Vocational Rehabilitation Association

## Reforming the Soft Tissue Injury ("Whiplash") Claims Process, January 2017

## Response to MOJ call for evidence in respect of Rehabilitation, by the Vocational Rehabilitation Association (VRA)

As a 'trade' organisation, which has members with clients impacted by the medico-legal claims process, we are responding only to Questions 26, 27 and 28 of the above consultation paper.

**Summary of Recommendations**

1. **The VRA considers the best approach is to adopt a market protocol for the provision of rehabilitation, which is agreed by all sides so that the route of access to treatment becomes irrelevant.**
2. **Such a protocol should have the following key attributes;**
    a. **Standard market treatment session prices,**
    b. **Qualification/accreditation criteria for treatment providers,**
    c. **A transparent invoicing and early payment structure,**
    d. **Standard outcome measures,**

**About the VRA**

Rehabilitation, in the health context, involves facilitating optimal participation for disadvantaged individuals in society; and vocational rehabilitation maximises participation in the workforce. Vocational rehabilitation professionals (VRPs) are mostly health/rehabilitation professionals who specialise in understanding the world of employment although a few are employment experts with specialist knowledge of health/disability issues. VRPs assist those who have difficulties in entering the workforce, those having difficulties with their current jobs and those who are out of work but seeking help to re-enter employment.

The VRA represents all those involved in delivering vocational rehabilitation services. A number of professional groups are involved from both health (NHS and private) and other government agencies e.g. the Department for Work and Pensions.

The VRA - as the preeminent representative of vocational rehabilitation service providers throughout the UK - strives to develop best practice vocational rehabilitation provision with an appropriately skilled workforce. We are keen to help and encourage employers (through both human resources and occupational health) to be more aware of, and better understand, the value of providing vocational rehabilitation, as it is proven the longer an employee is off work the less likely they are to return. This assists employers to embrace the value of Health Benefits of Good Work, and to support their employees through spates of ill health. As well a focus on vocational support, rehabilitation reduces unnecessary sickness absence and aids the economy through reducing the direct and indirect costs of ill-health benefits and chronic worklessness.

The VRA is also a member of the ABI-sponsored cross-industry Rehabilitation Code Independent Review Group. This Group comprises two members from the UK rehabilitation community, including the Vocational Rehabilitation Association, two insurers, two personal injury defendant lawyer representatives, and two personal injury claimant lawyer representatives. Our response to Question 28 reflects the in-principle agreement of that Group and is consistent with the direction for rehabilitation provision which all members of the Group believe would be most beneficial.

**Question 26**

Symptoms from soft tissue injury vary from individual both in intensity and time of presentation. Whilst for most people symptoms will be evident within 48 to 96 hours, this is not always the case.

Moreover, despite the general thrust of the consultation paper, rather than rushing for treatment, many injured people actually try to manage with their discomfort and do not seek treatment until a degree of chronicity develops, which might take several weeks. In these cases, far from it being a reasonable assumption that the injury is therefore 'minor', in fact the delay in treatment will mean that the condition is potentially more serious.

Early treatment is clearly effective and should, therefore, be encouraged; but, to restrict a right-to-remedy based on an arbitrary timeframe, and to assume that thereafter the injury must be 'minor', would seem to have little basis in logic or clinical understanding.

The point made at para 138 of the consultation paper is a good one. Reliance on the NHS to treat post-Road Traffic Accident (RTA) soft tissue injury is not sustainable; NHS waiting times are not conducive to early intervention treatment, which is critical both to speedy recovery and the avoidance of chronicity. Additionally, each patient accessing Musculoskeletal (MSK) services through the NHS has to be referred by a GP, which referral itself has its own extra delay time. Valuable, scarce, and socially-expensive GP appointment time would be unnecessarily lost to access treatment which is readily available at low cost in the private sector. It should not be for society and the tax player to defray a liability, which an insurer has agreed, in exchange for the payment of an insurance premium, to discharge.

**Question 27**

*General comments*

As a general observation, whilst there are undoubtedly some undesirable practices in the medico-legal[1] rehabilitation market, predominantly by agencies which are unregulated, the conclusion of the Independent Review Group was that such behaviours are not generally widespread, and are typically limited to small agency providers who often do not genuinely engage with appropriately qualified clinicians.

We would make the point very strongly that where treatments are provided by appropriately qualified clinicians they are delivered by people who are under oath and a regulatory obligation to act in their patients' best interests. Furthermore this professional commitment means that clinicians observe best practice guidelines and seek to promote evidence-based intervention. Consequently treatment is aimed at what is reasonable and necessary to achieving agreed outcomes.

Reflecting our members' experiences, we would strongly rebut the presumption that treatment is given inappropriately or disproportionately to patients, whether medico-legal[1], NHS, or from any other source, and we would observe that, were that to be the case, remedy already exists via the pursuit of the offending clinician through their regulators.

Poor market behaviours tend towards the misrepresentation of treatment which wasn't actually provided, not the provision of unnecessary treatment. Our market knowledge demonstrates that the vast majority of medico-legal[1] patients who eventually receive treatment do, indeed, need that treatment. That is certainly VRA members' experience, which can be contextualised because treatment is provided by our members who treat the same conditions across multiple work sources including the NHS, private health insurers and private clients. There is no, different, medico-legal [see definition, below] assessment or treatment model.

It is very important to emphasise at this point that not all medico-legal[1] patients referred to members by lawyers or insurers actually receive treatment at all. Clinical triage screens out approximately 25% of referrals as likely to recover through self-help or speedy resolution, and these

patients do not proceed to treatment. We understand that this level of screen-out is common across many medico-legal rehabilitation providers.

