Preamble

This document provides Medical Reporting Organisations ('MROs') with guidance as to how MedCo:

- Interprets key terms in the revised qualifying criteria ('QC') document ('QCD') published by the Ministry of Justice ('MoJ') on 25 October 2016 and
- Intends to apply them to audits of MROs registered on MedCo or applications to register with Medco.

The paragraph numbering in the sections below covering Tables 1 and 2 corresponds to the individual QC numbers in the QCD. As no guidance is deemed necessary for criteria 1.11, 1.14, 1.15, 2.7 and 2.8 there are no corresponding paragraphs in this guidance document.

General Principles

a) Compliance with all QC is important, even though individual criteria can vary significantly in their relative importance and the resources required to meet them. MedCo considers the cumulative effect of the criteria when making its decisions on a MRO's overall level of compliance with the QC:

b) Should a MRO fail to meet any one of the criteria in part or whole, Medco will consider that the MRO does not meet the QC in respect of Table 1 and/or Table 2, irrespective of how the MRO performs in any of the other criteria.

c) The onus is on each MRO to provide ***sufficient, relevant, reliable and substantive*** evidence to MedCo, as required, to demonstrate that it meets all individual criteria within the QC. The onus is not on MedCo to look for, and obtain, this evidence. MedCo defines these evidence requirements as follows:

   i. ***Sufficient*** relates to the quantity of evidence in breadth and depth.
   ii. ***Relevant*** means the evidence is fundamental to the criterion in question, not incidental.
   iii. ***Reliable*** relates to the source and type of evidence e.g. objective data vs. oral assertion.
   iv. ***Substantive*** refers to evidence that is based more upon demonstrable practice as compared to an entirely theoretical or paper exercise.

d) Should a MRO be unable to provide ***sufficient, relevant, reliable and substantive*** evidence to MedCo in respect of any individual qualifying criterion, MedCo will deem that the MRO does not meet that criterion until such time as the MRO provides this evidence.

e) MedCo considers the individual criteria in the QC to be part of an overlapping, coherent and consistent whole, such that it is not appropriate for each individual criterion to be assessed in isolation from the others. As a consequence, the wording of each criterion will be interpreted in light of the wording used in each of the other criteria. For instance, 1.8 (Ethical Policy) makes no explicit reference to MROs operating in a way "contradictory to the Government's stated policy objectives", but as this phrase is used in 1.1 (Definition of a MRO) MedCo considers it to be implicitly in the scope of the Ethics Policy.

f) When evaluating compliance with any criterion (both Table 1 and Table 2), unless explicitly stated otherwise, MedCo will normally consider evidence from the previous two years and forward projections up to 12 months. If a MRO commenced trading within two years, the start point will be from its date of commencement of trading as a MRO but only in respect of Table 1 criteria.

h) The QC refers to MROs producing medical reports of a certain **quality**. MedCo interprets this standard of quality as at least that set out by the Association of Medical Reporting Organisations (AMRO) in its Protocol C (Protocol with Experts) (http://www.amro-uk.co.uk/constitution-protocol) in addition to any other criteria specified in the QC or as interpreted in this guidance (e.g. managing medical experts and minimum service standards). This standard is applicable to all MROs.

i) The QC refers to "shells". A **shell** is a MRO that does not meet the Table 1 QC, in particular 1.1 (Definition of a MRO). MedCo presumes that the following MROs are shells, with the onus on the MROs affected to demonstrate to the contrary:
   i. Where a MRO with high volume, national status has one or more parent, subsidiary, fellow group company, associate or otherwise affiliated businesses registered with MedCo as MROs, all of these additional MROs are presumed to be shells. In these instances, the onus is on each and every MRO to demonstrate the contrary to MedCo. Where there is any doubt, the presumption will stand that the additional company is a shell;
   ii. The same principle as (i) above applies to MROs that are not registered as having high volume, national status but also have one or more parent, subsidiary, fellow group company, associate or otherwise affiliated businesses registered with MedCo as MROs; and
   iii. MROs that include within their name as it appears on the MedCo Portal references or associations to other MROs or to non-MRO organisations that service MROs.

j) It is possible that a MRO may fail to meet one or more numerical targets specified directly in the QC or by MedCo in relation to the SLA standards by a small margin. Therefore, when assessing compliance with any numerical targets specified directly in the QC or by MedCo in relation to the SLA standards, MedCo will apply a tolerance range of 10% to any of the stated targets to determine whether it was achieved or not, provided that the total number of numerical targets met by the MRO using the tolerance level is no more than 2 occasions. For example, each minimum service level (e.g. overall case lifecycle) would count as one occasion as would each numerical target mentioned in any individual qualifying criterion (e.g. 250 accredited medical experts).

k) MedCo may apply a tolerance limit to the requirements for evidence in respect of part of any one criterion provided that in all other respects the MRO meets all the other applicable QC. The circumstances where MedCo may consider applying a tolerance level are where a MRO:
   i. Lacks all the required evidence to demonstrate that it meets one particular criterion; or
   ii. Is unable to provide the requisite evidence for valid reasons that were not taken into account in the QC.

l) This guidance may be updated periodically and as required. Users are responsible for ensuring they have access to the latest version of this guidance. Reliance on an older version will not be acceptable/permitted.

