

The 2015 Rehabilitation Code

Introduction

The Code promotes the collaborative use of rehabilitation and early intervention in the compensation process. It is reviewed from time to time in response to feedback from those who use it, taking into account the changing legal and medical landscape.

The Code's purpose is to help the injured claimant make the best and quickest possible medical, social, vocational and psychological recovery. This means ensuring that his or her need for rehabilitation is assessed and addressed as a priority, and that the process is pursued on a collaborative basis. With this in mind, the claimant solicitor should always ensure that the compensator receives the earliest possible notification of the claim and its circumstances whenever rehabilitation may be beneficial.

Although the objectives of the Code apply whatever the clinical and social needs of the claimant, the best way to achieve them will vary depending on the nature of the injury and the claimant's circumstances. The Code recognises that the dynamics of lesser-injury cases are different to those further up the scale. A separate process is set out for claims below £25,000 (in line with the Civil Procedure Rules definition of low value). Separate provision is also made for soft tissue injury cases as defined in paragraph 1.1(16A) of the Pre-Action Protocol for Low Value Personal Injury Claims in Road Traffic Accidents.

It is important to stress, however, that even low value injuries can be life-changing for some people. The projected monetary value of a claim is only a guide to the rehabilitation needs of the injured person. Each case should be taken on its individual merits, and the guidelines for higher-value injuries will sometimes be more appropriate for those in the lowest category.

Sections 1 to 3 set out the guiding principles and the obligations of the various parties, and apply to all types of injury. After that, the sections diverge significantly depending on the size of claim.

Although the Code deals mainly with the Immediate Needs Assessment, it encourages all parties to adopt the same principles and collaborative approach right up until the case is concluded. In doing so, it does not stipulate a detailed process. Rather, it assumes that the parties will have established the collaborative working relationships that render a prescriptive document unnecessary.

Ten 'markers' that can affect the rehabilitation assessment, and therefore the treatment, are to be found in the Glossary at the end of the Code. They should be considered in all cases.

With the more serious injuries, it is envisaged that Case Managers will have an essential role to play in assessing the claimant's needs and then overseeing treatment. This Code should be read in conjunction with the Guide for Case Managers and those who Commission them, published separately.

1. Role of the Code

- 1.1 The purpose of the personal injury claims process is to restore the individual as much as possible to the position they were in before the accident. The Code provides a framework for the claimant solicitor and compensator to work together to ensure that the claimant's health, quality of life, independence and ability to work are restored before, or simultaneously with, the process of assessing compensation.
- 1.2 Although the Code is recognised by the relevant CPR Pre-Action Protocols, achieving the aims are more important than strict adherence to its terms. Therefore, it is open to the parties to agree an alternative framework to achieve the early rehabilitation of the claimant.
- 1.3 Where there is no agreement on liability, the parties may still agree to use the Code. The health and economic benefits of proceeding with rehabilitation at an early stage, regardless of agreement on liability, may be especially strong in catastrophic and other severe cases. Compensators should consider from the outset whether there is a possibility or likelihood of at least partial admission later on in the process so as not to compromise the prospects for rehabilitation.
- 1.4 In this Code, the expression 'the compensator' includes any person acting on behalf of the compensator. 'Claimant solicitor' includes any legal representative acting on behalf of the claimant. 'Case Manager' means a suitably qualified rehabilitation case manager.

2. The Claimant Solicitor

- 2.1 The claimant solicitor's obligation to act in the best interests of their client extends beyond securing reasonable financial compensation, vital as that may be. Their duty also includes considering, as soon as practicable, whether additional medical or rehabilitative intervention would improve the claimant's present and/or longer-term physical and mental well-being. In doing so, there should be full consultation with the claimant and/or their family and any treating practitioner where doing so is proportionate and reasonable. This duty continues throughout the life of the case, but is most important in the early stages.
- 2.2 It is the duty of a claimant solicitor to have an initial discussion with the claimant and/or their family to identify:
 - 1) Whether there is an immediate need for aids, adaptations, adjustments to employment to enable the claimant to perform their existing job, obtain a suitable alternative role with the same employer or retrain for new employment. They should, where practical and proportionate, work with the claimant's employers to ensure that the position is kept open for them as long as possible.
 - 2) The need to alleviate any problems related to their injuries.

