

# Getting Back to Work

A Rehabilitation Discussion Paper



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## 2. Foreword

The health and safety of people at work is a major concern to many - employer groups, unions, insurers, health and welfare practitioners, lawyers and the Government. The drive to effect comprehensive risk management programmes to ensure people are not harmed by the work they do or their workplace has been of primary importance for a number of years.

Yet injury and illness still occur. In the majority of cases people return to work after only a few days of absence but a significant number remain absent for many weeks and months. It is widely accepted that the longer a person is away from work the less chance they have of returning to it. This has far reaching consequences for the injured person, their family, their employer and others.

Rehabilitation is used widely elsewhere in the world to facilitate an injured person's return to work. The timely implementation of a planned rehabilitation programme, structured to meet the individual needs and capabilities of the injured person, has been shown in other countries to improve recovery from injury or illness.

Yet the UK lags behind other industrialised nations in its provision of long-term treatment for people injured or made ill by work. There is a clear need to improve the current healthcare provision to optimise the opportunities of returning to the workplace.

ABI has held discussions with TUC and representatives of CBI, the Association of Personal Injury Lawyers, the Forum of Insurance Lawyers, Loss Prevention Council, the Department for Work and Pensions and the Department of Health. The ABI then set up the Joint Working Group on Rehabilitation (JRWG) with representatives of these organisations to examine how the practice of rehabilitation could become more widely used in the UK. This paper follows up the discussion of that group. It looks at what is happening within individual stakeholder groups and identifies those barriers – both real and perceived – that currently inhibit access to rehabilitation services.

Rehabilitation is a complex matter and no one involved with this report underestimates the time and effort needed from stakeholders to effect change. Achieving change will require a major shift in attitude and approach to existing working practices. But we believe that by engaging interested parties in the debate for change now, we can overcome the barriers and see consistent, high-quality rehabilitation become commonplace in the UK.

In order to improve and deliver an effective system of rehabilitation, current practices must be examined, critically appraised and discussed. This report aims to promote discussion and debate on the subject of rehabilitation to the workplace, to advance knowledge and interest in the subject and ultimately to facilitate the introduction of a more effective system of rehabilitation in the UK. We invite you to contribute to this vital discussion and look forward to hearing from you.



Mary Francis, Director General, ABI

June 2002



John Monks, General Secretary, TUC

### **3. Scope of This Report**

It is the case that the majority of accident victims referred to hospital for treatment, incurred their injuries at home or at leisure. A minority of cases occur at work, and only a small proportion of patients are injured in circumstances where someone else was responsible, entitling them to proceed with a compensation claim. For the purposes of this paper, the discussion is limited to the provision of rehabilitation for injury and illness that occurred in the workplace. Focusing on workplace injuries has allowed the group to examine the role of a large number of interested parties, including the injured persons, claimant solicitors, defendant solicitors, employers, insurers, Government and healthcare providers.

Ultimately, the Working Group would wish to see the UK operate a system whereby all those injured or ill and off work, regardless of the cause, could benefit from a rehabilitation programme.

### **Responding to this Discussion Document**

If you are replying on behalf of an organisation, it would be helpful if you could tell us what that organisation does and its aims.

Responses are requested by 1st September 2002 to:

Rehabilitation Consultation  
Association of British Insurers  
51 Gresham Street  
London  
EC2V 7HQ

or

rehab@abi.org.uk

## 4. What is Rehabilitation?

The Joint Working Group on Rehabilitation agreed that rehabilitation is not an isolated activity. It should be a seamless process whereby all the physical, psychological and social needs of the injured person are considered. It is integral to a continuum of care that starts with the provision of medical treatment(s) necessary to maximise recovery, moves through a functional assessment to set a baseline which reflects current abilities and how these can be maximised, to vocational (re) training to assist with current or alternative employment. It may be brief or prolonged, be provided in a single episode or require several interventions over a considerable period.

Therefore, the Working Group believes that:

“Rehabilitation should restore a person who has been injured or suffered an illness to as productive and as independent a lifestyle as possible through the use of medical, functional and vocational interventions”

Q1. Do you agree that the definition is appropriate for the promotion of an overall objective for rehabilitation to the workplace?

## 5. Introduction - Why Rehabilitation Now?

### Background

Back in June 1998, ABI and TUC co-hosted the conference “Rehabilitation: Getting People Back to Work”. This brought together delegates from across the wide range of stakeholders to hear both US and German practitioners outline their rehabilitation systems and consider what lessons the UK could learn from them.

That conference took place at a time of considerable change in the UK - economically, legally, politically and socially - that challenged, and continues to challenge, stakeholders’ traditional attitudes to and methods for dealing with injured people. It became clear that the long-term treatment of personal injury claimants had to be reassessed for the 21<sup>st</sup> century.

### Absence from the workplace- the cost to industry

The cost of workplace sickness absence<sup>1</sup> in the UK is significant. Statistics<sup>2</sup> published by the Confederation of British Industry indicate that in 2001 around 192 million working days were lost. It is suggested that 14.4 million<sup>3</sup> of these days lost could be due to work-related ill health. The costs – in both human and financial terms - of such injury and illness to individuals, business and the Exchequer are immense.

- **It is estimated that over 27 000 people<sup>4</sup> leave the workforce each year, never to return, as a result of injury or ill health caused by work.**
- **14.4 million days is equivalent to over 70 000 people off work all year round causing tax losses, benefits payments and health care costs.**

It can be argued that many businesses do not devote as much attention to health, safety and welfare matters as they should. Reasons for this vary from a lack of time and resources to not having a clear understanding of what actions they should take. But the cost of not assessing the risk to their business from employee accidents and workplace absence could have significant financial consequences.

#### *Impact on Small Businesses*

Employment in the UK is dominated by Small and Medium-sized Enterprises (SMEs – companies with less than 250 employees). SMEs account for 99% of all businesses in the UK and 32% of employees are in workplaces employing 49 workers or less<sup>5</sup>.

Small businesses are less likely to regularly experience serious threats to the health, safety and welfare of their employees. However, a bad accident could have a potentially devastating impact on an SME.

For example, the actual cost of employee absence and equipment damage will assume a greater significance for a small employer who cannot draw on a large balance sheet in order to maintain business continuity.

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1 This covers both ill health and personal injury

2 *Pulling Together: 2001 absence and labour turnover survey* - CBI

3 *Pulling Together: 2001 absence and labour turnover survey* - CBI

4 *Labour Force Survey 1997/98* - HSE

5 *Small & Medium Enterprises: their role in the economy* – Labour Market Trends Oct 99 – J Selden

### Direct and Indirect costs of Absence

Too often only the direct cost of employee absence is assessed by a business. However, there are significant indirect costs associated with absenteeism that go uncalculated and so are hidden from the company's profit and loss accounts.

Direct costs	Indirect costs
<ul style="list-style-type: none"><li>• Statutory sick pay</li><li>• Occupational sick pay</li><li>• Pension payments</li> <li>• Administration</li><li>• Overtime</li><li>• National Insurance payments</li><li>• Other insurances</li><li>• Compensation and legal costs</li><li>• Damage to property</li></ul>	<ul style="list-style-type: none"><li>• Unwanted staff turnover</li><li>• Lost or delayed production</li><li>• Inability to provide service to customers on time</li><li>• Damage to company's reputation</li><li>• Increased production or service costs</li><li>• Higher staffing levels</li><li>• Shortages of (skilled) labour</li><li>• Extra recruitment and training costs</li><li>• Low staff morale</li><li>• Increased risk of accidents</li></ul>

The HSE has undertaken research to try and measure the true cost of accidents. In 1997<sup>6</sup>, it sampled five organisations from various sectors of the economy and demonstrated that for every £1 spent in insured accident costs up to a further £36 can be spent in uninsured costs.

In 1994<sup>7</sup> a HSE report gave a breakdown of the costs of workplace accidents and ill health to industry: This estimated that:

- The average cost of an injury is between £550 and £630;
- The total cost of work accidents and ill-health to employers is between £170 and £360 per worker employed (as not every worker will suffer an injury or illness); for a business with 250 employees this amounts to an average cost of over £66,000 per year.

**The effect of workplace injury and illness is felt most keenly by the injured person themselves. Too often an incident results in permanent disability because the person didn't get the treatment they needed at the right time. This development into chronic injury has significant physical, financial and social implications.**

But employee injury and absence is not a matter solely of concern for employers.

Therefore, it is necessary educate all those concerned with employee injuries about the benefits that can accrue from undertaking a timely and effective rehabilitation programme. These include:

#### **The Injured Worker and their family**

- Medical recovery can be accelerated and enhanced by an assisted return to the workplace programme
- Successful rehabilitation would improve their long-term prospects in terms of quality of life, employment and reintegration into society.