Table 1 – Minimum Qualifying Criteria

1.1 – Definition of a MRO

Certain key terms in the QC are additionally interpreted by MedCo as follows:

a) **Independent**:
   i. A MRO is not independent if, as part of its MedCo and normal day-to-day trading activities, it expressly or on an implied basis uses or relies upon the name and/or branding in any way of a:
      a) MRO that is also its parent, subsidiary, fellow group company, associate or otherwise affiliated business (e.g. has individual shareholders in common for > 10% of shares); or
      b) Non-MRO organisation that services MROs.
   ii. Where a MRO uses parent, subsidiary, fellow group company, associate, or otherwise affiliated business resources, and vice versa, these transactions will be considered independent only if:
      a) They are subject to an "arm's length" contract operating on normal commercial terms;
      b) Each MRO has the ability to switch to a non-affiliated third party service provider and has entered into the current contract through an arms' length commercial tender process; and
      c) This structure pre-dated MedCo. Such structures set up post-MedCo will be presumed to be set up specifically to exploit the random allocation model, such that all the affected MROs will not be independent and all affected may also each breach criterion 1.8 (Ethics Policy);
   iii. MRO receives payments directly from instructing parties and pays medical experts directly; and
   iv. Physically different premises permits physically separate spaces (e.g. separate floors) within a single office building that allows multiple unconnected companies to operate from it, provided that no MRO in that building has any other connection to any other MRO in that building.

b) MROs may be part of a "**common third party (individual and/or corporate) ownership model**" ("CTHOM") already existing or, by exception, newly formed (e.g. MRO acquired as a byproduct of a larger transaction and not to boost a CTHOM's share of instructions) as long as they are also "**fully functioning**" i.e. the fact that the MRO is part of a CTHOM is incidental to its ability to operate as a fully functioning MRO and if it lost access to any resources provided (e.g. accounting, legal) by that CTHOM the impact on its ability to trade as a MRO would be negligible. Examples of this structure:

   i. Include:
      a) A fully decentralised group structure, where each decentralised business unit ('DBU') has different trading names, client markets, management and operational structures and each MRO operates under a different DBU so that it has to be fully functioning in its own right.
      b) Separate executive management teams are in place for each MRO at a comparable level of seniority (in titles and remuneration) to each other and neither one reports into the other, in a management or other group structure or ownership capacity.

   ii. Exclude:
      a) White labelling arrangements i.e. an MRO / third party producing the medical report service (the producer) provides it to another MRO (the marketer) within the common ownership model that rebrands the service as if to appear as though the marketer had produced it.
      b) A centralised group structure, where common operating processes (e.g. 1.13) are provided in some form of shared service or central processing unit to customer-facing entities.
      c) A decentralised group structure where more than one MRO operates in the same DBU and all the MROs are subject to common management and operational processes and structures for that DBU i.e. no MRO is fully functioning in its own right, but are inter-dependent.
      d) Where one MRO executive management team either shares executive resources with another or, to all effect and purposes, is subordinate to another MRO's executive management in practice e.g. through level of seniority and/or remuneration

c) What constitutes "**properly staffed and resourced**" will vary according to each MRO's business model. However, the levels and factors involved should be consistent with the levels of instructions accepted and the objective of ensuring the provision of good quality and timely independent medical evidence. Indications of a MRO having appropriate staffing and resourcing:

i. Include having the capability to:
   a) Undertake an effective quality assurance role in the medical report production process in recognition that the onus on report quality does not rest solely with the medical expert.
   b) Establish and maintain formal relationships and interactions with medical experts and claimant solicitors to facilitate better quality medical reports, efficient use of appointment slots, resolve complaints / queries and provide prompt report turnaround for claimants.
   c) Use technology (software and hardware), where the volume of reports is such that it enables a MRO to better directly manage the provision of good quality medical reports.
   d) Use third party providers in non-core areas and/or areas that are not significant. The QC describes and implies (set out as appropriate in this guidance) activities that MROs must directly manage. MedCo considers such activities to be core / significant areas of a MRO and so a MRO cannot outsource these and retain its MRO status.
   e) Employ at least 40% of staff (including directors, officers and management) either each with at least 6 months' prior experience working for a MRO or, if within the first year of tracing, having undertaken relevant training to provide MRO services.
   f) To remain solvent and self-sufficient (which includes bank loans in the normal course of business) in terms of its funding to carry on in business.
   g) Develop new service models through the competitive process, where the resultant new MRO form meets the QC as applied by MedCo, has support from the claimant community and is expected to improve the standard of independent medical report production.

ii. Exclude organisations with one or more of the following characteristics:
   a) Clearing houses or entities that are not fully functioning in their own right e.g. MROs that have structured their resources to operate as a transaction processor rather than as a service provider, such that the MRO has no discernible functions relative to the volume of instructions received, to provide customer service for claimants and medical experts or for managing quality of the medical reports produced.
   b) Use of organisational short-cuts e.g. the use of such structures as virtual organisations, white labeling arrangements and reciprocal "swap" arrangements (where a MRO has been selected but does not have the resources to produce the report, so engages (directly or otherwise) for another MRO to complete it on its behalf that it then submits to MedCo as if it had done the work itself – this service may be reciprocated if the other MRO encounters a similar issue).
   c) The use of rented, purchased or otherwise acquired third party content that is fundamental to a MRO's principle function (e.g. pre-set medical expert panel established by another MRO or other third party, or use of pre-agreed access rights to medical experts' diaries established by an IT provider or other third party).
   d) Organisations which are not on a solid financial base, or which have "going concern" issues i.e. they may be dependent for day-to-day funding on periodic capital injections, loans or other financing from group companies/owners.
   e) Staffing models based on a high proportion (i.e. 50% or more) of temporary, seasonal, agency, standby, secondee (from other group companies) or otherwise transitional staff.

d) **Direct management** – see guidance on section 1.13.

