acts as a gateway to the following benefits:

- Disability Premium;
- Severe Disability Premium;
- Independent Living Funds;
- Motability Scheme.

DLA comprises a care component and a mobility component. The care component is for personal care needs and is paid at three different rates. The mobility component is paid at two different rates.

#### Industrial Injuries Benefit

This benefit is paid to those who are disabled by a loss of physical and mental capacity caused by an industrial accident or disease.

It is paid in addition to any other non means-tested benefit.

#### Incapacity Benefit

This is paid to those who are unable to work due to disability. It is non means-tested, but it is only payable if sufficient national insurance contributions (NIC) have been made.

#### MEANS-TESTED BENEFITS

- Income support
- Housing benefit
- Council tax benefit
- Tax credits
- The social fund

#### Income Support

The entitlement to income support is the gateway to the other means tested benefits.

The Income Support Regulations are changed often and regard must be given to the income and capital limits in current amendments.

Income support is paid to a claimant aged between 16 and 60 if he/she is incapable of working, and to a carer if regularly and substantially engaged in caring for another person.

There is an upper limit on the amount that can be earned while receiving income replacement benefits (such as Incapacity Benefit, Income Support and Jobseeker's Allowance). These are linked to other benefits (such as Housing Benefit and Council Tax Benefit). Payment of both income related and any linked benefits may be reduced or cease if income is over the permitted limits.

Capital owned by a claimant's partner is taken into account.

There is a lower limit of £6000 (or £10,000 if in residential care), which is taken into account on a sliding scale equated to income up to the upper limit of £16000 beyond which he/she does not qualify for income support.

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The capital limits apply to most other means tested benefits.

Income support is not payable if the claimant works more than 16 hours per week or his partner works more than 24 hours but Disability Working Allowance was introduced in April 1992. It was designed to help people with long term disability or illness to find or stay in work. DWA worked by topping up low wages of those working at least 16 hours per week but having an illness or disability which limited their earning capacity. Disability Working Allowance was withdrawn and replaced by a cash "tax credit" as from 5th October 1999, linked to the PAYE system and paid by employers as from April 2000.

### **Housing Benefit**

This applies to claimants who pay rent but there is a sliding scale if income exceeds income support limits.

### **Council Tax**

Similar to Housing benefit in that there is a sliding scale if income exceeds income support limits. There are reductions for those who live alone or have adapted their accommodation because of disability. Carers living with and spending more than 35 hours a week caring for a claimant who gets the care component of Attendance Allowance or Disability Living Allowance may be entitled to exemption.

### **Working Families Tax Credit**

Working Families Tax Credit is for working people who are bringing up children and in employment for 16 hours or more a week. It is for two parent and one-parent families. Employees and the self-employed can claim.

### **The Social Fund**

The Social Fund is a system of grants, loans and payments administered by the Benefits Agency including Community Care Grants, Budgeting Loans, Crisis Loans, Funeral Payments, Maternity Payments and Cold Weather Payments. There are different rules for Grants and Loans than there are for Payments. Loans and Grants depend on the amount of money available in the Social Fund Budget and also on the current list of priorities the Social Fund Office has at that particular time.

### **How to Claim**

There is discretion to accept anything in writing "as sufficient" in the circumstances of a particular case.

Income support is paid from the date of notifying the Department of Work and Pensions, so long as the claim form is returned within one month. There is discretion to extend time limits in some cases.

DLA is paid from the date a claim form is requested, provided the claim form is returned within six weeks.

Claims for Benefits should be made to a local DWP Office or claim forms can be downloaded from the DWP website.

Appeals are made to the local DWP Office. An appeal can be made within three months of any decision. There is some discretion to extend the time limit up to six years, but it is difficult to make a late appeal.

Claims for Housing or Council Tax benefits are made to the local authority for the area where the claimant lives.