The focus of any reforms in respect of medico-legal rehabilitation should be on the patient. Any proposals that place hurdles in the way of unrestricted, timely access to appropriate treatment would, in our opinion, be retrograde.

Any reforms should seek to address poor market practices without penalising those who are genuinely injured. We do not consider that any of the 5 proposals within Question 27 - in isolation - would achieve this balance of outcome. We will comment briefly on each proposal and then outline an alternative in response to Question 28. The proposed alternative has the in-principle agreement of all members of the Rehab Code Independent Review Group.

*Specific Options*

Option 1. We consider that a voucher scheme has potential merits and, indeed, there have been trials of similar bilateral arrangements with some insurers in the past. These have proved unsuccessful because (a) the insurers found the process administratively challenging and they could not ensure consistent behaviours by their case handlers and (b) unless all rehabilitation providers are prepared to accept the vouchers, a patient may not be able to access treatment in their locality. Whilst not without merit, therefore, we consider that a voucher scheme could only be practicable within the context of a revised universal market protocol. As a stand-alone scheme it would not work.

Option 2. Handing control of rehabilitation to insurers would be diametrically opposed to the clinical interests of an injured person. Rehabilitation services, when procured by insurers, are often contractually restricted by the insurers' focus on cost reduction rather than patient care. Whilst this focus may be commercially understandable, we consider that the cost to health, both for individual patients and for society at large, in adopting this model as standard would represent a materially and unnecessarily negative outcome.

The assertion that such an approach would speed up access to treatment is flawed; medico-legal patients have immediate access to treatment already. Indeed we understand that most medico-legal patients are in treatment long before even the CNF can be completed, and an insurer informed. Similarly the proposal to provide services through a small panel of providers undermines, not enhances, the independence of that provision. In order to be, and remain, on a restricted insurer panel, providers would have to offer 'lowest price' services and act at the direction of the insurer regardless of the clinical needs of the patient. They would be entirely dependent on, not independent of, that insurer. There would be no transparency for the patient of the terms under which the provider was engaged.

**The VRA considers a far better approach is to adopt a market protocol for the provision of rehabilitation, which is agreed by all sides so that the route of access to treatment becomes irrelevant.**

Option 3. We cannot understand the logic of this option. Claimants who require treatment have been damaged through no fault of their own by the actions of another, in just the same way as the claimants' cars have been damaged. Is there also a proposal to deny a non-fault driver the right to recover the cost of repairing their car? Why should damage to person rank below damage to property? To exclude the right to remedy and reparation for a damage done seems to us to undermine the whole principles of tort and insurance. This proposal is rather like seeking to remove credit card fraud by banning credit. It might work, but the social cost would be disproportionate. Delay to treatment is proven to negatively impact outcomes and add to the cost as well as unnecessary suffering of the claimant

Option 4. MedCo has proved, thus far, to be a deeply unsatisfactory tool. As widely reported, it has been manipulated by medico-legal agencies and, as we understand from discussions at the Independent Review Group, has resulted in a deterioration in the service provided to claimants,

insurers and their solicitors. It has not addressed the behaviours it was intended to remedy. To ensure the best value for both payer and recipient any service providers report on outcome measures to clinically justify their treatment". See http://www.worksafe.vic.gov.au/health-professionals/treating-injured-workers/outcome-measures.

Whilst some aspects of the MedCo environment, such as qualification/accreditation criteria, may have merit, the expansion of a flawed process in an attempt to remedy behaviours - which could be much more effectively dealt with by other means - would seem to us to be not the most sensible way forward.

Option 5. The difficulties highlighted in the commentary are real, and full-package fixed fees, like direct insurer control of rehabilitation, would undoubtedly encourage non-optimal treatment pathways for patients and result in an increase in future chronicity and further unnecessary burden on the NHS.

However, setting more flexible price structures, which are pre-agreed by all sides in the market, coupled with early payment protocols for treatments which fall within those pre-agreed parameters, would, in our view, contribute significantly to a less dysfunctional market without impacting on patient clinical outcomes.

**Question 28**

Following the publication of the consultation, the Independent Review Group focussed its discussions on exploring cross-party agreement for an approach to medico-legal rehabilitation, which would address the concerns of insurers without prejudicing patient access to treatment, and which was clinically independent of commercial concerns.

Clearly, this is a complex issue and will require a good deal more thought and consultation regarding the detail but, at an in-principle level, the Group determined the following:

1. Poor behaviours should be addressed by the development of an agreed market protocol for the delivery and cost of treatment, not by seeking to irrevocably place control over access to treatment in the hands of any one party. Such a protocol should carry real weight and should replace existing voluntary Codes of Conduct which simply lead to confrontational approaches, further litigation and claims costs, and uncertainty;

2. Such a protocol should have the following key attributes;

   a. Standard market treatment session prices,

   b. Qualification/accreditation criteria for treatment providers,

   c. A transparent invoicing and early payment structure, possibly through the use of an OSI voucher scheme, to ensure that only the cost of treatment, actually provided, is claimed,

   d. Standard outcome measures

      - *http://www.worksafe.vic.gov.au/health-professionals/treating-injured-workers/outcome-measures*

Whilst not yet discussed, I am sure that most, if not all, members of the VRA would be keen to participate in any future consultation/protocol design process which the MOJ may be minded to explore.

**John Pilkington**

**Chair, Vocational Rehabilitation Association**
**January 3rd 2017**

Note: “Medico-legal may have three different meanings:

1. A formal request for a medical (ie doctor) for an expert opinion at the request of a solicitor; other health professionals may also be asked to provide expert opinions, which may deal with (for example) ‘causation’, which may or may not be irrelevant to the clinical recommendations
2. Any medical (ie doctor) contact where an individual is involved in litigation
3. Any health professional contact where an individual is involved in litigation