1.2 – Direct Financial Links

a) MROs should declare all potential financial links and changes thereto to MedCo at the earliest opportunity i.e. as and when they happen and not just at the time of making the annual declaration.

b) If in doubt as to whether a link constitutes a direct financial link, MROs should inform MedCo to avoid potential non-compliance if it subsequently turns out that the link in question does constitute a direct financial link and it was not previously declared. For example, MedCo considers the role of company secretary to fall within the definition of a direct financial link as set out in the Data Contributor User Agreement.

c) Should a MRO fail to declare a direct financial link, whether deliberate or inadvertent, and MedCo identifies this through its own activities the MRO will be considered to have:
   i. Failed to meet this criterion and 1.8 (MedCo's Ethics Policy, standards 3, 4, 6 and 7); and
   ii. Undermined MedCo's confidence in the MRO's ability to self-declare all its direct financial links.

d) In the event that the situation in (cii) occurs and the MRO subsequently states that it has updated all its direct financial links correctly, MedCo will still be presented with a shortfall in evidence. To address this MedCo will:
   i. Not send its own Audit Team to assess whether the MRO has correctly declared all its direct financial links or not; and
   ii. Will require the MRO to commission (for its own account) its external auditors, or equivalent reputable third party, to conduct an audit of its direct financial links and submit that report to MedCo as evidence that the MRO has now correctly declared all its direct financial links. Only upon receipt of this report would MedCo consider whether the MRO then met this criterion.

1.3 – Payment of Experts

a) MROs are expected to demonstrate this via standard contractual terms and "aged creditors'" listings.

b) Where payment terms deviate significantly from the MRO industry norm, a presumption will exist that such medical experts may not be being managed appropriately (1.13), be sufficiently independent (2.2) and that such terms may compromise the quality of their medical reports. In such situations, the onus will be on the MRO to demonstrate that this is not the case.

1.4 – Financial Instrument

a) The MRO can purchase any financial instrument provided that it meets all of the following criteria i.e. it must:
   i. Operate in the event of the failure of the MRO and solely in favour of its contracted medical experts;
   ii. If enacted, be operated by a named independent third party administrator that has agreed to provide this service. That named party cannot be the MRO, MedCo or "medical experts"; and
   iii. Not be capable of being cancelled or lapsed through the sole actions or inactions of the MRO.

b) MedCo considers that insurance policies (and equivalent financial instruments) can meet (i) and (ii) above, but not (iii) as they are at risk of being cancelled or lapsed, risks that are likely to increase should a MRO get into financial difficulties.

c) MedCo is only aware of one type of financial instrument that meets all three of the above criteria – a standard escrow agreement, whether for cash or assets of at least equivalent value.

d) MedCo considers that MROs providing greater volumes of instructions to medical experts need to provide greater certainty of being able to pay them in the event of the MRO's failure. Consequently:
   i. A MRO only within its first 24 months of operation as a MRO, and only if within that timeframe it provides less than 1,000 instructions to medical experts pa (pro-rated where appropriate), may satisfy this criterion using an insurance policy;
   ii. All other MROs can only meet this criterion through an escrow agreement; and
   iii. Where MROs exist that are connected by any form of group ownership (including that of a common third party ownership model where the individual MROs are fully-functioning and independent entities) this criterion can only be met through an escrow agreement for each of these connected MROs. This is because the effect of cross-guarantees and other financial links within group structures can reduce the certainty of medical experts being paid in the MROs and it is not within MedCo's remit or abilities to assess or monitor group risks.

1.5 – Insurance

a) All liability insurance must specifically state / cover the business as a MRO. A description of the business for insurance purposes that is either partially or materially different to this (e.g. administration or call centre) will be indicative that the business does not meet criterion 1.1.

1.6 – Information Security Policy

a) MROs should be able to demonstrate that they have assessed and acted upon their information security risks through, as a minimum:
   i. Reading the Information Commissioner's Office's (ICO) guide to data protection (principle 7 – information security – https://ico.org.uk/for-organisations/guide-to-data-protection/principle-7-security/) and, if required, related links;
   ii. Completing the ICO's Data Protection self-assessment toolkit – https://ico.org.uk/for-organisations/improve-your-practices/data-protection-self-assessment-toolkit/;
   iii. Documenting its own information security risk assessment; and
   iv. Implementing controls, based on the above, that are appropriate to its size and business.

b) Where a MRO is processing higher volumes of reports, MedCo considers it unlikely that no breaches of a MRO's security policy e.g. use of shared passwords, would have occurred in a year, and that such a situation is more likely to be indicative of weaknesses in the MRO's information security controls e.g. breaches not being recognised by staff or reported than the controls being effective:
   i. Security breach means any adverse action that could affect the confidentiality, integrity or availability of information (in all formats) processed by the MRO e.g. use of shared passwords and unrestricted access to premises; and
   ii. Security incident means a security breach where sensitive or confidential information has potentially been stolen, viewed or accessed by an unauthorised person. Data security incident trends are published by the ICO – https://ico.org.uk/action-weve-taken/data-security-incident-trends/ – on the types of security incidents generally and by sector.

c) Given the importance of information security for claimants' sensitive personal data, minimum service levels are applicable for this criterion that attest to the effective operation of the above controls in their entirety – see 1.16.

1.7 – Anti-Bribery Policy

a) MROs should be able to demonstrate that they have assessed and acted upon their bribery risks through, as a minimum:
   i. Reading the MoJ's Bribery Act 2010 Quick Start Guide)and, if required, related links –

https://www.justice.gov.uk/downloads/legislation/bribery-act-2010-quick-start-guide.pdf;

ii. Documenting its own bribery risk assessment; and

iii. Implementing controls, based on the above, that are appropriate to its size and business.