### **The Effect of Receipt of Damages on Income-Related Benefits**

Lump sum payments of compensation are treated as capital and are added to any other capital that the claimant may have. The effect is that:

- A claimant or partner may have up to £6,000.00 (£10,000.00 if in residential care) in capital and benefit will not be affected;
- Deductions are made on a sliding scale in Income Support, DLA, Housing Benefit and Council Tax Benefit, depending on the amount of capital;
- Generally, means-tested benefits are not payable where there is capital in excess of £16,000.
- Benefits paid to a claimant can be preserved by creating a personal injury trust or ensuring the damages fund is administered by the court
- The trust may be set up by the claimant or someone acting on behalf of the claimant.
- The capital value of the trust fund is wholly disregarded;
- Payments from the trust fund to the claimant or on his/her behalf will be treated as income or capital, depending on frequency of payment and the terms of the trust;
- Regular discretionary payments will be disregarded, provided they are used for needs other than those intended to be covered by benefits.

A decision of the Social Security Commissioner (1996 3J.S.S.L.D.136) makes it clear that money in the Court of Protection should not be taken into account for entitlement to Income Support under the terms of Paragraph 12 to Schedule 12 of the Income Support (General) Regulations (as amended).

## Appendix F

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### Care in the Community

#### Aim

To ensure that disabled persons are provided with care and health services and accommodation, suitable to their needs, when they have insufficient financial resources to purchase such services or accommodation.

Community care services are created by statute to meet the needs of persons in need of care and attention. The duty to provide social care services falls primarily upon local authorities but may also be shared with the NHS who may have sole responsibility if the services are to meet health needs – see *R v North and East Devon Health Authority ex p Coughlan* [2000] 2 WLR 622

#### Social Services

Social services are provided pursuant to the National Health Service Community Care Act 1990 by local authorities' Social Services departments, who are entitled to call upon:

- Health Authorities; and
- Housing Departments.

The trigger for support is an request for assessment for a disabled person's needs by the local authority pursuant to Section 47 of the NHS and Community Care Act 1990.

Social Services are obliged to carry out an assessment within a reasonable time as soon as they are made aware that there is a person in need of care and attention who is ordinarily resident within the area for which they are responsible.

Notification of the need may come from any source.

The financial resources of the disabled person are irrelevant to the duty of social services to carry out an assessment.

Once an assessment has been carried out, a written copy must be provided by the Social Services department. A complaints and review procedure is available if the assessment is considered unsatisfactory.

Following assessment, the local authority must make a decision about whether to provide services and the type of services to be provided.

Social services available include:

- Home helps or carers;
- Respite breaks for carers;
- Laundry service;
- Therapies;
- Odd job scheme;
- Rehabilitation;
- Carer support;
- Residential care;
- Transport;
- Housing adaptation;
- Provision of accommodation suitable to the claimant's needs.

The provision of services may be dependent upon the resources of the local authority. Each local authority publishes eligibility criteria. Certain services must be provided under a legal duty. Other services may be provided on a discretionary basis, but there is no duty to do so.

Eligibility criteria are set out in policy guidance "Fair Access to Care Services" which may be found online at [www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_4009653](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4009653)

Section 2 of the Chronically Sick and Disabled Persons Act sets out services that must be supplied as a legal duty:

- Home help;
- Provision of radio, television, library or residential services;
- Home adaptations for greater safety, comfort or convenience;
- Holidays;
- Meals;
- Telephone.

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The local authority will formulate a case plan, which will be administered by a case manager. This will specify all needs, including those that cannot be met due to budget restraints. Local authorities are empowered to make direct cash payments to disabled persons so that they can purchase care services for themselves (Community Care (Direct Payments) Act 1996). In addition, cash payments are available from Independent Living Funds and from the DSS.

If the claimant needs suitable accommodation, the local authority has a duty to provide this pursuant to Section 21 of the National Assistance Act 1948.

Residential care can be arranged by both local authorities and health authorities. Provision of residential care by a health authority is free, but DSS benefits are treated as if the claimant were in hospital. A local authority has a duty to charge for residential care are subject to means testing. Residential care includes the provision of basic accommodation.