- 2.3 The claimant solicitor should then communicate these needs to the compensator by telephone or email, together with all other relevant information, as soon as practicable. It is the intention of this Code that both parties will work to address all rehabilitation needs on a collaborative basis.
- 2.4 The compensator will need to receive from the claimant solicitor sufficient information to make a well-informed decision about the need for rehabilitation assistance, including detailed and adequate information on the functional impact of the claimant's injuries. There is no requirement for an expert report at this early stage. The information should, however, include the nature and extent of any likely continuing disability and any suggestions that may have already been made concerning rehabilitation and/or early intervention. It should be communicated within 21 days of becoming aware of those injuries or needs once the compensator is known.
- 2.5 Upon receiving a rehabilitation suggestion from the compensator, the claimant solicitor should discuss it with the claimant and/or their family as soon as practical and reply within 21 days.
- 2.6 Many cases will be considered under this Code before medical evidence has actually been commissioned or obtained. It is important in these situations that rehabilitation steps are not undertaken that might conflict with the recommendations of treating clinical teams. It is equally important that unnecessary delay is avoided in implementing steps that could make a material difference to the injured person or their family. Early engagement with the compensator is crucial to discuss such issues.
- 2.7 Whilst generally in catastrophic and other particularly severe cases, it is recommended that an appropriately qualified Case Manager should be appointed before any rehabilitation commences, this may not always be possible even though it should be a priority. Methods of selecting Case Managers are described in paragraphs 7.3 and 7.4. The aim when appointing a Case Manager should be to ensure that any proposed rehabilitation plan they recommend is appropriate and that the goals set are specific and attainable. The Case Manager should, before undertaking an Immediate Needs Assessment (INA) as part of the claims process, make every attempt to liaise with NHS clinicians and others involved in the claimant's treatment, and to work collaboratively with them, provided this does not unduly delay the process. If possible, they should obtain the claimant's rehabilitation prescription, discharge summary or similar, including any A&E records and/or treating consultant's report and medical records.

3. The Compensator

- 3.1 It is the duty of the compensator, from the earliest practicable stage, to consider whether the claimant would benefit from additional medical or rehabilitative treatment. This duty continues throughout the life of the case, but is most important in the early stages.

- 3.2 If the claimant may have rehabilitation needs, the compensator should contact the claimant solicitor as soon as practicable to seek to work collaboratively on addressing those needs. As set out in paragraph 2.5, the claimant solicitor should respond within 21 days.
- 3.3 Where a request to consider rehabilitation has been communicated by the claimant solicitor, the compensator should respond within 21 days, or earlier if possible, either confirming their agreement or giving reasons for rejecting the request.
- 3.4 Nothing in this Code modifies the obligations of the compensator under the Protocols to investigate claims rapidly and, in any event, within the relevant liability response period.

LOWER-VALUE INJURIES

4. The Assessment Process – lower-value injuries

- 4.1 Different considerations apply for soft-tissue injury cases compared to other lower-value cases of £25,000 or below. In all cases, the claimant’s solicitor should consider, with the claimant and/or the claimant’s family, whether there is a need for early rehabilitation. The results of that discussion should be recorded in section C of the electronic Claims Notification Form, which will be transmitted through the Ministry of Justice Claims Portal to commence the claim. That form requires details of any professional treatment recommendations, treatment already received (including name of provider) and ongoing rehabilitation needs.
- 4.2 For lower-value injuries generally, this might involve physiotherapy, diagnostics and consultant follow-up, psychological intervention or other services to alleviate problems caused by the injury. In soft-tissue injury cases, in particular, it is understood that there is not always necessarily a requirement for a rehabilitation intervention. It is considered likely that, where there is an initial intervention, it will focus on treating any physical need, for example through physiotherapy.

In all cases, the claimant solicitor should communicate with the compensator as soon as practical about any rehabilitation needs, preferably by electronic means. The mechanism of completion and transmission of the Claims Notification Form should facilitate this process and should take place before any significant treatment has been commenced, subject always to any overriding medical need for urgent treatment.

- 4.3 Nothing in this Code alters the legal principles that:
 1. Until there has been a liability admission by a compensator (through the Compensator’s Response in the Claims Portal), the claimant can have no certainty about the prospect of recovery of any treatment sums incurred.