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6 "The costs of accidents at work" HS (G) 96, Second Edition HMSO 1997

7 "The cost to the British economy of work accidents and work-related ill-health" N V Davies & P Teasdale HSE 1994

## **Lawyers**

- Rehabilitation fits with the requirements of the new Civil Procedure Rules (Woolf Reform) for more rapid assessment of personal injury cases.
- The assessment of damages for the injured person can be based upon more reliable calculations if the claimant has been enabled to undergo an energetic, concentrated and co-ordinated programme of rehabilitation at an early stage in the post-accident period;

## **Insurers**

- Provide the opportunity to reduce the injured person's loss and consequently reduce the magnitude of the claim.
- Reduce the likelihood of an aggressive adversarial position developing thus speeding up the settlement process and decreasing legal costs.

## **Government**

- Reduce the revenue lost to the Government through diminished income tax and national insurance contributions;
- Reduce the amount of State benefits paid to injured workers;
- Ease pressure on health services for treatment of chronic illness and injury arising from the workplace.

Q2. What fundamental concerns do you have, if any, with developing the UK's rehabilitation system?

Q3. Do you believe that a commitment to rehabilitate injured or ill workers should feature in a workplace health and safety strategy? Or should a mandatory Rehabilitation Policy be introduced for all companies, similar to the mandatory H&S policy requirements?

Q4. If yes, how do think this could most effectively be brought about?

Q5. In view of their widespread potential benefits, how do you think rehabilitation services should be funded?

## 6. The Injury Cycle

The timing of any rehabilitation intervention is a vital factor in determining its impact or success. A specialist intervention provided too early would waste resources in treating those cases that would recover fully with primary medical care. However, an intervention provided too late would use increased resources to manage a chronic condition that could have otherwise been avoided.

### Reporting of accidents

Whilst a number of indicators suggest rehabilitation services should generally be made available between 3 and 6 months from the date of injury, rehabilitation is often beneficial at a much earlier stage. Therefore, opportunities for referral to rehabilitation could be maximised by the earlier reporting of accidents and improved sharing of information along the employee-union-employer-insurer line.

RIDDOR (Reporting of Injuries, Disease and Dangerous Occurrences Regulations 1995) requires employers to report a major injury or an over-three-day injury – that is when an employee has an accident at work and is unable to work for over 3 days - to the Health and Safety Executive. However, only 40% of reportable workplace injuries are reported and occupational disease reporting is significantly lower<sup>8</sup>.

That said, RIDDOR has been simplified to allow employers to send information on all reportable incidents to a single point – the Incident Contact Centre based in Caerphilly. This aims to remove the concern about which office or enforcing authority an employer needs to report to and so, it is hoped, improve the reporting rate.

Notifications thereafter, in particular to insurers, vary according to the size and type of company; the employer's protocol for managing injuries; and the type and severity of injury.

Q6. What practices do you use currently, or are aware of, that are effective in ensuring early referral to rehabilitation services?

Q7. How could the current system be improved?

### Rehabilitation programme management

Research<sup>9</sup> by the Rehabilitation Studies Unit of the University of Edinburgh has indicated that while clinical management of personal injury claimants is good, often excellent, in the early stages following injury, there is a very real possibility that the benefits of such high quality care are offset by inadequate follow-up arrangements for the delivery of all the different services that may be required by individual claimants.

In some countries, the task of maximising the benefits of rehabilitative help is assigned to specially trained rehab coordinators/case managers recruited from various professions, including nursing. The UK does not have a formal rehab coordinator/case management system although there are several compelling reasons for developing such a service.

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<sup>8</sup> HSE evidence to the Environment Sub-Committee on The Work of the HSE – Oct 1999

<sup>9</sup> *Implementation and Evaluation of a Rehabilitation Coordinator Service* – Christine Davey, Disability Management Research Group, 1999

A coordinator/case manager must be able to deal effectively with all of the issues likely to arise throughout a rehabilitation programme and access specialist care as and when required. This advocates centralised case co-ordination in order to avoid conflictual plans being developed.

Two important principles underpinning any case manager programme are:

- That assessment and intervention should occur early; and
- Clients should have a participative role in their rehabilitation.

This second principle - the degree of autonomy or control given to patients within a healthcare or rehabilitation setting - has been the subject of much debate.

**Traditionally, the health or rehabilitation professional, as the "expert" has taken the active role; identifying both the problem and the solution and assuming that the patient both agrees with, and is willing to follow, the advice given. But the suitability of this type of relationship, particularly for rehabilitation, can be called into question by current thinking. Recent research tends to support a participative patient or client-centred approach is the most effective.**

In such a relationship - more accurately a partnership - there is a recognition that both the injured person and healthcare/rehabilitation professional have important contributions to make to the rehabilitation programme. Therefore, decision-making is joint and based on negotiation and mutual agreement within the overall objective of a rapid return to the most independent and productive lifestyle possible. Not only is this thought to improve outcomes, but this is also in keeping with widely held values about self-determination and people's rights to be involved in issues that affect their lives. Consequently the Joint Working Group believes that a participative, client-centred approach is needed in any coordinator/case manager system.

Q8. What professional experience do you think is best suited for the role of coordinator/ case manager?

Q9. Do you think an independent system of case managers should be developed in the UK?

Q10. How do you think a case manager system should be funded?

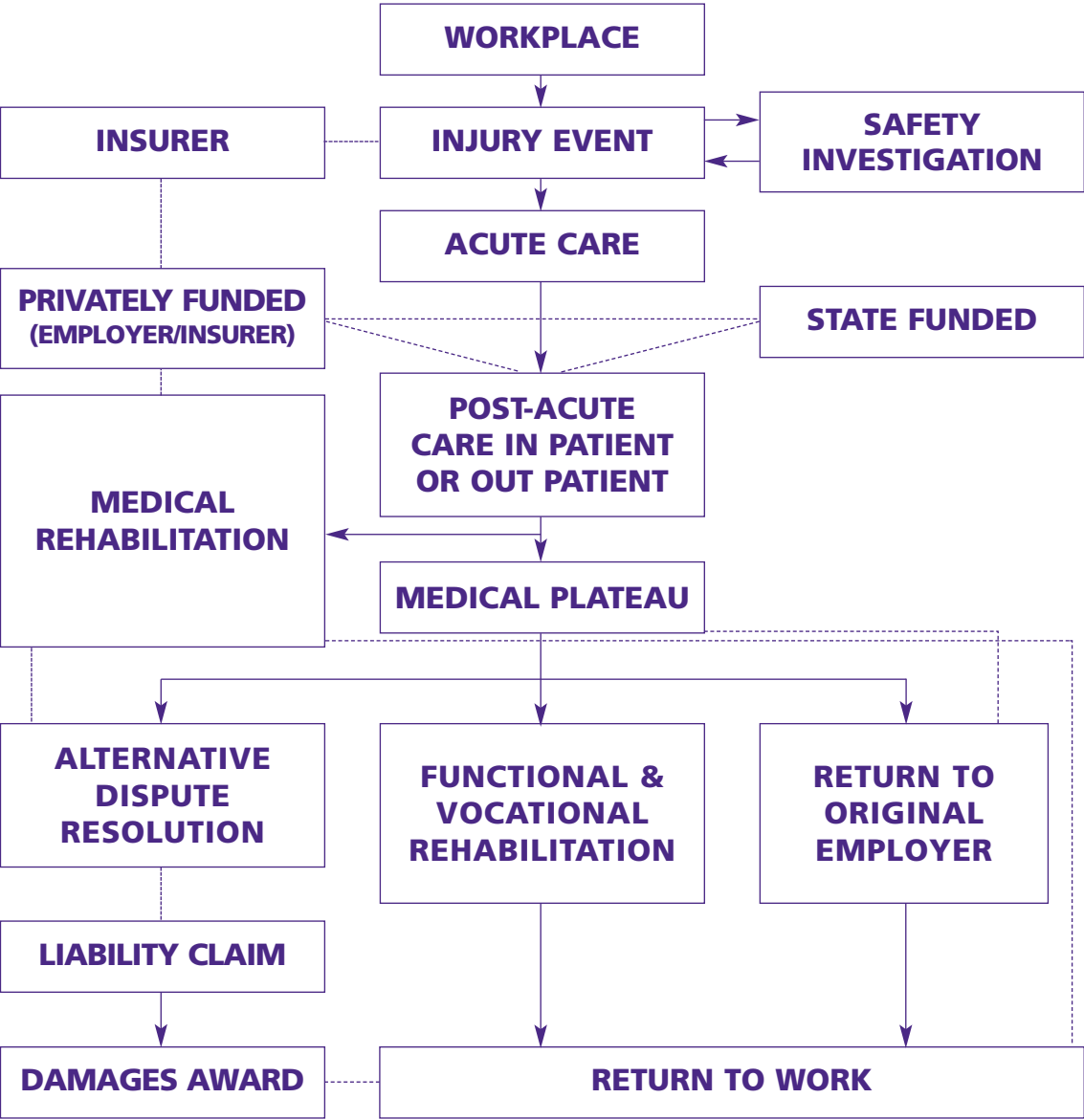
## Treatment Procedures

At the start of this paper we defined rehabilitation as a process through which an injured person would move and receive the necessary medical, functional and vocational interventions to return them to as productive and independent a lifestyle as possible. Further, it was suggested that these services should generally be made available between 3 and 6 months from the date of injury. The following treatment procedure flowchart is a very broad representation of the steps that could be taken to integrate rehabilitation into a return-to-work strategy. Any system that is developed must engender trust and co-operation across the employee-union-employer-insurer line and instil confidence in the injured person that they will be returned to work.