1.8 – Ethics Policy

a) MROs must adhere to the MedCo Ethics Policy ('Ethics Policy') that forms part of their Data Contributor Agreement with MedCo. MROs may adhere to their own internal company ethics policy ('Internal Ethics Policy'), only when the latter is judged by MedCo to be of a higher standard than the MedCo Ethics Policy http://www.medco.org.uk/core-documents-help/ i.e. it incorporates as a minimum all the elements of the Ethics Policy and more besides.

b) **Commitment** to the Ethics Policy means that an MRO:

i. Operates to both the **spirit** and the letter of the QC, with spirit referring to the MoJ's published policy objectives, intentions and any future updates thereto; and

ii. Embraces standard 3 of the Ethics Policy in particular, specifically that its "actions should not undermine **confidence** in the MedCo service", which MedCo interprets as meaning both an MRO's actual and perceived actions or inactions, with equal emphasis on actual and perceived.

c) **Compliance** with the Ethics Policy includes the following:

i. Conducting business in accordance with each standard in the Ethics Policy and not conducting activities that contravene commitment to, or compliance with, it; and

ii. Where potential actions might contravene the Ethics Policy, that these have been fully evaluated as to whether or not they breach it (see below) and compliant actions taken as a result.

d) Where a MRO's actions might contravene the Ethics Policy, MedCo will consider a MRO to have fully evaluated these and reached a compliant outcome if it has performed all of the following:

i. Applied a suitable framework to evaluate its ethical decisions. An example of such a framework and its application is set out in sections 3 and 4 of the Brown University paper "Making Choices: A Framework for Making Ethical Decisions" – https://www.brown.edu/academics/science-and-technology-studies/sites/brown.edu.academics.science-and-technology-studies/files/uploads/Framework.pdf;

ii. Recognised ethical matters that it should have considered. Where a MRO is processing higher volumes of reports, MedCo considers it unlikely that no ethical issues would have occurred since the inception of MedCo, and that such a situation is more indicative of weaknesses in the MRO's ethical controls e.g. breaches not being recognised by staff or reported than its controls being effective. Examples of matters that MedCo considers to be ethical issues include:

a) "Multiple registrations" for each and every MRO connected to another. Failing to disclose any such connections will be considered a breach of the Ethics Policy by each MRO so connected;

b) Business models and organisational and ownership structures that may, or be perceived to have been, designed to circumvent MoJ or MedCo objectives, including MROs whose business has grown disproportionately rapidly since registering as High Volume National status rather than due to e.g. business competency;

c) Acquiring another MRO primarily to boost its share of instructions received; and

d) Aiding, by any means, organisations not registered with MedCo as MROs to act as, or be perceived as, MROs. MedCo will consider MROs aiding such organisations to be breaching standard 3 i.e. "should not undermine confidence in the MedCo service".

iii. Considered these matters predominantly in ethical terms rather than in:

a) Legal terms, as it is entirely possible for an outcome to be legal, but unethical; and

b) Commercial terms, as commercial considerations do not make an unethical activity ethical.

iv. Documented:
  a) The nature of the potential conflict with the Ethics Policy;
  b) The actions it proposes to take to address any conflicts;
  c) Plausible, rational explanations that explicitly set out how any actions it proposes to take are consistent with (i) all the MoJ's stated policy objectives; (ii) maintaining confidence in the MedCo service; and (iii) the MRO's commitment to the Ethics Policy; and
  d) The names and job titles of all those involved in the final decision and dates of discussion.

1.9 – Complaints Handling Process

a) An MRO's end-to-end complaints process should:
  i. Differentiate between a complaint and an enquiry;
  ii. Apply to claimants, defendants/compensators (and their representatives) and to medical experts;
  iii. Be of no lesser standard than that specified in the AMRO Complaints Procedure (http://www.amro-uk.co.uk/constitution-protocol, section E);
  iv. Include the compilation of statistics on the MRO's performance and root cause analysis to identify and rectify any systemic issues in the service it provides;
  v. Be appropriate to the size and nature of the MRO in terms of the volume of reports produced and resources required to support timely, effective and efficient handling of complaints; and
  vi. Be documented.

b) Given the importance of customer service, minimum service levels are applicable for this criterion that attest to the effective operation of the above controls in their entirety – see 1.16.

1.10 – Responsible Officer / Compliance Officer

a) MedCo considers there to be two separate roles, which in smaller MROs may be combined into a single role:
  i. Responsible Officer – this is an executive role, accountable for the MRO's overall compliance with the QC and Data Contributor Agreement. This role would be expected to deal primarily with key issues (e.g. areas of potential non-compliance) that relate to MedCo.
  ii. Compliance Officer – this is a management or senior clerical role. This role is expected to be fully informed about the MoJ's publications and stated objectives for the MedCo service, the QC, MedCo's guidance document, the Data Contributor Agreement and MedCo's operation. This role is responsible for:
    a) Assessing whether the MRO complies with all the above requirements day-to-day;
    b) Providing at least quarterly reports to the MRO's senior management and Responsible Officer on the state of compliance, for any corrective actions to be agreed; and
    c) Retaining evidence of how the MRO complies with MedCo's requirements.

b) Where a MRO forms part of a larger group, the above roles could be performed by group functions. In such instances, responsibilities for MedCo compliance must be assigned to specific individuals within the group function and any group systems utilised must service the specific compliance requirements of MedCo. For example, where a MRO asserts that its MedCo risk assessments have been conducted as part of the overall group's risk assessment, this will not be considered compliant e.g. in a group context, the MRO and its associated MedCo compliance risks may not be material.