2. Until the compensator has accepted a treatment regime in which the number and price of sessions have been agreed, the level of recovery of any such sums will always be a matter for negotiation (most likely through exchange of offers in the portal system), unless the subject of a Court order.
 3. Where a claimant has decided not to take up a form of treatment that is readily available in favour of a more expensive option, the reasonableness of that decision may be a factor that is taken into account on the assessment of damages.
- 4.4 Unless there is a medico-legal report containing full recommendations for rehabilitation, which both parties are happy to adopt, an initial Triage Report (TR) should be obtained to establish the type of treatment needed. In most cases, the Triage Report will be the only report required. Where both the claimant's solicitor and the compensator agree that further reports are required, the assessment process is likely to have two further stages:
- (i) A subsequent Assessment Report (AR) provided by the healthcare professional who is actually treating the claimant;
 - (ii) A Discharge Report (DR) from the treating healthcare professional to summarise the treatment provided.

It is, however, understood within the Code that a treatment discharge summary should routinely be included within the claimant's treatment records.

It is always possible for the Assessment Report (AR) and Discharge Report (DR) to be combined into one document.

- 4.5 The Triage Report (TR) assessment should be undertaken by an appropriately qualified and experienced person who is subject to appropriate clinical governance structures. Guidance on this may be obtained by reading the British Standards Institute standard PAS 150 or the UKRC Standards. It is permissible under the Code that the assessor providing the Triage Report could also be appointed to implement the recommendations.
- 4.6 The person or organisation that prepares the Triage and, if appropriate, Assessment and Discharge Reports and/or undertakes treatment should, save in exceptional circumstances, be entirely independent of the person or organisation that provided any medico-legal report to the claimant. In soft-tissue injury cases, the parties are referred to Part 45.29I of the Civil Procedure Rules.
- 4.7 The Triage and the preparation of any subsequent Assessment and Discharge Report and/or the provision of any treatment may be carried out or provided by a person or organisation having a direct or indirect business connection with the solicitor or compensator only if the other party agrees. The solicitor or compensator will be expected to reveal to the other party the existence and nature of such a business connection before instructing the connected organisation.

- 4.8 The assessment agency will be asked to carry out the Triage Report in a way that is appropriate to the needs of the case, which will in most cases be a telephone interview within seven days of the referral being received by the agency. It is expected that the TR will be very simple, usually just an email.
- 4.9 In all cases, the TR should be published simultaneously or made available immediately by the instructing party to the other side. This applies also to treatment reports (AR and DR) where the parties have agreed that they are required. Both parties will have the right to raise questions on the report(s), disclosing such correspondence to the other party.
- 4.10 It is recognised that, for the Triage Report to be of benefit to the parties, it should be prepared and used wholly outside the litigation process. Neither side can rely on the report in any subsequent litigation unless both parties agree in writing. Likewise, any notes, correspondence or documents created in connection with the triage assessment process will not be disclosed in any litigation. Anyone involved in preparing the Triage Report or in the assessment process shall not be a compellable witness at court. This principle is also set out in the Protocols.
- 4.11 The compensator will usually only consider rehabilitation that deals with the effects of the injuries that have been caused in the relevant accident. They will not normally fund treatment for other conditions that do not directly relate to the accident unless these conditions have been exacerbated by it or will impede recovery.

5. The Reports – lower-value injuries

- 5.1 It is expected under the Code that all treatment reporting described in this section will be concise and proportionate to the severity of the injuries and likely value of the claim.
- 5.2 The Triage Report should consider, where relevant, the ten ‘markers’ identified at the end of this Code and will normally cover the following headings:
1. The injuries sustained by the claimant;
 2. The current impact on their activities of daily living, their domestic circumstances and, where relevant, their employment;
 3. Any other relevant medical conditions not arising from the accident;
 4. The past provision and current availability of treatment to the claimant via the NHS, their employer or health insurance schemes;
 5. The type of intervention or treatment recommended;
 6. The likely cost and duration of treatment;
 7. The expected outcome of such intervention or treatment.
- 5.3 The Triage Report will not provide a prognosis or a diagnosis.