The flowchart includes the three phases mentioned above but, noticeably absent from it, are any indicators to the optimum time when the interventions should be provided. The dashed lines indicate where the Joint Working Group believes greater communication between stakeholders is required.

- Q11. Do you agree with the flowchart (see below)?
- Q12. When, following injury, do you think the intervention phases should generally occur?
- Q13. Do you think it is necessary to produce procedural flowcharts for individual rehabilitation interventions? If so, should they be generic or for specific conditions?
- Q14. What do you think the various stakeholders could do to bring about closer co-operation for the more extensive use of rehabilitation?

**Treatment Procedure Flowchart**



## 7. Reports

### Union and Employer Activity at Workplace Level

Unions and employers are approaching the issue of rehabilitation from different standpoints, but where they work together they could potentially help deliver effective rehabilitation and retention strategies in the workplace. A direct incentive for employers to promote rehabilitation can be taken from the fact that the majority of people who successfully return to work after an absence of more than six weeks on Statutory Sick Pay do so with their current employer rather than switching jobs.

#### Drivers to action

Unions have traditionally emphasised the need for prevention of work-related sickness and injury, and, when prevention has failed, have sought compensation. Unions handle over 85,000 personal injury cases a year (a far higher proportion of the total number of work-related cases than would be suggested by unions' share of the labour force), and secure over £300 million in compensation annually. But unions know that their members would prefer to return to health and to work rather than be paid off. They are also increasingly interested in the inter-relationship of rehabilitation and prevention. For example, where rehabilitation requires adaptations to the work process or workplace that may prevent further illness or injury.

Meanwhile, employers have become increasingly conscious that skilled labour is in shorter and shorter supply, that their increasing investment in staff training goes to waste when an injury or illness cuts short a career. Also, popular work-systems such as just-in-time production require people to be at work and not away for long periods of time. Sickness absence rates have reduced substantially over the last two decades, especially in the private sector, and rehabilitation and retention strategies offer the possibility to reduce them still further. There is a competitive advantage to ensuring that human capital is being used efficiently, an issue which will only increase in importance as European competition to British Industry also increases.

Other drivers, such as disability discrimination legislation and the costs of insurance and litigation are also important but are dealt with elsewhere.

#### Action by Unions

Unions have, for some time, promoted debate on rehabilitation. Starting in December 1996 with a conference on insurance and prevention, which focused for the first time on the potential for unions and insurers to co-operate on rehabilitation, the TUC has been raising the issue of rehabilitation wherever it can be usefully discussed.

In its response<sup>10</sup> to the Government/HSC *Revitalising Health and Safety Strategy* discussion document, the TUC submitted that everyone injured or made ill by work should have access to an individual back to work plan that would include extending employers' health and safety duties to cover rehabilitation.

They expanded this idea in their document "Getting Better at Getting Back"<sup>11</sup> – a consultation document that sought the views of trade unionists and others on rehabilitation.

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10 *Better Jobs for Better People* – TUC 1999

11 "Getting Better at Getting Back" – TUC February 2000.

This was followed up with a series of awareness-raising conferences in May and November/December 2000 at which representatives from across the key stakeholder groups, including Government Ministers from three departments as well as Ministers from the Welsh Assembly and the Scottish Executive, spoke. These conferences were reported in the papers "Getting Britain Back to Work"<sup>12</sup> and "Restoring Health, Returning to Work".<sup>13</sup>

The emerging themes from these conferences are echoed elsewhere in this paper namely:

- Changing cultural barriers
- Education of stakeholders
- Defining responsibility
- The role of the medical professions
- Encouraging good practice.

The TUC has also surveyed union workplace safety representatives to identify the proportion of unionised workplaces offering rehabilitation services – a proportion that grew from 13% to 23% between 1998 to 2000 [Focus on health and safety, TUC December 2000 – the 2000 survey covered 9,000 workplaces – the same question will be asked in the forthcoming 2002 survey].

In addition, the TUC is currently running a major study of 1,000 representative unionised workplaces, funded by the DWP, to identify what aspects of workplace organisation are most often linked to good rehabilitation policies, and exploring the relationship between sickness absence and rehabilitation – this will be published in 2002.

Q15. Unions have sought to promote the issue of rehabilitation to the workplace to date, how can they develop their work in this area?

## Action by Employers

Concern has been expressed that a concentration upon rehabilitation could shift the emphasis away from accident prevention and risk management. However, effective rehabilitation should function within an integrated healthcare system that manages all sickness, absence and other injury-related issues.

In their report "Their Health in Your Hands"<sup>14</sup>, the CBI agreed that there is scope for improving the UK's occupational health management, that British business has identified the main occupational health issues it faces and that businesses of all sizes understand the need to manage areas such as stress and rehabilitation.

58% of respondents (Businesses) to the survey said they had a rehabilitation policy. These varied according to the business sector and size of company. The CBI anticipates that this provision will increase in view of various social and legislative requirements.

The CBI recommends that further research be conducted on rehabilitation policies undertaken by employers to identify and promote best practice solutions suitable to different types of workplace.

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12 "Getting Britain Back to Work" – TUC October 2000

13 "Restoring Health, Returning to Work". – TUC July 2001

14 *Their Health in Your Hands – Focus on occupational health partnerships* – CBI, September 2000

Overall, the key to sustainable success in occupational health is a partnership between business, government, insurers, trade unions and employees in the workplace.

Q16. What problems do Employers face in bringing about improvements to their approach to rehabilitation? How might these problems be overcome?

### Action at the Workplace

Most practical initiatives have been taken at the level of the individual enterprise. Major blue chip companies like Rolls Royce, BAe, Nestle and the Post Office have worked with their unions and occupational health departments to develop sophisticated packages of support for individuals.

Q17. What fundamental rehabilitation services should be available (for all employees) in the workplace?

### Case Study

#### *Identification and management of musculo-skeletal disorders*

Type of business	Manufacture of non-metallic mineral products
Numbers employed	<400

#### *Background*

A review by the company of self-certified ill-health and medical certificates issued to employees identified two areas within the workforce which had an above average level of sickness/absence associated with musculo-skeletal disorders.

#### *Performance improvement measures*

Workplace assessments to identify practical solutions to secure improvement.

Introduction of physiotherapy with a fortnightly onsite clinic.

Safety road shows to address the educational aspects of manual handling and the need for employees to report symptoms.

#### *Performance improvement results*

Since implementation of physiotherapy the number of days lost due to musculo-skeletal disorders has reduced by 47%.

The company received a "Silver Award" from the Derbyshire Peak Health Awards at Work in 1999 for implementation of its physiotherapy service.

### Insurance Industry Activity

The insurance industry provides the majority of funds paid out to meet personal injury damages awards. In cases of workplace injury this would fall principally to the Employers' Liability insurer. Insurers, therefore, have a key role in the administration and settlement of work-related personal injury claims.

In recent years insurers have faced a wide range of external changes - civil justice reform, increases in damages awards, an increase in social expectation, all of which have challenged traditional attitudes to and methods for dealing with personal injury claims. The role of insurers in this area has traditionally been fairly reactive. Moving forwards, they may be required to be more pro-active in their approach to rehabilitation and their role in intervention and case-management.

The business case to support a definitive statement on the cost-effectiveness of rehabilitation for insurers in the UK has yet to be made. However, active participation in the rehabilitation process by insurers in other countries has been shown to provide them with a mechanism to control claim costs more effectively.

Insurers have long been interested in the role rehabilitation could play in the claims management process. ABI believes there is widespread support amongst the industry for providing rehabilitation in personal injury cases. The challenge is to make it work in practice.

## Research

The industry first supported the work of the University of Edinburgh's Rehabilitation Studies Unit – one of only two professorial units of rehabilitation studies in the UK – in 1980. The then Accident Offices Association (a predecessor of the Association of British Insurers) supported a series of clinical studies into people suffering hand injuries, lower limb fractures and catastrophic injuries. As well as identifying the most appropriate care for people with serious accidental injury, the studies suggested that only a small proportion of patients incurred these injuries in circumstances that entitled them to proceed with a compensation claim against a negligent third party.

The Unit also undertook further studies in order to specifically examine insurance claimants including:

- A review of scientific literature on compensation neuroses;
- The rehabilitation and return to work of personal injury claimants; and
- Trialling the use of a rehabilitation services co-ordinator.