1.12 – Directors and Officers

a) Directors and Officers (i.e. all managers) should have credit reference checks performed as part of the recruitment process, and annually thereafter, to ensure that no bankruptcies or fraud convictions exist.

b) In respect of assessing whether owners are people of appropriate character, the same checks as above should be applied to individual shareholders or owners that are not directors or officers of the MRO, at the time that they invest and annually thereafter, where:
   i. The business is privately owned (whether directly, through trusts or investment funds) i.e. it is not listed, or part of a group that is listed, on the UK or overseas stock markets; and
   ii. Each individual shareholder or beneficial shareholder owns or controls in aggregate, including through related parties, at least 10% of the equity or voting rights in the MRO or entity that owns or controls the MRO.

1.13 – Direct Management of an MRO's Panel of Medical Experts

a) **Direct management** means substantive and good quality decision-making being taken by a MRO based upon information at its disposal. It does not include a MRO rubber-stamping decisions effectively made by other MROs or other third parties based on information at their disposal.

b) **Direct management** means that staff of that MRO must deal directly with a medical expert. The MRO cannot delegate part or all of the management process to:
   a) Intermediaries, whether medical agencies or other third party service providers, and whether external or fellow group companies; or
   b) Automated software, unless the software is directly managed by the MRO i.e. it:
      i. Has been developed in-house; or
      ii. If owned or rented from a third party, the software enables the MRO to establish and maintain its own medical expert panel and set up its own access rights with medical experts to allow electronic diary access. Neither the use of a pre-set medical expert panel established by another MRO or other third party, nor use of pre-agreed access rights to medical experts' diaries established by the IT provider or other third party, constitute direct management of a panel of medical experts by a MRO.

c) A MRO demonstrates its responsibility for **recruitment** of medical experts by:
   a) Developing and documenting a recruitment process that is robust and consistent with the objective of ensuring the provision of good quality and timely independent medical evidence, setting out e.g.:
      i. Its views as to what type, size and geographical coverage of its medical expert panel is appropriate for its business and why;
      ii. How, and from where, it sources medical experts;
      iii. The breadth and depth of the criteria it uses to determine whether medical experts:
         a) Can provide good quality independent medical evidence; and
         b) Should be added to its panel or not;
      iv. How it assesses whether medical experts meet the above criteria.
   b) Executing the above process and retaining evidence thereof;
   c) Periodically reviewing the effectiveness of its recruitment process in the light of claimant / solicitor complaints, medical experts' performance and the MRO's internal report quality assurance activities; and
   d) Avoiding such poor practices as:
      i. Relying upon another MRO or organisation to have interviewed and/or performed all the appropriate checks on a potential recruit so that it does not have to;
      ii. Recruiting experts only after instructions are received or on an ad hoc basis, such that it effectively has no fixed regular panel of experts.

d) A MRO demonstrates its responsibility for **validation** by checking, and retaining evidence of, the:
   a) On-going validity of the medical credentials of the medical experts on its panel at least monthly to identify e.g. any disciplinary matters that may affect medical experts' ability to produce credible medical reports and act accordingly.
   b) Medical experts have processes in place to ensure that they remain up-to-date on relevant medical matters.
   c) On-going validity of the MedCo accreditation of the medical experts on its panel at least monthly.

e) A MRO demonstrates its responsibility for **managing** by:

   a) Developing, documenting and executing processes (with evidence retained) for:
      i. Treating its medical experts fairly on a day-to-day basis;
      ii. Agreeing suitable protocols with medical experts e.g. of no lesser standard than that specified by the AMRO in its Protocol C (Protocol with Experts) (http://www.amro-uk.co.uk/constitution-protocol) and ensuring that a physical (not virtual) face-to-face appointment takes place with the injured party.
      iii. Suspending individual medical experts from its panel promptly as required.
      iv. Removing individual medical experts from its panel promptly as required.
      v. Reviewing the quality of medical reports produced by its medical experts e.g.:
         a) Sample reviews of the initial reports of newly appointed medical experts.
         b) Trend analysis for signs of potential concerns about existing panel members' reports.

   b) Effective capacity monitoring and planning, so that it has sufficient availability of appointment slots with medical experts to deal with all instructions received:
      i. Planning strategies can range from being fully planned e.g. block-booking of appointment slots to fully ad hoc i.e. contact medical experts for availability as and when the need arises.
      ii. MROs with more of their capacity planning conducted on an ad hoc basis are less likely to demonstrate appropriate levels of management of their medical experts.
      iii. Capacity planning should allow for lost appointments e.g. "no shows" and cancellations.

   c) Geographical planning, so that it has sufficient numbers of medical experts in the geographical regions that it purports to serve, which is consistent with its business strategy to service claimants representatives in that area and represents a credible selection option for Users e.g.:
      i. Population density differences are accounted for between urban and rural areas i.e. a couple of medical experts may constitute sufficient coverage for a low density rural location but not for a high density major metropolitan area.
      ii. A MRO can claim geographical coverage in a postcode area (see 2.2.3 (a)) where:
         a) It has sufficient medical experts under contract to service the demand in that area i.e. 3 per urban area and 1 per rural area;
         b) At least 60% of expert consultations are at fixed, and not mobile, consulting rooms; and
         c) Reports are produced for claimants living in this area year-on-year.
      iii. A MRO cannot claim geographical coverage in a postcode area where:
         a) More than 40% of its medical experts servicing the area operate from mobile locations; or
         b) It has not produced any medical reports in the 2 years since it claimed to provide geographical coverage in that area.

