

Issue 1

Rehabilitation news | Summer 2007

Rehabilitation news - a new resource from BLG

Welcome to the first edition of Barlow Lyde & Gilbert LLP's Rehabilitation news! As BLG's in-house Rehabilitation Adviser, part of my role includes reviewing information from conferences, journals, newsletters, and other publications, to ensure that our Casualty and Commercial Risk Department is up-to-date with key changes and progress within this developing industry. Given the time that this process takes, we thought it would be useful to share the information gathered.

This newsletter draws upon a range of resources, including national newspapers, industry magazines, relevant websites, conference materials and journals. All articles are referenced should you wish to refer to the original source. If you would like to discuss any of the items within Rehabilitation news, please feel free to contact me on 020 7643 7037, or lstewart@blg.co.uk.

By way of introduction, I am a qualified occupational therapist, having studied and begun my career in Australia. I acquired

several years of clinical and case management experience in Australia before moving to the UK, where I built on my clinical skills within the NHS, before ultimately returning to my preferred field of case management. Prior to taking up my position at Barlow Lyde & Gilbert LLP, I worked with a private case management firm in London. I am registered with the Health Professions Council (HPC), and am a member of CMSUK, VRA, BABICM and SIA.

In addition to keeping our department up to date with rehabilitation news, I work

collaboratively with our lawyers and clients across many areas, including personal injury, employer liability, clinical negligence and catastrophic injury. I provide rehabilitation advice on specific cases, including brain injuries, amputations and complex musculoskeletal conditions.

Given this is the first edition of Rehabilitation news, your feedback on its value, other items you would like to see, and any comments to improve the service would be welcomed. ■

News digest

No VAT on rehab

HM Revenue and Customs has confirmed VAT ruling on medical services. From 1 May 2007, rehabilitation services - including the likes of case management - which are to improve the medical situation of the person will be exempt from VAT. Medical examinations for litigation (expert reports) will attract VAT, however, as the purpose is to assist a third party to decide upon a course of action, rather than to improve the health of the individual.

In order to apply, the guidelines indicate that

services must be provided by a registered health professional, or closely supervised by one. As such, Vocational Rehabilitation Consultants may find themselves in a grey area as often return to work assistance is provided by non-health professionals. Morag Heighway (Norwich Union Claims Manager) called for a universal exemption on rehabilitation services to address this issue (Post Magazine, 19 April 2007).

See www.hmrc.gov.uk/briefs/brief0607.htm. ■

Further qualifications for rehab providers

A new international qualification for providers of return to work assistance has been established. The qualification was developed in Canada, where it is now often requested during recruitment for new positions. Australia, Germany and New Zealand are also offering this exam for the first time, despite well established

rehabilitation provision as part of their Workers Compensation schemes. As of May 2007, UK providers can sit an exam for this qualification. WorkMatters (associated with UnumProvident) will oversee this. We may start to see this international qualification on CVs for case managers. ■

Choosing the right case management provider

The responsibility of choosing the right rehabilitation provider remains with the purchaser. Whilst a Shadow Rehabilitation Council is now meeting, and discussions have been held regarding a single set of standards from the likes of CMSUK, VRA and BABICM, we are still a significant distance from an accreditation system for case managers in rehabilitation provision (Post Magazine, 26 April 2007 (p13 -14)).

CMSUK can self-regulate but cannot accredit. Furthermore, standards of case management are not enforced in the UK,

although individual organisations generally incorporate these into their internal operations. Essentially, this means that as purchasers we still need to use a stringent vetting system to identify the right provider to meet the claimant's individual and specific needs. This should go as far as identifying the specific individual within a company. It also means monitoring rehabilitation progress by challenging providers about how their recommendations will achieve an improvement in function and/or return to work. ■

Updated Rehab Code 2007

The updated version of the Rehab Code is now available on the BICMA website - <http://www.bicma.org.uk/news.php> (see news on 29 June 2007). This is the third version, with the original introduced in 1999, and the second edition in March 2003.

There are a number of amendments worth noting, including:

- earliest possible notification to the compensator of the claim is expected (where rehab is likely);
- new duty on claimant solicitor to consider employment initiatives (to keep job open, to find alternative work with same employer, or re-training);
- no requirement for claimant solicitor to obtain full medical report (i.e. need for rehab may be obvious, as such no need for confirmation of rehab potential from medical personnel);
- compensator to respond to request for rehab from claimant solicitor within 21 days;
- assessment and delivery of rehab needs should be a collaborative process (between compensator and claimant solicitor);
- claimant solicitor and compensator should endeavour to agree to a rehab provider (no solicitor or compensator may insist on a particular provider if the other party has reasonable objections);
- confirms INA (Immediate Needs Assessment) is outside litigation but rehab reports/notes are covered by usual Rules of Disclosure;
- INA should be sent by rehab organisation to both claimant solicitor and compensator simultaneously and both parties have the right to raise questions on the report (and disclose

this to other party);

- compensator will pay for INA report within 28 days; and
- sentence about funds being treated as interim has been deleted.