The results of these studies were incorporated into work completed by, LIRMA (The London International Reinsurance Market Association) in 1997. It published its UK Bodily Injury Awards Study<sup>15</sup> into the medical, legal and actuarial trends over the previous decade in personal injury claims from motor accidents.

This Study highlighted that the UK lagged behind other industrialised countries in its long-term treatment of injuries. It stated that a paraplegic injured through work stood a:

- 50% chance of returning to work in Scandinavia;
- 30% chance in the US;
- but only a 15% chance in the UK.

The second bodily injury study published in October 1999 by the IUA (International Underwriters Association - the successor organisation to LIRMA) and ABI, included a Code of Best Practice on Rehabilitation, Early Intervention and Medical Treatment in Personal Injury Claims (reproduced in Annex 1). The Code was developed to encourage insurers and

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<sup>15</sup> Bodily Injury Awards Study, LIRMA 1997

personal injury lawyers to consider the rehabilitation needs of claimants as soon as possible after an accident. The traditional approach of waiting until after the legal process had been exhausted usually meant it was too late for rehabilitation to be effective, compared with an early, optimal intervention.

## Whiplash injury

Each year in the UK there are as many as 250 000 motor vehicle crashes which result in some degree of whiplash neck injury. Many of these accidents will involve vehicles driven for work purposes – lorries, vans, taxis, buses and company cars. It is estimated that the cost of all such accidents, in terms of claims paid for personal injury amounts to £600 – £700 million per year. This figure continues to grow yet this injury receives little attention.

Motor insurers have recognised the need for a reduction in the frequency, chronicity and severity of harm associated with whiplash neck injury events. Through the ABI, insurers have agreed to undertake a series of projects<sup>16</sup> for the objective assessment of the knowledge, medical skills and case management of whiplash sufferers.

- At present, assessment and advice for whiplash injury victims is inconsistent from one A&E department to another. ABI is sponsoring a small number of pilot studies in centres around the country to:
  - Deliver training and assessment tools to selected A&E staff;
  - Observe the way in which cases are assessed and managed;
  - Compare outcomes for cases cared for with and without the new tools;
  - Assess any variances from anticipated usage of the tools; and
  - Provide information for the fine-tuning of assessment methodology and advice.

Current versions of the agreed assessment tool, guidelines and advice may be modified in light of the research findings.

- There is interest too on the medical care of whiplash injury victims.

ABI is undertaking large-scale studies of accident victims to obtain better information on prognosis and medical and other care. At present, a small but increasingly costly proportion of cases will develop long-term symptoms and disability unless they are identified early and corrective treatment is made available. The research should enable those dealing with whiplash cases to undertake more accurate assessment and case management. Research into treatment methods should identify the most effective medical and other care for acute and chronic cases.

## Insurer Provision

Rehabilitation is undoubtedly easier to provide in a no-fault system of workplace compensation. The absence of tort - the need to establish blame – removes the adversarial difficulties that are a feature of such a system. The UK's tort culture has built a lack of trust between parties that creates delays and so reduces the chances of an injured person being referred for treatment at an early stage. That said there are many examples of liability (third party) insurers providing for rehabilitation within their products.

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16 ABI research briefing: Prevention and Management of Whiplash Neck Injury

### *First party insurance*

Both income protection insurance (previously known as permanent health insurance or PHI) and private medical insurance offer access to a range of rehabilitation services within a flexible package of benefits. The ABI estimates that over 9m people<sup>17</sup> (see below) have such cover either through a group scheme arranged by their employer or through a policy they have purchased individually.

Group IPI cover	- 1,700,000 individuals (estimate)
Individual IPI cover	- 1,400,000
Group PMI cover	- 5,000,000
Individual PMI cover	- 1,200,000

### *Third party insurance*

A number of liability insurers – Iron Trades, Zurich Financial Services and Norwich Union – and reinsurers – Swiss Re and Munich Re – have found ways around the problems created by the tort system to offer claimants access to rehabilitation services. The approach taken differs from company to company and provision is not universal for all personal injury claimants. But certainly liability insurers are keen to examine the possibilities for rehabilitation.

The following example is included for illustrative purposes only.

AIG Europe is one of the UK's largest commercial lines insurers. In 1998, it formed a specialist company – AIG Medical and Rehabilitation Ltd (AIGMR) – to assess all its medical cases. AIGMR is staffed by qualified medical practitioners whose primary concern is the injured person and how to facilitate their return to work. It is not concerned with the issue of an insured's (the employer) liability for the event that gave rise to the injury.

- AIGMR is responsible for gathering the medical evidence about the injured person's condition;
- It establishes direct contact with the injured person immediately after the accident is reported to it;
- A case manager is appointed who is responsible for co-ordinating all the services provided thereafter.

AIG Europe believes its approach to personal injury claims allows staff involved in a personal injury claim, from the claims handler through the various clinical staff, to keep focussed upon the issue within their speciality. The advantages include:

- The extent of the injury is understood more quickly;
- The relationship between the claimant and the insurer is improved;
- The claim settlement is negotiated sooner than under normal circumstances;
- Reserving for the claim is speeded up;
- The accuracy of the reserve is improved.

## Case Study

In July 1998, a 47-year old warehouse operator suffered a pelvic fracture when he was crushed by 3 trailers.

AIGMR received immediate notification of the accident and were kept informed as to when the injured person was discharged from hospital. Following this, and after obtaining the appropriate permissions, an AIGMR nurse visited the injured person to assess him for rehabilitation.

He was in a lot of pain and there was no apparent structure to his rehabilitation (for example there was no intensive physiotherapy provision). He was unclear as to what he could or couldn't do to improve his recovery. AIGMR felt if they did not intervene promptly, the case could develop a downward spiral and lead to a lengthy time off work.

A 3-week intensive rehabilitation programme at an in-patient rehabilitation centre was provided. At this point the injured person submitted a claim for damages and permission was sought from the solicitor to continue with the care – this was forthcoming.

The nurse visited the injured person during his rehabilitation and the change in his condition was noticeable – he was pain free and walking without the aid of crutches. A graduated return to work programme over an eight-week period was established following discharge from the rehabilitation centre. This was fully endorsed by the employers. The injured person returned to work in November 1998.

AIGMR's fees on this case were £7,500. The estimated cost saving on this case was £150,000.

Since starting this programme AIG MR's claims handling costs have stayed about the same. What is significant is that expenses have shifted away from paying for litigation to covering medical expenses. In cutting the time people spend away from work, the size of settlements made for loss of earning are also cut.

### The delivery of compensation

Finally, the interest in rehabilitation has, to some extent, focused attention on the UK's traditional mechanism for delivering compensation – the lump sum payment. Though not directly related to the provision of rehabilitation, issues inhibiting the development of structured settlements in the UK show some interesting parallels with those facing rehabilitation stakeholders.

Insurers recognise that lump-sum payments are an imperfect tool for delivering "good" compensation. Difficulties with assessing accurately the future losses and expenses of the claimant inhibit the early settlement of a claim.

Structured settlements feature some or all of the following:

- A lump sum to be paid on settlement to cover past expenditure and any immediate capital needs such as adaptations to a house;
- Periodic (usually monthly) annuity payments that can be "stepped" to change in amount at specific dates to reflect the anticipated changes in the claimant's needs; and
- Future lump sums to be paid at specific dates for anticipated future capital requirements such as the purchase of a new vehicle.

Therefore, a structured settlement provides a claimant with income throughout their life and so eliminates the risk of a compensation award running out. Flexibility can be built into the package to meet the claimant's likely needs, including expenditure for future education, care and housing needs.

The insurance industry fully supports the further development of structured settlements. Again all parties involved in personal injury claims need to alter their current behaviours if structured settlements are to be more widely used. Anecdotal evidence of the first year's experience of the new Civil Procedure Rules suggests that a significantly less adversarial approach in personal injury litigation is emerging. Structured settlements, as with rehabilitation, need to become part of the ordinary settlement process and not a further complication to be addressed once a general agreement to settle has been reached.

Q18. Do you agree that insurers role in rehabilitation had traditionally been reactive?

Q19. From an insurers perspective, is there is a business case for rehabilitation?

Q20. Do you think that the approach adopted by AIGMR, as outlined, can provide a model for other insurers to follow? If not, why not?

## Legal Sector Activity

To date the legal profession has not always included rehabilitation as a specific aspect of the claims or litigation process. In general, there is a lack of awareness of the need, reasons and facilities available, for rehabilitation to take place.

On the 26 April 1999 the most significant change to the litigation process for over a century came into effect. The Woolf Reform of the Civil Justice System intended to increase access to justice by reducing the costs of litigating. In practice, parties in dispute are encouraged to settle earlier, with recourse to mediation or other Alternative Dispute Resolution techniques, to avoid pursuing proceedings to trial with its lengthy delays and costs.