f) For clarity, where the above processes, documentation and procedures are substantially the same across multiple MROs that appear to be commercially and/or organisationally related, this will constitute evidence that those MROs are not independent of one another; and/or are not properly staffed or resourced to carry out these functions on their own (as they share resources); and/or do not directly manage their panel of medical experts.

g) A MRO may appoint its Chief Medical Officer and/or other internal suitably qualified staff as medical experts to produce medical reports for it where:
   i. Tthe individual concerned:
      a) Satisfies all the above requirements, just as any other medical expert on the MRO's panel;
      b) Has a clearly defined time allocation to spend performing his/her role for the MRO as well as that of a medical expert e.g. 60% as Chief Medical Officer and 40% as a medical expert; and
      c) Has clearly defined roles and responsibilities in respect of his/her role for the MRO and that of a medical expert; and
   ii. The MRO:
      a) Has appropriate processes in place to manage any conflicts of interest e.g. an employee cannot be involved with (or perceived to be able to influence) in any way a complaint or internal quality review matter related to any medical report that he/she has produced;
         i. Further, whoever is performing such roles in lieu of the "normal" MRO employee has to have sufficient statute within the MRO to perform these roles effectively; and
      b) Is not owned or controlled in whole or in part, directly or indirectly, by any medical expert producing reports for it. In such circumstances, the MRO is judged incapable of putting in place sufficient safeguards to mitigate any conflicts of interest due to the medical expert's actual or perceived degree of control or influence over the MRO's actions or inactions.

1.16 – Minimum Standards and Service Levels as Set by MedCo

a) The minimum standards and service levels for a Regional-Based MRO are set out at Appendix 1, all of which have to be met to satisfy this criterion, and are grouped into the following four areas:
   i. Efficiency, so that claimants receive their reports on a timely basis;
   ii. Customer service so that claimants are treated fairly and appropriately;
   iii. Quality, so that MROs perform their quality assurance role effectively over medical experts and claimants receive a fair and accurate report; and
   iv. Data security, so that claimants' sensitive personal data is adequately protected at all times.

b) For clarity, these standards and service levels do not represent good or best practice, but acceptable practice for an organisation to operate as a RB MRO and still be registered with MedCo. Any RB MRO looking to deliver good or best practice should aim to exceed these standards and service levels e.g. by aspiring to those for HVN MROs.

c) Key definitions and relevant thresholds are also included at Appendix 1.

Table 2 – Additional Qualifying Criteria

a) MedCo considers that the over-riding requirement for a MRO applying for High Volume National ('HVN') status is that it is genuinely capable of acting at that level to the expected quality standards both in the spirit and letter of the QC. The sections that follow set out further guidance, definitions and clarifications as to the letter and spirit of the Table 2 QC, as interpreted by MedCo.

2.1 – Trading History

a) **Trading history, confidence in the MRO's sustainability** and **demonstrable record of delivery** are interpreted as follows, the MRO has:
   i. Audited financial statements where the signed Auditor's opinion on these is "unqualified". In the absence of this, the MRO is not considered sufficiently large or credible to operate at HVN level;
   ii. Turnover based on delivery of either 40,000 medical reports of any type or, if less than that, the number the MRO uses to satisfy the capacity element of criterion 2.2 (Operational Capability);
   iii. A track record of profitability i.e. profit before tax and margins;
   iv. Material net assets (i.e. all assets less current liabilities) to demonstrate solvency; and
   v. Positive cash flow (i.e. cash less overdrafts / bank loans) to demonstrate solvency and longevity.

2.2 – Operational Capability

2.2.1 – Capacity

a) **Independent** means that the medical expert:
   i. Has not treated the claimant, save for as provided in the RTA Pre-Action Protocol – https://www.justice.gov.uk/courts/procedure-rules/civil/protocol/pre-action-protocol-for-low-value-personal-injury-claims-in-road-traffic-accidents-31-july-2013;
   ii. Is not contracted by any one MRO or MRO group to either work exclusively for it or to not work as a medical expert for any other MROs / MRO groups, whether named or not; and
   iii. Is not beholden to, or perceived to be beholden to, any MRO or MRO group (including parent, subsidiary, fellow group company, associate or other affiliated business) by contingent payments (see 1.3 – Payment of Experts) or volume of reports produced for that MRO e.g. exceeds 33% of all the expert's reports pa year-on-year. The onus is on the MRO to ensure report quality is maintained and that it's use of medical experts does not compromise their independence.

b) **Unlinked source** means an entity with no direct financial links to the MRO.

c) All MROs should be able to analyse their independent medico-legal reports produced as follows:
   i. By type of medico-legal report e.g. whiplash only, non-soft tissue personal injury, psychiatric;
   ii. As (i) above, split between directly and indirectly contracted medical experts;
   iii. As (ii) above, split between initial and all follow-on reports;
   iv. As (iii) above, split by medical expert e.g. GP, physiotherapist, orthopaedic and A&E consultant.

d) A MRO automatically meets the capacity requirement if it has physically produced at least 40,000 medical reports pa in any one continuous 12 month period in the previous 4 continuous calendar years, provided that the earliest period start date is no earlier than 1 January 2013.

e) For a MRO that has not previously produced 40,000 independent medico-legal reports, **business strategy** means a written, comprehensive and credible business plan of a standard suitable for a MRO to use to apply for a bank loan from any high street bank or equivalent. One section of this business plan must address specifically:
   i. The growth required to consistently produce 40,000 medical reports pa from its current position;
   ii. How that growth will arise i.e. why claimant representatives would select it over other MROs in the required additional volumes. This requires:
      a) Analysis of its current and proposed customer base;
      b) Including in its capacity calculations the investments it will need to make to encourage Users to select it more often, based on recognition that simply by being registered as a HVN MRO does not guarantee it will receive new instructions – only that it will be presented more frequently. Examples of factors to consider include:
         i. Analysis of its competitive position relative to peers, both HVNs and RBs; and
         ii. Having a clear, unique selling proposition.
   iii. Its historic growth rate.