- 5.4 The assessment reports (TR, or any AR or DR) should not deal with issues relating to legal liability and should therefore not contain a detailed account of the accident circumstances, though they should enable the parties to understand the mechanism by which the injury occurred.
- 5.5 Where agreed as needed, any Assessment Report (AR) will normally have the following minimum headings:
1. Nature, symptoms and severity of injury(ies);
 2. Relevance of any pre-existing conditions or injuries;
 3. Primary rehabilitation goal and anticipated outcome;
 4. Expected duration, number, type and length of treatment sessions;
 5. Impact of injuries upon work and or activities of daily living and barriers to recovery and return to work.
- 5.6 Where agreed as needed, such as where a treatment discharge summary is considered inadequate, any Discharge Report (DR) will normally have the following minimum headings:
1. Current nature, symptoms and severity of injury(ies);
 2. Whether the primary rehabilitation goal has been attained;
 3. Number, type and length of treatment sessions/appointments attended or missed/DNAs (Did Not Attend);
 4. Current impact of injuries on work or activities of daily living;
 5. Whether the claimant has achieved, as far as possible, a full functional recovery;
 6. Whether additional treatment is required to address the claimant's symptoms.
- In cases where no AR or DR has been agreed, it is expected that the notes and discharge summary of the treatment provider will contain the necessary information.
- 5.7 The provision as to the report being outside the litigation process is limited to the Triage Report and any notes or correspondence relating to it. Any notes and reports created during the subsequent treatment process will be covered by the usual principle in relation to disclosure of documents and medical records relating to the claimant.
- 5.8 The compensator will normally pay for the TR within 28 days of receipt. Where the claimant's solicitor and the compensator have agreed that such reports are required, the compensator will also pay for any AR and DR within 28 days of receipt. In either case, the compensator may challenge bills that they believe to be excessive or disproportionate.

5.9 The reporting agency should ensure that all invoices are within reasonable market rates, are clear and provide the following detail:

1. Type of treatment provided, e.g. telephonic CBT, face-to-face physiotherapy;
2. Dates of treatments/sessions attended and DNAs of treatment sessions;
3. Total number of treatments delivered and whether those treatments were provided remotely or in person;
4. Total cost and whether this is for treatment provided or an estimate of future cost.

5.10 Where any treatment has been organised prior to notification to or approval by the compensator, any invoice submitted to the compensator will also need to be accompanied by a discharge summary recording treatment outcome in addition to the information contained in paragraph 5.9. The need for the discharge summary to be included in the treatment records is covered in paragraph 4.4.

5.11 The parties should continue to work together to ensure that the recommended rehabilitation proceeds smoothly and that any further rehabilitation needs continue to be assessed.

6. Recommendations – lower-value injuries

6.1 The compensator will be under a duty to consider the recommendations made and the extent to which funds will be made available to implement the recommendations. The claimant will be under no obligation to undergo intervention, medical or investigation treatment. Where intervention treatment has taken place, the compensator will not be required to pay for treatment that is unreasonable in nature, content or cost.

6.2 The compensator should provide a response to the claimant's solicitor within 15 business days from the date when the TR is disclosed. If the Insurer's Response Form is transmitted via the portal earlier than 15 business days from receipt of the CNF and the TR, the response should be included in the Response Form. The response should include: (i) the extent to which the recommendations have been accepted and rehabilitation treatment will be funded; (ii) justifications for any refusal to meet the cost of recommended rehabilitation and (if appropriate) alternative recommendations. As stated in paragraph 4.3, the claimant may start treatment without waiting for the compensator's response, but at their own risk as to recovering the cost.

6.3 The compensator agrees that, in any legal proceedings connected with the claim, they will not dispute the reasonableness or costs of the treatment they have funded, provided the claimant has undertaken the treatment and it has been expressly agreed and/or the treatment provider has been jointly instructed. If the claim later fails, is discontinued or contributory negligence is an issue, it is not within the Code to seek to recover such funding from the claimant unless it can be proven that there has been fraud/fundamental dishonesty.

- 6.4 Following on from implementation of the assessment process, the parties should consider and agree at the earliest opportunity a process for ensuring that the ongoing rehabilitation needs of the claimant are met in a collaborative manner.