A further clarification relates to the issue of clawback. Martin Bare (APIL's future president) discussed one outcome of the revised Rehabilitation Code in a recent Post Magazine article. There has been a lack of clarification as to whether an insurer can clawback a portion of rehabilitation costs spent to date when a decision of contributory negligence is made post-commencement of rehabilitation (when rehabilitation is considered 'special damages'). This can impact upon a claimant's willingness to engage in rehabilitation, delaying necessary intervention to achieve recovery/return to work, and facilitate an adversarial relationship early on. The revised Rehabilitation Code clarifies that no clawback will be permitted in this instance. (Post Magazine, 3 May 2007 (p14 - 15)).

What does this mean for rehabilitation providers in meeting the claimant's needs? Providers may need to be mindful of potential contributory negligence discounts when identifying rehabilitation strategies to meet their client's needs, i.e. investigating all possible statutory provision if the claimant is likely to have future care and treatment needs post-settlement. This investigation of statutory services should be a quality standard for all rehabilitation providers according to BICMA. ■

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News digest continued

Vocational Rehabilitation update

Standards of Practice formulated by the Vocational Rehabilitation Association (VRA) had their initial launch at the DWP/VRA annual conference on 18 June 2007. These standards are available to buy by contacting the VRA. The standards are extremely detailed, and representatives of rehabilitation purchasers requested a shorter version to summarise the questions we should be asking service providers when considering them for service provision. According to a Post Magazine article on 21 June 2007, a streamlined version will soon be published for this purpose.

As per the CMSUK and BABICM standards, the VRA standards are not yet part of an accreditation/certification process, but do lead providers in this direction. We should definitely be asking any vocational rehab providers how they are implementing these standards into their personal practice.

There was some talk of providing these standards to Disability Employment Advisors (DEAs) in Job Centres, although this will need to be discussed with Lord McKenzie (Lords Minister, DWP). He made a point of supporting the standards, however, and indicated he would support their implementation in any way he could.

What stood out was the point that there are many people claiming to provide vocational rehabilitation who simply do not have the skills and experience; for example, a case manager providing medical case management and dabbling in vocational rehabilitation. In many situations, a separate individual/service may need to be engaged to facilitate the most effective vocational rehabilitation. Given the significant cost of future loss of earnings on our claims, this is worth considering.

In addition, the DWP confirmed that 'Pathways to Work' will be launched across the country by April 2008 (currently in 19 districts). This is a government-funded scheme delivered by PCTs which is triggered by any new application for incapacity benefit. Another term linked with this scheme is 'Condition Management Programme' which is part of the 'Pathways' project. This scheme has succeeded in helping 30,000 people into work, hence the nationwide roll out. We should start to see mention of this programme in a claimant's records, and this service may reduce the need for privately funded vocational rehabilitation packages in some cases. ■

Regulation of 'talking therapists'

Further steps are being made to regulate psychologists, counsellors and psychotherapists. In a White Paper - 'Trust, Assurance and Safety - The Regulation of Health Professionals in the 21st Century', the following proposals were made:

1. Talking therapists (listed above) are to be added to the HPC (Health Professions Council). This Council has previously implemented a rigorous system of establishing educational and practice requirements for professionals such as occupational therapists and radiographers.
2. The GMC is no longer to make final

decisions in complaints against doctors. Instead, they are to carry out the investigation, but the end decision is to be made by an independent panel.

3. A working party has been established to look into regulation of less conservative therapists, such as acupuncturists.

(The Daily Telegraph, February 22, 2007)

What does that mean for purchasers of rehabilitation? It means that as regulation for rehabilitation providers tightens, we can feel more reassured that we are paying the right people to provide the right service which is evidence-based. ■

Best practice - treatment of depression and anxiety

Cognitive behavioural therapy (CBT) is now a commonly requested treatment item for claimants with a range of injuries. Long waiting lists are commonplace within the NHS, meaning requests for privately-funded treatment are frequent. What is it, and how much treatment is necessary?

Depression and anxiety are common secondary diagnoses stemming from an initial physical injury, and are often the primary diagnosis in employer liability claims. These conditions are recognised to increase the costs of the claim and delay return to work due to the complex nature of objectively measuring symptoms and improvement.

Cognitive behavioural therapy (CBT) is now a well-recognised term, and is more commonly seen as part of rehabilitation plans for injuries including musculoskeletal injuries.

What is it?

"CBT is brief, highly structured, problem-orientated and prescriptive, and individuals are active collaborators."

How much is reasonable?

"For mild and moderate depression, brief CBT of six to eight sessions over 10 to 12 weeks is usual. For moderate to severe depression, the duration is typically in the range of 16 to 20 sessions over 6 to 9 months. For anxiety, the optimal range of duration of CBT is between 7 and 14 hours."

How much does it cost?

Psychological therapy can range from £80 to £120 per treatment session, and more for assessments and reports. Travel costs may

also be accrued if the injured party is unable to travel due to his or her anxiety/physical symptoms.

More recently, Computerised CBT (CCBT) has been added to methods of providing this treatment in addition to qualified therapists, such as chartered psychologists. NICE recommends specific computer-based programmes for specific diagnoses and suggests it is only appropriate in treating mild to moderate symptoms. It could be said that this gives a more flexible approach, allowing the person not suitable/not willing to engage in drug therapy or face-to-face therapy an alternative. This is not something which is regularly seen in our industry, but it may be something to watch out for. The NHS is using this as part of the stepped-care approach.

Reference:

<http://guidance.nice.org.uk/TA97/guidance/pdf/English/download.dspix> ■

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