f) Demonstrating that operational functions are sufficiently robust and scaleable involves the MRO:
   i. Already performing at the upper end of the RB spectrum e.g. in the top 20% of all HVN and RB MROs in terms of the number of medical reports it produces per annum:
      a) Equally, should a MRO with HVN status subsequently perform at a level outside the top 20% of all HVN and RB MROs in at least 2 of the previous 3 years, it would suggest that it no longer has the means to operate at HVN level and RB status may be more appropriate;
   ii. Performing a gap analysis on the structures / resources used by MROs producing significantly more reports per annum than it does, to identify any significant improvements it needs to make. MedCo considers that step changes in resources are required at certain report volume levels, so straight line scaling up of existing resources is not considered to be sufficiently robust;
   iii. Producing a resourcing plan that sets out, with rationale and supporting calculations, the additional resources it requires (consistent with 1.1, definition of a MRO) and when to produce at least 40,000 medical reports pa of sufficient quality within the next 12 months;
   iv. Demonstrating that it can achieve the HVN SLAs within 12 months, through:
      a) Its current performance levels at its current report volumes; and
      b) New or spare capacity within the existing teams / systems to maintain these standards at higher volumes, including any stress testing that the MRO has conducted.

g) Where a HVN MRO shares any of its resources with any other MRO, the presumption will be that its capacity to operate to HVN levels/standards has been compromised. The onus will be on the HVN MRO to demonstrate the presumption to be incorrect for each resource shared and that its behaviour and relations with the other MROs is compliant with the other QC e.g. 1.1 (Definition of MRO) and 1.8 (Ethics Policy).

2.2.2 – Medical Experts

a) **Contractual arrangements** between an MRO and a medical expert for the purposes of assessing HVN status are interpreted to be those which meet all of the following:
   i. They must be direct arrangements between a MRO (organisation) and a named medical expert (individual). Any other arrangement (see 1.13 - Direct Management of Experts) is considered to be indirect and not a relevant contractual arrangement;
   ii. A terms of business (ToB) document is considered a valid contract, with or without a SLA, where it is signed by both parties and, as a minimum, the terms include the areas recommended by the AMRO in its Protocol C (Protocol with Experts) (http://www.amro-uk.co.uk/constitution-protocol);
   iii. Arrangements must be such that MROs are able to secure a medical expert's capacity in terms of available appointment slots on a forward basis, en bloc, and not be in a position of having to contact medical experts to find available appointments only once an instruction is received; and
   iv. Contractual arrangements must be open-ended i.e. a medical expert can produce reports without entering into a new ToB each time as opposed to ad hoc arrangements where a new ToB is required for each report.

b) A medical expert is considered to be **active** for the purposes of assessing HVN status where all of the following are met:
   i. There is an on-going relationship between the MRO and medical expert demonstrable through the nature of their interaction, the MRO's regular use of that expert and his/her contribution to the MRO's SLAs in respect of efficiency, customer service and quality;
   ii. **Regular use** of a contracted medical expert is where each produces for the MRO on average:
      a) At least 16 medical reports pa (10% of the average), where the expert is either a generalist (e.g. GP) or services an urban area;
      b) At least 4 medical reports pa (2.5% of the average), where the expert is either a specialist (e.g. Orthopaedic consultant) or services a rural area;
      c) The above minimum report numbers:
         i. Are pro-rated to reflect the time that medical experts are on a MRO's expert panel during the year, to take account of on-going changes made by the MRO to its panel;
         ii. Are considered on a three year horizon to allow for fluctuations in instructions year-to-year (e.g. an urban GP producing 20, 10 and 18 reports for the same MRO over 3 consecutive years constitutes regular use by that MRO); and
      d) The average number of medical reports expected per medical expert pa is 160, based on 250 medical experts producing 40,000 medical reports. This enables MROs to select, in their view, better performing experts and develop more productive relationships with them.
   iii. Where medical experts produce fewer medical reports pa than is considered to be regular use (above), these medical experts do not count towards the 250 metric. This is to prevent MROs establishing contracts with medical experts in a largely nominal capacity i.e. they are on its panel primarily to boost the MRO's numbers of medical experts but, in practice, do not form part of its day-to-day business.

c) All the above requirements apply in full to a RB MRO applying for HVN status on the basis that it has not produced 40,000 medical reports historically, but has capacity to operate at HVN levels.

d) A c**ontracted medical expert** is a MedCo accredited medical expert that is active (as set out above) and with which the MRO has the above contractual arrangements.

2.2.3 – National Coverage

a) MedCo interprets **postcodes** using the Royal Mail postcode format and defines "**postcode**" as the postcode area (first two letters of the postcode), of which there are c.110 in England and Wales, and not the postcode district or any other smaller zone.

b) A medical expert is "**in**" a postcode area if that area includes the postcode for his/her fixed consulting rooms. Where the the expert travels to the injured party and sees him/her in a temporary consulting room ('temporary'), the expert's residential postcode should be used as if it was his/her fixed consulting rooms.

c) The threshold of **80%** is met where a MRO has at least one active contracted medical expert in 80% of the postcode areas in which MedCo has at least one accredited medical expert.

d) When calculating the distance the injured party has to travel to attend an appointment with a medical expert, this should be measured from the full post code of the injured party's residential address (which could be a prison or hospital) to the full postcode of the medical expert's consulting rooms using public highways.
   i. If the injured party prefers to see the medical expert closes to his/her work address, the work postcode may be used instead of the residential address.

e) Both metrics apply in full to a RB MRO applying for HVN status on the basis that it has not produced 40,000 medical reports historically, but has capacity to operate at HVN levels.