MEDIUM, SEVERE AND CATASTROPHIC INJURIES

7. The Assessment Process – medium, severe and catastrophic injuries

- 7.1 The need for and type of rehabilitation assistance will be considered by means of an Immediate Needs Assessment (INA) carried out by a Case Manager or appropriate rehabilitation professional, e.g. an NHS Rehabilitation Consultant. (For further information about Case Managers, refer to the Glossary and The Guide for Case Managers and those who Commission them, published separately.)
- 7.2 The Case Manager must be professionally and suitably qualified, experienced and skilled to carry out the task, and they must comply with appropriate clinical governance. With the most severe life-changing injuries, a Case Manager should normally be registered with a professional body appropriate to the severity of the claimant's injuries. The individual or organisation should not, save in exceptional circumstances, have provided a medico-legal report to the claimant nor be associated with any person or organisation that has done so.
- 7.3 The claimant solicitor and the compensator should have discussions at the outset to agree the person or organisation to conduct the INA, as well as topics to include in the letter of instruction. The INA should go ahead whether or not the claimant is still being treated by NHS physicians, who should nonetheless be consulted about their recommendations for short-term and longer-term rehabilitation. A fundamental part of the Case Manager's role is to make immediate contact with the treating clinical lead to assess whether any proposed rehabilitation plan is appropriate.
- 7.4 The parties are encouraged to try to agree the selection of an appropriately qualified independent Case Manager best suited to the claimant's needs to undertake the INA. The parties should then endeavour to agree the method of instruction and how the referral will be made. When considering options with the claimant, a joint referral to the chosen Case Manager may maximise the benefits of collaborative working. Any option chosen by the parties is subject to the claimant's agreement. In all situations, the parties should seek to agree early implementation of reasonable recommendations and secure funding. In circumstances where trust has been built, it is recommended that the parties agree to retain the Case Manager to co-ordinate the implementation of the agreed rehabilitation plan.
- 7.5 With catastrophic injuries, it is especially important to achieve good early communication between the parties and an agreement to share information that could aid recovery. This will normally involve telephone or face-to-face meetings to discuss what is already known, and to plan how to gain further information on the claimant's health, vocational and social

requirements. The fact that the claimant may be an NHS in-patient should not be a barrier to carrying out an INA.

- 7.6 No solicitor or compensator may insist on the INA being carried out by a particular person or organisation if the other party raises a reasonable objection within 21 days of the nomination. Where alternative providers are offered, the claimant and/or their family should be personally informed of the options and the associated benefits and costs of each option.
- 7.7 Objections to a particular person or organisation should include possible remedies such as additional information requirements or alternative solutions. If the discussion is not resolved within 21 days, responsibility for commissioning the provider lies ultimately with the claimant as long as they can demonstrate that full and timely co-operation has been provided.
- 7.8 A rehabilitation provider's overriding duty is to the claimant. Their relationship with the claimant is therapeutic, and they should act totally independently of the instructing party.
- 7.9 The assessment may be carried out by a person or organisation having a direct or indirect business connection with the solicitor or compensator only if the other party agrees. The solicitor and compensator must always reveal any business connection at the earliest opportunity.
- 7.10 The assessment process should provide information and analysis as to the rehabilitation assistance that would maximise recovery and mitigate the loss. Further assessments of rehabilitation needs may be required as the claimant recovers.
- 7.11 The compensator will usually only consider rehabilitation that deals with the effects of injuries for which they are liable. Treatment for other conditions will not normally be included unless it is agreed that they have been exacerbated by the accident or are impeding the claimant's recovery.

8. The Immediate Needs Assessment (INA) Report – medium, severe and catastrophic injuries

- 8.1 The Case Manager will be asked to carry out the INA in a way appropriate to the case, taking into account the importance of acting promptly. This may include, by prior appointment, a telephone interview. In more complex and catastrophic cases, a face-to-face discussion with the claimant is likely.
- 8.2 As well as the ten 'markers' identified in the Glossary at the end of this Code, the INA should consider the following points, provided doing so does not unduly delay the process:
 - a. The physical and psychological injuries sustained by the claimant and the subsequent care received or planned;