A local authority has discretion to charge for domiciliary services provided in other than residential care.

The right to charge for services is subject to a two-stage test:

- 1. Whether it is reasonable in all the circumstances;
- 2. Whether the claimant has sufficient means to pay for the services.

A damages fund derived from a personal injury claim may be disregarded for means testing by placing it in a personal injury trust or if it is administered by the court. The mechanism by which this is achieved was introduced by the National Assistance (Assessment of Resources) Regulations 1992 SI no. 2977 which mirrored the disregard of resources provided by the Income Support Regulations – see Social Security Benefits below.

There is government guidance on means testing binding on local authorities. In the case of residential care see “Charging for Residential Accommodation Guide” and in the case of domiciliary services “Fairer Charging Policies for Home Care and other non residential Social services.” These Guides may be found online at ;

- [www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_4107292](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4107292)

A claimant can choose his/her preferred accommodation and can ask a third party (e.g. an insurer or tortfeasor) to meet any shortfall if the cost is more than the local authority would normally pay.

If a local authority provides services free of charge, a claimant may not be able to make a claim against a tortfeasor in respect of such services.

### **NHS Services**

NHS services are free and not subject to means testing.

The relevance is illustrated by the Coughlan case referred to above in which the claimant had been charged by her local authority for residential care. She successfully claimed that her residential care was not due to social care needs but to health needs which meant the NHS should pay for her care home and could not charge her.

It is unlawful for social services to provide a service which can be provided by the NHS. The distinction between social care and health care is blurred and residence in a care home rather than a nursing home does not mean the NHS has no responsibility for continuing care.

Home care by a spouse or untrained carers may also be a NHS responsibility if health needs are the primary cause of the need for care – see The Health Service Ombudsman report in the Pointon Case no. E.22/02/02 – 03 Funding for Long Term Care.

NHS duties for care are set out in the “National Framework for NHS Continuing Healthcare and NHS funded Nursing Care in England, 2007” and the “NHS Continuing Healthcare ( Responsibilities ) Directions 2007, accessible online at ;

- [www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_076288](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_076288)
- [www.dh.gov.uk/en/Publicationsand statistics/Legislation/DH\\_078059](http://www.dh.gov.uk/en/Publicationsandstatistics/Legislation/DH_078059)

A duty is placed upon the NHS by the Community Care (Delayed Discharges ) Act 2003 and the Delayed Discharges (Continuing Care) Directions 2007 to ensure a safe discharge from hospital. This means that steps must be taken to assess continuing healthcare needs and, if social care is required, to notify social services of the need for a s.47 Community Care Act 1990 assessment. If social services fail to meet the needs a safe discharge cannot be given and social services must pay a daily charge to the NHS for the delay. It follows that the hospital discharge co-ordinator should be made aware of the lack of suitable accommodation or care before discharge is contemplated.

It remains to be seen whether the NHS may make Direct Payments to fund care in the community. The National Framework says not but that is contrary to the finding in *Gunter v SW Staffordshire PCT* [2005] EWHC 1894 (Admin). In any event policy guidance is that in determining whether to maintain an existing package the PCT should take into account the individual's preferences wherever possible and there is no bar to a PCT funding care from a private agency.

## Appendix G

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### Emotional and Psychological Care

Any injury can give rise to or amplify psychological and social problems. Dealing with these is every bit as important as tackling physical symptoms and physical impairments. There is good evidence that psychological and social problems are among the most significant obstacles to full recovery and rehabilitation and that these obstacles can be accurately identified and dealt with.

Often, obstacles to recovery will not be apparent immediately after the injury is sustained and will be first identified by a practitioner when the expected recovery path is not followed e.g. there is an apparently inexplicable deterioration.

Around 20% of injured adults encounter significant difficulties disproportionate to the physiological injury that persist after the best medical plateau has been reached. These difficulties stem from involuntary psychological factors, such as beliefs and expectations and, occupational or social constraints: collectively termed "psychosocial" problems.