The new Civil Procedure Rules now include "pre-action protocols" suggesting how parties in dispute should deal with each other in the conduct of claims before proceedings are issued – in effect they are statement of best practice. It is worthy of note that the first protocols to be published covered clinical negligence and personal injury claims.

Both claimant and defendant legal representatives have had to change their approach to litigation. The legal profession has realised that the moral responsibility to an injured party, as well as a strict legal responsibility, is to obtain good compensation where injuries have been caused by the fault of others. Rehabilitation should be considered as it can enhance the quality of life of the injured party.

However, difficulties continue and the following discusses the specific areas that need to be addressed.

### Lack of Trust between the Parties

Despite the Woolf reform and the efforts of such groups as APIL (the Association of Personal Injury Lawyers) and FOIL (the Forum of Insurance Lawyers), there is still a significant element of mistrust between the two sides of the profession. It is to be expected that the pre-action protocol system - transparency of information and teamwork - will progressively lead to both parties working in the best interests of claimants. Any concerns that a claimant and their legal representative(s) might have about the motives of their employer and/or their employer's insurer in offering rehabilitation must be overcome.

## **Lack of Timely Notification**

It is commonly accepted that delay in treatment has a significant impact on the prospects of recovery in many circumstances. Whilst the pre-action protocol system means that both sides in a claim will each receive much more information than before, it is the case that litigation occurs some time after the accident occurred. There is nothing in common law that ensures a potential claim is notified to insurers immediately an accident occurs.

It is essential, therefore, that as soon as a legal representative is aware of a personal injury claim they should approach the insurer to investigate the opportunity for rehabilitation. In this regard, both APIL and FOIL endorse the Code of Best Practice for Rehabilitation, Early Intervention and Medical Treatment in Personal Injury Claims.

## **Liability**

The need to establish Legal liability in workplace accidents resulting in injuries is constantly being put forward as a bar to rehabilitation initiatives. A considerable amount of resource is committed by both sides into investigating liability before moving forward with the claims process.

The difficulty arises where liability is not clear-cut. In these cases there needs to be further discussion between the parties so a preliminary view can be formed and an early decision taken on the provision of rehabilitation.

## **Compensation Awards**

The consideration of damages falls into two areas - General Damages and Special Damages and within the latter the concept of future losses.

### *General Damages*

Claimants' solicitors have to balance the value of their claim against the benefit to be had from rehabilitation - there may well be a reduction in general damages. If a claimant goes through rehabilitation he will be treated better and more quickly and thus his pain and suffering will be diminished. Claimants' solicitors must decide whether or not this is an abrogation of their responsibilities to maximise the damages they obtain for their client or whether the moral responsibility is stronger. They will also need to ensure that their clients meet their obligation to do all they reasonably can to mitigate the losses they have suffered.

### *Future Losses*

Serious consideration must be given as to whether or not rehabilitation is encouraged by the system of lump sum payments or by annual payments based upon needs (structured settlements).

Q21. Do you broadly agree with this analysis of the current barriers to effective rehabilitation in legal claims?

Q22. What would you consider to be the 'best outcome' for the claimant, and would it include a package of rehabilitation?

Q23. How, in your view, could claimants, lawyers and defendants most effectively build on the culture of the Woolf reforms further to promote rehabilitation?

## Government Activity

The organisation of compensation for the victims of occupational injuries and diseases in the UK is significantly different to other industrialised countries. At present, a system combining two elements: a state administered compensation scheme (the Industrial Injuries Disablement Benefit - IIDB) and a regime of tort-based liability backed by compulsory Employers' Liability (EL) insurance, operates. The Department for Work and Pensions estimates<sup>18</sup> their 1999/2000 IIDB expenditure to be £770m with EL expenditure running at approximately similar levels.

The IIDB scheme is a weekly benefit payment arrangement. It does not provide rehabilitation or intervention for return to work or utilise any form of case management. In countries that operate State workers' compensation schemes - notably the US, Canada and Australia - rehabilitation and (variously) re-employment, accommodation and case-managed support for return to work are prominent features.

The Government has stated that it sees a case over the medium term for reforming the compensation, benefits and insurance systems to motivate employers more effectively to raise standards and rehabilitate injured workers.<sup>19</sup>

In terms of recent activity in this area, several Government departments and their predecessors have been/are involved in initiatives linked to rehabilitation. Several of these schemes were brought into focus by the *Revitalising Health & Safety*<sup>20</sup> campaign introduced in 1999 which set out definitive targets to reduce work related accidents and ill-health by 2010. Included in the many 'Action Points' designed to achieve the *Revitalising* targets points 30, 31 and 32 are specifically aimed at addressing rehabilitation and job-retention:

- AP 30 – *As part of the next stage of the New Deal for Disabled People, the Government is considering how best to strengthen retention and rehabilitation services for people in work who become disabled or have persistent sickness.*
- AP 31 – *The Health and Safety Commission will consult on whether the duty on employers under health and safety law to ensure the continuing health of employees at work, including action to rehabilitate where appropriate, can usefully be clarified or strengthened. For example, organisations might be required to set out their approach to rehabilitation within their health and safety policy.*
- AP 32 – *The Health and Safety Commission will work in partnership with the Department for Education and Employment and the Disability Rights Commission to ensure that health and safety law is never used as a false 'excuse' for not employing disabled people, or continuing to employ those whose capacity for work is damaged by their employment, for example by highlighting this point in relevant publications and guidance.*

Government representatives from DETR (DTLR), Department of Health and Lord Chancellors Department attended and contributed to the work of the Joint Working Group on Rehabilitation. Please see Annex 2 (also see page 27) for a summary of the government agenda in Health & Safety activity and initiatives, as of 2000.

Q24. What can the Government do to coordinate efforts to effect improvements to rehabilitation in the UK?

18 The Government's Expenditure Plans 2000/01-2001/02 - Social Security Departmental Report

19 *Revitalising Health & Safety, Strategy Statement* June 2000

20 *Revitalising Health & Safety, Strategy Statement* June 2000

## 8. A Note on Funding Rehabilitation

### *International Diversity*

Possible methods of funding a system of rehabilitation might include the following;

- Centrally funded scheme, supported by general taxation
- Private sector scheme paid for by stakeholders, including;
  - Employers
  - Insurers
  - Individuals
  - Classes of potential claimants (e.g. Self Employed etc.)
- Public/Private partnership - a combination of the above

Different countries apply different systems of rehabilitating injured employees back to the workplace. Few countries (if any) operate a system that is completely centrally funded from general taxation. Perhaps the closest example of a rehabilitation system funded largely from general taxation is the scheme operated by the Accident Compensation Corporation (ACC) in New Zealand, which is funded by a levy on all New Zealanders.

The ACC scheme offers no-fault compensation to any injured party in New Zealand in the form of income replacement benefits and a rehabilitation program. Claimants are divided into one of seven groups (employers, self-employed, earners, motor vehicle group etc.) with each group being responsible for raising sufficient premiums to fund the claims arising from that group. Other sources of funding in the ACC scheme include investment income and Central Government who contribute for the non-earning class (children, students etc.).

In a large number of developed nations, rehabilitation costs for injured employees are largely paid for by a workplace compensation system funded by employers (for example USA, Germany). Countries such as Australia and Holland operate a public/private partnership, whereby the costs of rehabilitation are dispersed across the major stakeholders. The UK system, although much fragmented, would also fall into this category, although the costs are not currently equally distributed amongst the major stakeholders.

The current UK system is relatively cheap for employers, who benefit from healthcare provided free by the NHS. Also, the industrial injury scheme is State funded from general taxation, not levied as a cost on business.

### *Insurer commitment*

From an insurance companies perspective, some insurers are firmly committed to rehabilitation partly because they see that, potentially, savings can exceed expenditure and this can give them a competitive advantage. Others are less convinced and are less committed. The former of these groups would be less likely to support a central funding approach.

A continuing problem faced by some insurers is the belief by some claimant's lawyers that funding by insurers in some way taints the process and that the providers would then be acting on behalf of the insurer. This is leading in some instances to the concept of 'adversarial' rehabilitation, where the claimants solicitors are instructing their own case managers and then insurers are instructing a case manager in a consulting capacity to oversee the programmes and costs implemented and incurred by the claimant solicitor.

One proposal that might be explored further is the concept of providing first party benefits under a policy for the early costs of rehabilitation - similar to Before the Event Legal Expense cover. A similar approach is being offered under Employers' Liability contracts by at least two insurers in the UK, although the practice is not particularly widespread.

Q25. In developing the rehabilitation system in the UK, which funding approach would be the most appropriate? Are there any other methods not outlined above that should be considered?

Q26. What would be the advantages/disadvantages of a policy offering first-party benefits designed to meet the early costs of rehabilitation? Is this a feasible approach to helping to fund rehabilitation costs?

## 9. Barriers to Rehabilitation and Endemic Problems with The Current System

In discussing rehabilitation from the viewpoints of interested parties we have tried to identify some of the key issues affecting each stakeholder. It may also be useful to provide an overview of some of the general barriers to rehabilitation that are related to the current approach taken in the UK.