- b. The symptoms, disability/incapacity arising from those injuries. Where relevant to the overall picture of the claimant's rehabilitation needs, any other medical conditions not arising from the accident should also be separately noted;
 - c. The availability or planned delivery of interventions or treatment via the NHS, their employer or health insurance schemes;
 - d. Any impact upon the claimant's domestic and social circumstances, including mobility, accommodation and employment, and whether therapies such as gym training or swimming would be beneficial;
 - e. The injuries/disability for which early intervention or early rehabilitation is suggested;
 - f. The type of clinical intervention or treatment required in both the short and medium term, and its rationale;
 - g. The likely cost and duration of recommended interventions or treatment, their goals and duration, with anticipated outcomes;
 - h. The anticipated clinical and return-to-work outcome of such intervention or treatment.
- 8.3 The INA report will not provide a medical prognosis or diagnosis, but should include any clinically justifiable recommendations for further medical investigation, compliant with NICE guidelines and, where possible, aligned to the NHS Rehabilitation prescription, discharge report or similar. Where recommendations are in addition to or deviate from the NHS recommendations, these should be explained with appropriate justification provided.
- 8.4 The INA report should not deal with issues relating to legal liability, such as a detailed account of the accident circumstances, though it should enable the parties to understand the mechanism by which the injury occurred.
- 8.5 The Case Manager will, on completion of the report, send copies to the claimant solicitor and compensator simultaneously. Both parties will have the right to raise questions on the report, disclosing such correspondence to the other party. It is, however, anticipated that the parties will discuss the recommendations and agree the appropriate action to be taken. Subject to the claimant's consent, their GP and/or treating clinical team will also be informed of the INA and its recommendations once funding to proceed has been obtained. In most cases, the INA will be conducted, and the report provided, within 21 days from the date of the letter of referral to the Case Manager.
- 8.6 For this assessment report to be of benefit to the parties, it should be prepared and used wholly outside the litigation process, unless both parties agree otherwise in writing.
- 8.7 The report, any correspondence related to it and any notes created by the assessing agency will be deemed to be covered by legal privilege and not disclosed in any proceedings unless the parties agree. The same applies to notes or documents related to

the INA, either during or after the report submission. Anyone involved in preparing the report or in the assessment process will not be a compellable witness at court. (This principle is also set out in the Protocols.)

- 8.8 Any notes and reports created during the subsequent case management process post-INA will be covered by the usual principle in relation to disclosure of documents and medical records relating to the claimant. However, it is open to the parties to agree to extend the provisions of the Code beyond the INA to subsequent reports.
- 8.9 The compensator will pay for the INA report within 28 days of receipt.

9. Recommendations – medium, severe and catastrophic injuries

- 9.1 When the Immediate Needs Assessment (INA) report is received, the compensator has a duty to consider the recommendations and the extent to which funds are made available to implement them. The compensator is not required to pay for treatment that is unreasonable in nature, content or cost. The claimant will be under no obligation to undergo treatment.
- 9.2 The compensator should respond to the claimant solicitor within 21 days of receiving the INA report. The response should include: (i) the extent to which it accepts the recommendations and is willing to fund treatment; and (ii) justifications for any refusal, with alternative recommendations.
- 9.3 The compensator will not dispute the reasonableness or costs of the treatment, as long as the claimant has undertaken the treatment and it was expressly agreed in advance (or the treatment provider had been jointly instructed). Where there is disagreement, general interim payments are recommended to provide continuity of services with an understanding that recovery of such sums is not guaranteed and will always be a matter for negotiation or determination by a court. Where a claimant has decided not to take up a form of treatment that is readily available in favour of a more expensive option, the reasonableness of that decision may be a factor that is taken into account on the assessment of damages. If the claim later fails or is discontinued or contributory negligence is an issue, the compensator will not seek to recover any agreed rehabilitation funding it has already provided unless it can be proven that there has been fraud/fundamental dishonesty.
- 9.4 Following implementation of the INA, the parties should consider and attempt to agree, as soon as possible, a collaborative process for meeting the claimant's ongoing rehabilitation needs.
- 9.5 The overriding purpose of the INA should be to assess the claimant's medical and social needs with a view to recommending treatment rather than to obtain information to settle the claim.

GLOSSARY – THE TEN ‘MARKERS’

The ten ‘markers’ referred to in this Code that should be taken into account when assessing an injured person’s rehabilitation needs are summarised below:

1. Age (particularly children/elderly);
2. Pre-existing physical and psycho-social comorbidities;
3. Return-to-work/education issues;
4. Dependants living at home;
5. Geographic location;
6. Mental capacity;
7. Activities of daily living in the short-term and long-term;
8. Realistic goals, aspirations, attainments;
9. Fatalities/those who witness major incidence of trauma within the same accident;
10. Length of time post-accident.

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The working parties that drew up the 2015 Rehabilitation Code included representatives of ABI, APIL, CMSUK, FOIL, IUA, MASS and PIBA. Although it is for the parties involved in personal injury claims to decide when and how to use the Code, it is envisaged that it should become operational from December 1, 2015.