The common misconception is that psychosocial problems experienced after injury will be entirely resolved by physical medical interventions. This may lead to persistent treatment seeking behaviour; a **key** stumbling block for patients, colleagues and close contacts alike. Unless social problems such as transport, workplace adaptations, domestic adaptations, and communications are effectively addressed they can maintain or amplify psychological difficulties.

Without appropriate psychological, occupational and social interventions, problems become self propagating in around 5% of injury cases. This inevitably interferes with treatment, therapy and social rehabilitation. The injured person often looks de-motivated, fearful, anxious and even depressed. In these cases, where the pathology does not seem to provide a ready explanation for the degree of disability or loss, and continued deterioration, it is important to recognise that exclusive focus on biomedical care could actually delay recovery and rehabilitation.

Psychiatric injury and brain injury cases are likely to involve some psychosocial problems. These are a small minority of injury cases, perhaps disproportionately represented in liability rehabilitation practice. The great majority of problematic psychosocially mediated outcomes concern people with minor injury or minor injury symptoms.

Potentially significant psychosocial problems are usually apparent within a matter of days or weeks following injury. It is important that health care providers and others try to identify these as early as possible and develop a plan to provide suitable support and/or interventions.

Normal early responses to injury include confusion, uncertainties, anger, denial and inaccurate expectations. Early reassurance is important to normalise these experiences and to begin the process of acceptance and coming to terms with the injury and its meaning. This process is important for both the injured person and their close social contacts. Such reassurance ought to be provided at each stage in the process of medical care e.g. by emergency workers, and throughout the process of social and occupational rehabilitation. Close social supports can be important contributors to this process.

Early psychological and social interventions prevent deterioration and accelerate good outcomes. Interventions also work in those cases where difficulties have become self propagating, but the intensity of work required is much greater.

A return to work process can often be started while physical and psychological interventions continue.

If work absence exceeds a few weeks it is common practice to use a graduated return to work, beginning part time. Workplace adaptations or changes in job tasks can help meet intermediate goals. Early return to work contributes to recovery.

Interventions should be reviewed to ensure that they do not become maintaining factors for other problems.

A stepped care approach is often the most appropriate one. This means that specialist involvement increases as diagnostic severity increases or as the case fails to respond as expected. Some more severe cases will require specialist psychological/psychiatric attention from the outset and some may need psychotropic medication e.g. brain injury (neuropsychologist or neuropsychiatrist) or psychiatric diagnosis (clinical psychologist or psychiatrist). There is a **considerable** overlap of skills between clinical psychologists, neuropsychologists and neuropsychiatrists. Initially less severe cases may only require such assessment and treatment if they fail to respond as expected.

In most injury cases, early identification of potential obstacles to full rehabilitation requires training in using the bio-psychosocial model and assessment tools.

Occupational therapists, increasing numbers of rehabilitation case managers, counselling psychologists and many degree level allied health professionals may offer this service. Each should be able to recognise when referring up is required. Each should be able to provide, or facilitate, goal identification, problem solving, consensual planning, basic cognitive and behavioural interventions and, most of the common social and occupational interventions.

Psychologists and psychiatrists use interviews to form a diagnosis, Psychologists often use questionnaire based tools as well. Diagnosis provides the basis for selecting appropriate interventions. Interviews and questionnaires are then used to assess

## Appendix G

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the progress of interventions. Occupational therapists, case managers, counselling psychologists will probably use questionnaires to identify obstacles to recovery in cases where no psychiatric diagnosis is suspected.

Psychological interventions should ideally be coordinated with biomedical, social and occupational care but in practice the different professionals often do not communicate well. Case managers can help with this.

Patients and their advisors can be surprised to learn that the real obstacles to rehabilitation are not purely medical ones and some will be unable to engage. This reaction must be handled with sensitivity but it is becoming less common.

Patients and those close to them e.g. relatives, friends and employers, should ideally be actively involved in a fully informed consensual process when deciding on social and occupational interventions and intermediate goals; this also is often left to the case manager to sort out.