The *Second UK Bodily Awards Study*<sup>21</sup> identifies several key problematic themes within the prevalent rehabilitation system currently applied in the UK;

- Lack of early intervention. Early assessments help establish a rehabilitation framework centred on the needs of the injured person and on making the most use of predicted functional capacity and other abilities. The injured person is rarely involved in decision making processes and setting ultimate targets for rehabilitation. Too often the current system leads to disability, dependence upon the state and lump sum compensation payments.
- The current approach focuses almost solely upon restoring functional capacity. This process is often extremely lengthy and the injured party is often not encouraged to return to work due to concerns over re-injury or deterioration. This can lead to a loss of contact with the employer and diminished motivation of the injured person.
- An over-emphasis on major trauma – many other injuries become disabling because they are neglected or because treatment is delayed beyond the timescale in which it might have achieved optimum results. This is a further example of how the financial and organisational responsibility for care and rehabilitation is comparatively fragmented.
- Unlike most well developed European systems of rehabilitating injured parties to the workplace, the UK approach does not consistently give the physical and emotional well-being of victims of occupational injuries significant priority status, nor does the present system clearly define responsibilities or offer a well-developed, integrated infrastructure for caring for victims of injury in the workplace.
- The absence of state funded rehabilitation has impacted upon the practical provision of rehabilitation, particularly regarding the training of personnel for such services in the UK. The NHS has the potential to provide cost-effective rehabilitation services that benefit both the NHS and businesses. Whilst it is acknowledged that the NHS is not the

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<sup>21</sup> *Second UK Bodily Injury Awards Study* – October 1999, sponsored by International Underwriting Association and Association of British Insurers

only potential rehabilitation service provider, the role of the NHS within the rehabilitation framework cannot be pursued effectively until its resources and facilities are improved.

- The rehabilitation services that are available are spread unevenly throughout the UK and, as mentioned above, the services that are available are often highly focused on major trauma. However, the focus on major trauma itself is not an issue, rather the lack of parity between acute and post-acute care is more of a cause for concern.
- The total service provision by individual rehabilitation centres, compensators and the Government is widely fragmented at present with no proper or effective co-ordination between the service providers.
- There is a lack of accurate and up-to-date occupational health data. In the recent past, the absence of such material has led to statistical under-estimates regarding the number of people injured in the workplace, which we believe have led, in part, to the under allocation of resources mentioned above. Poor understanding and under researching of the extent of the problem have resulted in occupational ill health being given a low priority for public health which has only recently been addressed in the HSC's long-term occupational health strategy – Securing Health Together<sup>22</sup>.
- There is a highly fragmented and disjointed approach to the organisation of rehabilitation within Government. No single government department or agency has responsibility for researching and promoting rehabilitation. There are initiatives currently running in;
  - Department of Transport, Local Government and the Regions and the Health and Safety Commission/Executive (for example, *Revitalising Health and Safety Strategy* and *Securing Health Together*)
  - Department for Work and Pensions (various well-established employment and training programmes for example, *Welfare to Work*, *Access to Work* and *New Deal for Disabled People*)
  - Departments of Health (for example, in England, *Saving Lives: Our Healthier Nation*, *Health Action Zones* etc)
  - Department of Trade and Industry (for example, *Small Business Service*).

Furthermore, there is no single source of information about these initiatives or how other stakeholders may become involved

There is a need for co-ordination of these projects across Government Departments and linking with industry initiatives.

Also, due to the various agendas and stances adopted by the current stakeholders within the UK rehabilitation system, it is likely that proposed improvements to the current approach may encounter difficulties in satisfying the requirements of all interested parties.

Q27. Do you agree with the barriers to rehabilitation and endemic issues outlined above?

Q28. Are there any further points or issues you would add to this summary?

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<sup>22</sup> *Securing Health Together* – HSC August 2000

## 10. The Way Forward?

The following suggestions have been put forward following the discussions of the JRWG. However, these conclusions do not necessarily reflect the views of the organisations represented in the group. The conclusions provided are intended to stimulate debate amongst the stakeholders in the provision of rehabilitation.

To create the right environment for rehabilitation to become valuable and commonplace in the UK, it may be necessary to effect change both individually within stakeholder groups and collectively on a universal level. Ultimately it is hoped that this process will lead to providing all injured or ill people with access to rehabilitation services.

One of the key questions this consultation is asking is **'What would improve rehabilitation in the UK?'**. Some responses to this direct question are noted below, divided into short term and medium/long term issues. Many of the points raised are inter-related but have been separately stated for ease of consideration.

### Short Term

1. The injection of capital/resources
  - Would help develop an infrastructure
  - Would help pay for service delivery
2. Improved awareness and education of;
  - Injured person/claimant
  - Judiciary/Legal representatives
  - Employers
  - Insurers
  - General Practitioners – particularly in relation to rehabilitation being addressed in the medical reports of all personal injury claimants submitted by general practitioners
3. Introduction of independent Case-Managers in a defined organisational role
4. Improve awareness/interest in non-business matters for insurers
  - Social utility of rehabilitation – outside of Employers' Liability policy requirements – the introduction of a focus on potential benefits beyond claims environment
5. A Union rehabilitation representative
  - Shop-floor access to representation regarding rehabilitation for the injured party
6. Co-ordination of state-funded activity and Government initiatives
  - Clear lead-responsibility for rehabilitation at one Department of Government
7. Improved information and better access to information
  - Improved occupational health data
  - Improved reporting on occupational injury
  - Identify, perhaps through a central register, the full range of rehabilitation services available in the UK so that comprehensive rehabilitation programmes can be developed

### Medium/Long Term

8. Cultural change
  - Take steps to reduce adversarial nature of Tort system, such as the development of 'joint instructions' and the ABI/UA Code of Practice on early intervention (see Annex 1)
  - Shift focus from damages as a goal to focusing on returning injured person to work
  - Can Employers' Liability 'best practice' and rehabilitation 'best practice' be drawn together and promoted as an industry 'best practice' model?

9. More research;
  - Into the most effective methods of intervention
  - Examining the cost-implications of early intervention
10. Introduction of Absence Management programs in the workplace, with rehabilitation as a primary feature
  - Education of employers on the extent of direct and indirect costs of workplace absence
  - Identifying service providers who can help establish a business case to support such programmes
11. Greater employers commitment to rehabilitation through, for example, the introduction of a mandatory rehabilitation policy or Approved Code of Practice
  - Obligation to observe an early intervention policy as defined in the Rehabilitation Code Of Practice (See Annex 1)
12. Establishing a solid business case for rehabilitation
  - Would help convince insurers to commit to early intervention and the rehabilitation process
  - More pilot studies, with a more diverse approach i.e. focus on Small or Medium Enterprises (SME's) will help identify a financial motive for rehabilitation
13. Improved risk management and preventative measures
  - Prevention better than cure
  - Ease strain on rehabilitation resources due to reduction in numbers requiring acute/post-acute care
  - Improved appraisal-reporting of how to lessen chronicity and ultimately stop workplace injury

Q.29 Do you agree with the points raised above? What other issues do you think need to be addressed in the short, medium and long term?

Q.30 Which Government Department would be the most suited to lead on this issue?

## Annex 1

### Code of Best Practice on Rehabilitation, Early Intervention and Medical Treatment in Personal Injury Claims

#### 1. Introduction

- 1.1 It is recognised that in many cases for which damages for personal injuries are claimed the claimant's current medical situation, and/or the long term prognosis, may be improved by the appropriate medical treatment, including surgery, being given at the earliest practicable opportunity, rather than waiting until the claim has settled (referred to in this document as "medical treatment"). Other cases may require non-medical treatment, such as physiotherapy, counselling, occupational therapy, speech therapy and so forth ("rehabilitation").
- 1.2 It is also recognised that in cases of serious injury the claimant's quality of life can be immediately improved by the undertaking of some basic home adaptations and/or the provision of aid and equipment and/or appropriate medical treatment when these things are needed, rather than when the claim is finally settled ("early intervention").
- 1.3 It is further recognised that where these medical or other issues have been dealt with that there may be employment issues which can be addressed for the benefit of the claimant to enable him or her to keep the job that they have, to obtain alternative suitable employment with the same employer, or to re-train for new employment. Again, if these needs are addressed at the proper time the claimant's quality of life and long-term prospects may be greatly improved.
- 1.4 Solicitors acting for claimants understand that, taking all these matters into account, they can achieve more for the claimant, by making rehabilitation available, than just the payment of compensation. The insurance industry realises that great benefit may be had in considering making funds available for these purposes.
- 1.5 It is therefore desired to create a Code of Best Practice, which will ensure that those acting for claimants and those responding to claims against the insurance industry, or acting for such persons, act in future to ensure possible improvements in the quality of life, and the present and long term physical and mental well-being of the claimant, are being addressed as issues equally as important as the payment of just, full and proper compensation.

