Minutes to APIL East Midlands Regional Group Meeting – 10th March 2003

Guest Speaker – Rehabilitation Consultant (Kynixa) – Steve Williams.

Steve Williams provided quite a detailed introduction to himself confirming this experience in independent health care. He dealt with catastrophic injury at Eagle Star and then developed rehabilitation unit at the Zurich. He was of the view that if liability issues were resolved then each party was under an obligation to try and settle the claim.

A – Insurance News

SW indicated that he felt the insurers were looking for opportunities on saving money which can be as much as 20% or 25% if they can introduce significant rehabilitation developments. He suggested that insurers have to have claimant solicitors on board and that they should be working towards co-operation. Apparently Insurers incentives for providing rehabilitation is that additional policies can be sold on the back of the rehabilitation. He stated that Insurers were trying to introduce some consistency which would be to the benefit of all concerned. SW was confident that there was validation that it worked already existing and that Norwich Union, AXA, St Paul and Churchill were already proactive with rehabilitation but that it was a change in attitudes that was really required to progress matters.

He referred to the 3rd Bodily Injury Study produced by the ABI which encouraged early notification and encouraged opportunities for rehabilitation. One of the main concerns was that it was felt that it was getting insurers to fund the treatment at all that was quite difficult and they were not particularly open to the idea. SW felt that Kynixa and other similar health care or rehabilitation providers had a role in convincing the insurers that it was also in their interest. The reason being of course the savings that the Insurers could make. He referred to a further ABI Study which indicated that litigation was down by 25% and again he felt that was in part due to this more recent notation of co-operation. (He accepted that this may be a separate problem for FOIL).

SW indicated that a solution focused response was what was required by all parties. He was concerned that the insurers were not looking for medico-legal expertise and emphasising that in Kynixa they were not obtaining that but were looking at real solutions to rehabilitation and treatment issues. He was of the view that the Claimant solicitors were still able to get the medico-legal report but that Kynixa could provide guidance as to what experts were required.

B - The Problems Encountered

SW accepted that Insurers provided completely inconsistent approaches to rehabilitation and the loss of experienced staff was not helping with this. In addition the insurance policies are all different and again this lack of consistency meant that approaches to rehabilitation and paying for such treatment in the long term could not be predicted and could not necessarily be relied upon by Claimants. He referred to a MASS Conference where it was indicated that members who have requested this type of rehabilitation were getting knocked back and experienced claims handlers were relying on the strict terms of the CPR rather than the spirit. He accepted that there was a lot of reluctance within both sides of the litigation and that to put the Claimant first both sides needed to be pro-active. He felt that trust was a major problem. This was certainly agreed by the attendees.

C – Principles of Rehabilitation within Litigation

These are governed by the Rehabilitation Code of Practice 1999 which provided a frame work for practitioners. Again as with the CPR it has been argued, that it should be adhered to by the letter but some, including the speaker felt that it was the spirit that was important. There were concerns across the board that it provided no penalty on those that did not comply with it and as such, did not put the pressure on both sides to comply. A protocol for rehabilitation implementation is under review.

SW felt that the original assessment of the injured party should be part of the legal process if everyone was happy and that the revised code would suggest that rehab recommendations, if accepted by all, could be part of normal disclosure.

It was emphasised by the APIL Co-ordinator that independence was of the utmost importance in considering medico-legal experts.

In relation to rehabilitation SW felt that it applies to all cases not just serious cases but economically the attendees at the meeting felt that it did not work out this way.

NB – New code published 7th March 2003.

D – Strategies

SW emphasised that the Personal Injury Protocol made no mention of rehabilitation but a revised protocol should do. Also there may be some consideration of identifying rehabilitation representatives within the insurance industry that would mean the process could be streamlined and that he felt the major insurers were already formulating a strategy to this effect. He felt concerned that Defendant approach was often that the matter was too far gone for rehabilitation if the matter was issued but that APIL and MASS were generally positive in relation to rehabilitation as long as the client was protected. He emphasised the importance of Claimants solicitors seizing opportunities for the rehabilitation and the initiative rather than just waiting for the insurers to make the request.

SW indicated he was prepared to provide a sample report from Kynixa to show APIL members what kind of information that Kynixa are in a position to advise on. SW did highlight the differences between client expectation between rehabilitation and medico-legal diagnosis and that client expectation from consultants was of treatment and rehabilitation rather than just diagnosis and prognosis for the purposes of the claim. He was of the view that rehabilitation would enhance both the medico-legal reports and the recovery of the client. Rehabilitation was to form part of the compensation.

E – Kynixa – How they can help

SW indicating independence and their national coverage. He also indicated that they provided community programmes rather than just being placed at a particular health

centre. He emphasised the experience and qualification of the consultant physician who lead any rehabilitation team and the specialists that were involved at every level. He indicated that there was a clinical advisory unit to ensure they met the normal standards and emphasise that they were outside the litigation process.

F – Practical Aspects

The areas of assessment were in effect pathology, impairment disability, handicap and quality of life. He emphasised the difference between rehabilitation experts and case managers and felt that rehabilitation was about moving on and recovery rather than case management which he felt was about learning to live with disability. This was not generally agreed but was clearly the view of SW.

G – Summary

In summary SW concluded that rehabilitation was here to stay and it was in the Claimant's best interest to work with the Insurers to try and obtain appropriate assistance from independent consultants as soon as they were able to.

A general discussion followed.

Attendances – 14 members.