#### 2. The Claimant's Solicitor's Duty

- 2.1 It shall be the duty of every claimant's solicitor to consider, in consultation with the claimant and/or the claimant's family, whether it is likely or possible that early intervention, rehabilitation or medical treatment would improve their present and/or long term physical or mental well-being.
- 2.2 It shall be the duty of a claimant's solicitor to consider, with the claimant and/or the claimant's family, whether there is an immediate need for aids, adaptations or other matters which would seek to alleviate problems caused by disability, and thereupon communicate with the insurer as soon as practicable to see if this Code of Practice can be put into effect.
- 2.3 It shall not be the responsibility of the solicitor to decide on the need for treatment or rehabilitation or to arrange such matters without appropriate medical consultation. Such medical consultation must involve the claimant and/or the claimant's family, the claimant's primary care physician and, where appropriate, any other medical practitioner currently treating the claimant.

- 2.4 Nothing in this Code of Practice shall in any way affect the obligations placed on a claimant's solicitor by the Pre-Action Protocol annexed to the Civil Procedure Rules 1999. However, it will be appreciated that very early communication with the insurer will enable the matters dealt with here to be addressed more effectively.

### **3. The Insurer**

- 3.1 It shall be the duty of the insurers to consider, in any appropriate case, whether it is likely that the claimant will benefit, in the immediate, medium or longer term terms, from further medical treatment, rehabilitation or early intervention.
- 3.2 If the insurer decides that a particular claim might be suitable for intervention, rehabilitation or medical treatment, the insurer will communicate this to the claimant's solicitor as soon as practicable.
- 3.3 On receipt of such communication, the claimant's solicitor will immediately discuss these issues with the claimant and/or the claimant's family, pursuant to his duty as set out above, and, where appropriate, will seek advice from the claimant's treating physicians/surgeons.
- 3.4 Nothing in this or any other Code of Practice shall in any way modify the obligations of the insurer under the Pre-Action Protocols to investigate claims rapidly and in any event (except where time is extended by the Claimant's solicitor) within three months from the date of the formal letter of claim. It is recognised that although the rehabilitation assessment can be done even where liability investigations are outstanding, it is essential that such investigations proceed with the appropriate speed.

### **4. Assessment**

- 4.1 Unless the need for such intervention or treatment has already been identified by medical reports obtained by either side and disclosed, the need for and extent of, such intervention, rehabilitation or treatment will be carried out by means of an independent assessment.
- 4.2 It must be recognised that the insurer will need to receive from the claimant's solicitor sufficient information for the insurer to make a proper decision about the need for intervention, rehabilitation or treatment. To this extent the claimant's solicitor must comply with the requirements of the Pre-Action Protocol to provide the insurer with full and adequate details of the injuries sustained by the claimant, the nature and extent of any, or any likely, continuing disability and any suggestions that may already have been made concerning rehabilitation and/or early intervention. There is no requirement under the Pre-Action Protocol, or this Code of Practice, for the claimant's solicitor to have obtained a full medical report. It is recognised that many cases will be identified for consideration under this Code of Practice before medical evidence has actually been commissioned.
- 4.3 "Independent assessment" in this context means that the assessment will be carried out by either:
- a. The treating physicians/surgeons, or some of them
  - or
  - b. By an agency, suitably qualified and/or experienced in such matters, which is financially and managerially independent of the claimant's solicitors firm and the insurers dealing with the claim.

- 4.4 It is essential that the process of assessment and recommendation be carried out by those who have an appropriate qualification (to include physiotherapists, occupational therapists, psychologists, psychotherapists and so forth). It would be inappropriate for these assessments to be done by someone who did not have a medical qualification. Those doing the assessments should not only have the appropriate qualification but should have experience in treating the type of disability from which the individual claimant suffers

## **5. The Assessment Process**

- 5.1 Where possible the agency to be instructed to provide the assessment should be agreed between the claimant's solicitor and the insurer. The instruction letter will be sent by the claimant's solicitor to the agency, a copy of the instruction letter being sent to the insurer.
- 5.2 The medical agency will be asked to interview the claimant at home (or where the claimant is still in hospital, in hospital, with a subsequent visit to the claimant's home) and will be asked to produce a report which covers the following headings:
1. The injuries sustained by the claimant
  2. His/her present medical condition
  3. The claimant's domestic circumstances, if relevant
  4. The injuries/disability in respect of which early intervention or early rehabilitation is suggested
  5. The type of intervention or treatment envisaged
  6. The likely cost
  7. The likely short/medium term benefit to the claimant
- 5.3 The report will not deal with diagnostic criteria, causation issues or long-term care requirements.

## **6. THE ASSESSMENT REPORT**

- 6.1 The reporting agency will, on completion of the report, send a copy of the report both to the instruction solicitor and to the insurer simultaneously. Both parties will have the right to raise queries on the report, disclosing such correspondence to the other party.
- 6.2 It is recognised that for the independent report to be of benefit to the parties, it should be prepared and used wholly outside the litigation process. Neither side can therefore rely on its contents in any subsequent litigation. With that strict proviso, to be confirmed in writing by the individual solicitor and insurer if required, the report shall be disclosed to both parties.
- 6.3 The report, any correspondence relating to it, and any notes created by the agency will be covered by legal privilege and will not under any circumstances be disclosed in any legal proceedings. Any notes or documents created in connection with the assessment process will not be disclosed in any litigation, and any person involved in the preparation of the report or involved in the assessment process shall not be a compellable witness at court.
- 6.4 The insurers will pay for the report within 28 days of receipt.
- 6.5 The need for any further or subsequent assessments shall be agreed between the claimant's solicitor and the insurer. The provisions of this Code of Practice shall apply to such assessments.

## **7. Recommendations**

- 7.1 When the assessment report is disclosed to the insurer, the insurer will be under a duty to consider the recommendations made and the extent to which funds will be made available to bring about implementation of all, or some of, the recommendations. The insurer will not be required to pay for such intervention or treatment as shall be unreasonable in nature, content or cost. The claimant will be under no obligation to undergo intervention, medical investigation or treatment which is unreasonable in all the circumstances of the case.
- 7.2 Any funds made available shall be treated as an interim payment on account of damages. However, if the funds are provided to enable specific intervention, rehabilitation or treatment to occur, the insurers warrant that they will not, in any legal proceedings connected with the claim, dispute the reasonableness of that treatment nor the agreed cost, provided of course that the claimant has had the recommended treatment.

## Annex 2

### Overview of Government Department's Activities and Other Initiatives on Rehabilitation and Job Retention (2000)

#### DETR

1. The *Revitalising Health & Safety* statement aims to stimulate a new impetus for securing higher health and safety standards to reflect the changing world of work. It sets out the following challenging targets to reduce work related accidents and ill-health by 2010:
  - To cut deaths and major injury accidents by 10% by 2010;
  - To reduce the rate of work related ill-health by 20% by 2010;
  - To cut working days lost due to health and safety failure by 40% by 2010; and
  - To achieve half of the improvement by 2004
2. These have an Action Plan to lead the way to deliver them which the following three concern rehabilitation and job retention:
  - AP 30. As part of the next stage of the New Deal for Disabled People, the Government is considering how best to strengthen retention and rehabilitation services for people in work who become disabled or have persistent sickness.
  - AP 31. The HSC will consult on whether the duty on employers under health and safety law to ensure the continuing health of employees at work, including action to rehabilitate where appropriate, can usefully be clarified or strengthened. For example, organisations might be required to set out their approach to rehabilitation within their health and safety policy.
  - AP 32. The HSC will work in partnership with the DfEE and the Disability Rights Commission to ensure that H&S law is never used as a false 'excuse' for not employing disabled people, or continuing to employ those whose capacity for work is damaged by their employment, for example by highlighting this point in relevant publications and guidance.

#### Securing Health Together

3. The long-term occupational health strategy for Great Britain has been the next step in achieving *Revitalising Health and Safety* targets. It takes a wide view, considering not only prevention through controlling the effect of work on health, but also the effects of health on work, and the contribution occupational health can make to rehabilitation. The Strategy has the following goals:
  - To reduce ill health in workers and the public caused, or made worse, by work;
  - Help people who have been ill, whether caused by work or not, to return to work;
  - Improve work opportunities for people currently not in employment due to ill health or disability; and
  - Use the work environment to help people maintain or improve their health.
4. To help reach these goals there are five headline targets:
  - A 20% reduction in the incidence of work-related ill health;
  - A 20% reduction in ill health to members of the public caused by work activity;
  - A 30% reduction in the number of work days lost due to work-related ill health; and

- Everyone currently in employment but off work due to ill health or disability is, where necessary and appropriate, made aware of opportunities for rehabilitation back into work as early as possible; and
- Everyone currently in employment but off work due to ill health or disability is, where necessary and appropriate, made aware of opportunities for rehabilitation back into work as early as possible; and
- Everyone currently not in employment but off work due to ill health or disability is, where necessary and appropriate, made aware of and offered opportunities to prepare for and find work.

#### Occupational Health Advisory Committee Report and Recommendations on Improving Access to occupational health support

5. Employers, especially SMEs will often need occupational health advice on the best way of helping sick and injured employees back to work. The issue of making occupational health advice made available to employers, was addressed in the Occupational Health Advisory Committee Report on Improving Access to Occupational Health Support, published in July 2000. It recommends a number of practical solutions to delivering occupational health support to hard pressed small businesses and stresses the importance of local partnerships in tackling occupational health priorities like rehabilitation needs.
6. The joint HSE/DH action programme agreed by the Board in March 2000 (B/00/94 refers) is now underway; free guidance on how to obtain competent advice has been published and an occupational health distance learning package for GPs is now available. A number of initiatives e.g. the piloting of a telephone helpline (which will include advice on rehabilitation and retention), the evaluation of Occupational Health Projects in primary care and the development of a self assessment package for micro businesses are in hand.

#### DWP as successor to DFEE/DSS

7. There is a range of well-established employment and training measures to help disabled<sup>1</sup> people into employment. Working from the premise that some 70% of unemployed disabled people are helped through mainstream activities – jobcentres etc – the remainder require help through specialist disability services run by the Employment Service and associated agencies. Examples of programmes include:
  - **Welfare to Work** – a general title for a series of practical and policy initiatives designed to help people into work and off benefits. WtW is a key element in achieving the Government’s aim of reducing social exclusion by removing structural and institutional barriers that prevent various groups of people from participating in employment.
  - **Access to Work** – aims to provide support to overcome the effects of disability at work, so that disabled people can participate in mainstream employment.
  - **Job Introduction Scheme** – provides a weekly grant of £75 towards the costs of employing people with disabilities for a trial period of employment. The scheme is used in situations where a disabled applicant is considered suitable, but the employer has genuine doubts about the person’s ability to cope with the proposed job or place of work. It is expected that 3000 people a year will be helped by this measure.

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<sup>1</sup> As defined by DDA

- **Supported Employment Programme** – provides support for around 25,000 people. It is open to disabled people who because of their disability face more complex barriers to work but who can work effectively with the right support. In effect this provides subsidised work within a supportive but commercial environment.
  - **ONE** – ONE is a partnership between the Benefits Agency and the Employment service and local authorities. ONE is currently being piloted in 12 areas using different delivery models. In the ONE pilot areas all those making a fresh claim to working age benefits will have their work and benefit enquiries dealt with in one place. ONE offers all clients a personal adviser who will help them explore ways of becoming more independent.
  - **Working Age Agency** - The new agency makes a major step forward in the government's welfare reform programme. It will put into practice a welfare to work approach with jobs and benefits delivered through a single body. It will bring together the responsibilities of the Employment Service and the Benefits Agency for people of working age. The agency will offer working age people a single point of access for advice on looking for work and accessing benefits. In a development of the New Deal Programme, the ONE service pilots and the Employment Action Zones, it will use personal advisers to provide an active and efficient service helping every person who is able to work to do so and ensuring proper support where they cannot.
8. There are 50 **Disability Service Teams** (DSTs – available via the jobcentre) which provides a coherent employment advice and assessment service for employers and disabled people. The DSTs comprise of professionals including the Disability Employment Adviser and Occupational Psychologists. The function of these teams is to help disabled people select, obtain and keep jobs and help employers develop good recruitment policies. This includes offering support to employers to retain employees who become disabled, or for whom a worsening disability poses a threat to continued employment.

### **Job Retention and Rehabilitation Pilots**

9. Job Retention and Rehabilitation Pilots seek to reduce the number of people forced to give up work through prolonged sickness or disability. DWP and the Health Departments are taking this work forward. HSE has been closely involved in contributing to the project specification. The focus of the pilot will be on people at real risk of not working again and to establish the contribution of better co-ordinated, earlier, and boosted health and/or employment type interventions to help people stay in work and thus reduce the numbers flowing into economic inactivity and welfare dependence. It will be subject to a rigorous evaluation programme. The pilots will be in the region of £12 million.

### **Industrial Injuries Scheme**

11. A benefit which can be claimed by a person who has become disabled as a result of an accident which occurred, or a prescribed industrial disease which was contracted (not applicable to the self-employed). After 15 weeks from the date of the accident or onset of disease, they must be suffering from a disability normally at 14% or more (certain prescribed diseases may attract payment if they are assessed at less than 14%).
12. Reform of the Industrial Injuries Scheme could have an important potential role in preventing disability and improving job retention but this is not a priority at present.

British employers meet a much smaller proportion of the costs of failures in health at safety at work than employers in other countries. Equally employers are discouraged from playing their full part by treating employer funded rehabilitation facilities as a 'taxable benefit' similar to a company car in the tax system. However, this is not the case if the employer has accepted liability for an occupational disease, and also this is not the case for counselling services.

## DoH

13. The **NHS Plan** drives forward the work programme of DH. The Plan sets out a series of core principles that ultimately aims to provide a comprehensive range of services based on clinical need.

## Joint Investment Plans (JIP)

14. Joint Investment Plans (JIP) involves a number of government departments and requires co-operation between the range of agencies that deliver services intended to support disabled people who are already in work or who wish to enter employment. The aim of Joint Investment Plans is to map resources already used to support disabled people in employment and then to plan and prioritise the future use of these resources in the way that best meets the needs of users. Local authorities have been asked to lead on the production of these plans and are working closely with other local agencies, including the Employment Service and the Benefits Agency to develop them.
15. The JIP process consists of three stages:
  - Obtaining information about current activity and resources in the service area
  - Carrying out a detailed analysis of what services are required by the user group in question;
  - Prioritising investment or reinvestment to make sure that the services provided are the ones the people want.
16. **NHS Plus** – under this initiative the NHS provides occupational health services to employers in order to improve the health of the local healthforce.
17. **Saving Lives : Our Healthier Nation**, the English White Paper, is an action plan for tackling poor health and improving the health of everyone, especially amongst the worst off. As part of this, the Healthy Workplace Initiative, launched by HSE/DH Ministers in March 1999, seeks to put the health of working people into the mainstream of business thinking and organisational development. This is underpinned by a joint statement of intent between DH and HSC/E to work together in partnership. It describes a shared vision for a healthy workplace and maintains that '*Improving Health is Everybody's Business*'. Key elements of the initiative are the SignUp Network and Newsletter to inform those who have 'signed up' (approx 30,000) of developments.
18. The first major strand of the Initiatives is joint DH/HSE **Back in Work** project, which has funded 19 pilot projects to identify good practice for managing back pain at work, and includes rehabilitation to work programmes. Pilot projects will be evaluated.
19. **Health Action Zones** (26 to date) have also been established in partnership with the

NHS, Employment Service, Local Authorities, the voluntary and private sectors, and communities. These agencies are now working together on:

- Identifying and addressing the public health needs of the local area, in particular tackling health inequalities;
- Modernising services by increasing their effectiveness, efficiency responsiveness;
- Through the HAZ Employment Network, providing opportunities for HAZs to share good practice and innovation in promoting health and tackling ill-health through employment.

## **HM Treasury**

20. A cross-departmental review group, to which HSE provided advice, produced a recent report 'Review of Ill Health Retirement in the Public Sector'<sup>1</sup> which highlights good management practice as a key part of the strategy to reduce ill health retirement and to ensure that employees do not fall ill and when they do, all reasonable steps are taken to help them recover. Key recommendations involves each of the Government Departments (Ministry of Defence, Department of Environment, Transport and the Regions, Department for Education and Employment, Cabinet Office, Department of Health and the Home Office) which have been engaged in the review to draw up action plans by October 2000 specifying the steps, schemes and timetable for implementing these.

## **Cabinet Office**

21. A recommendation of the Cabinet Office's "Working Well Together" (Managing attendance in the public sector)<sup>2</sup> is that ONS with CO statisticians should revise their questions on sickness absence in the LFS so that data can be published as a percentage of time lost due to sickness absence. It might be possible to refine this further to identify work-related sickness absence.

## **Advisory, Conciliation and Arbitration Service (ACAS)**

22. ACAS aims to help improve the performance and effectiveness of organisations by providing an independent and impartial service to prevent and resolve disputes and to encourage good working relationships. Guidance booklets have been produced on the costs of absence and labour turnover, in particular certificated and uncertificated sick leave. Seminars are also regularly held to provide information to employers and employees on current health and safety and employment law to ensure that all stakeholders are aware of their duties and to promulgate the use of good management practices.

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1 HM Treasury. Review of Ill Health Retirement in the Public Sector. London: HM Treasury, 2000. Available at <http://www.hm-treasury.gov.uk>

2 Cabinet Office. Working Well Together; Managing Attendance in the Public Sector. London: Cabinet Office, 1998. Available at <http://www.cabinet-office.gov.uk>

## Notes

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