2.2.4 – Clients

a) **Clients** are interpreted to be regular customers of the MRO i.e. a claimant representative or defendants/compensators or their representatives that submits at least 100 instructions pa to the MRO covering any type of medico-legal report:
   i. Occasional or transactional (i.e. no on-going relationship) buyers of the MRO's services are not considered to be clients.
   ii. A claimant representative firm for an in-house MRO is considered to be a client.

b) **Total instruction volume** includes all types of medico-legal reports produced by the MRO, whether soft tissue injury only or not, initial or follow-up reports, produced for clients or occasional / transactional buyers and whether for in-house MROs or not.

c) The 40% threshold applies on a day-by-day basis throughout the year and not at a point in time, so a MRO may be below the 40% threshold at a given point in time, but if it has exceeded it repeatedly during the year (i.e. on more than 3 occasions within a 6 month period), it has breached this criterion on numerous occasions also.

d) Where a MRO remains in-house to a firm of claimant representatives and it is used by the latter for follow-up medical reports, the in-principle use of the in-house is considered to constitute multiple ethical concerns (see 1.8, Ethics Policy) and the onus is on the MRO to demonstrate to the contrary.

e) All the above requirements apply in full to a RB MRO applying for HVN status on the basis that it has not produced 40,000 medical reports historically, but has capacity to operate at HVN levels.

2.2.5 – Service Level Agreements

a) MedCo considers that the SLAs set out at Appendix 1, which include key definitions and relevant thresholds, are the minimum service standards for a high volume national MRO.

b) The SLAs, all of which have to be met to satisfy this criterion, are grouped into four areas:
   i. Efficiency, so that claimants receive their reports on a timely basis;
   ii. Customer service so that claimants are treated fairly and appropriately;
   iii. Quality, so that MROs perform their quality assurance role effectively over medical experts and claimants receive a fair and accurate report; and
   iv. Data security, so that claimants' sensitive personal data is adequately protected at all times.

c) For clarity, these standards and service levels do not represent good or best practice, but acceptable practice for an organisation to operate at as a HVN MRO. Any HVN MRO looking to deliver good or best practice should aim to exceed these standards and service levels.

d) All the above requirements apply in full to a RB MRO applying for HVN status on the basis that it has not produced 40,000 medical reports historically. On this basis, it has to demonstrate that within 12 months it can sustain these operating levels at report volumes of at least 40,000 e.g. by:
   i. Meeting all the HVN SLAs in full at its current volumes, without relying on tolerance levels to "pass", on the basis that the SLAs are easier to meet with lower volumes of reports;
   ii. Conducting stress testing on the MRO's performance of these SLAs to assess how robust the MRO is at operating at its current volumes; and
   iii. Identifying and implementing plans to obtain new or utilize spare capacity within the existing teams / systems to maintain these standards at higher volumes.

2.3 – Financial Instrument

a) See 1.4 in respect of the type of instrument that is considered appropriate.

2.4 – Disaster Recovery Plan / Business Continuity Plan

a) MedCo considers the scope of the **disaster recovery plan** (DRP) as being limited to the IT systems and data the **business continuity plan** (BCP) as applicable to the entire organisation.
   i. **Normal operation** is considered as being able to operate at the same volumes and standards as it was immediately prior to the DRP or BCP event.
   ii. **Testing schedule** incorporates annual tests of both the DRP and BCP with records retained of the testing performed, the results (in summary and detail) and any actions taken as a result.

2.5 – Chief Medical Officer

a) MedCo considers this to be an important indicator of a HVN MRO's ability to deliver medical reports at high volume to the required quality standards under criterion 1.13 (Direct Manage Medical Experts) and to the required SLAs under criterion 2.2 (Operational Capability). As such, should this role not exist or operate only on a nominal basis, MedCo will consider this prima facie evidence that the MRO may not meet these two criteria.

b) Whether a MRO's Chief Medical Officer can also act as a medical expert is considered at QC 1.13.

2.6 – Caldicott Guardian

a) The same principle applies as for criterion 2.5 above, except in respect of information security rather than managing medical experts i.e. criterion 1.6 instead of criterion 1.13.

APPENDIX 1 - MINIMUM SERVICE STANDARDS FOR MEDICAL REPORTING ORGANISATIONS (MROs)

No.	Minimum Service Level	High Volume National (HVN) MRO		Regional Based (RB) MRO	
		Standard	% Met	Standard	% Met
Efficiency (so that claimants receive their reports on a timely basis)					
1	Elapsed time from instructions being received to date of appointment: - In all instances (including e.g. "do not attends", reschedules, "no shows" & requested delays) - Excluding instances where solicitors / claimants specifically request a delay in appointment	 25 business days 20 business days	 90 90	 - -	 - -
2	Overall case lifecycle from instruction received to final report despatched to solicitor / claimant: - In all instances (including e.g. where supplemental report required) - Excluding instances where solicitors / claimants specifically request a delay in appointment	 35 business days 25 business days	 90 90	 35 business days 25 business days	 90 90
3	Expert response to questions / supplementary report provision: - Proportion of instructions received requiring follow-up work - Length of time to resolve queries / despatch any supplemental report to solicitor / claimant	 Less than 10% 15 business days	 90 90	 - -	 - -
Customer Service (so that claimants are treated fairly and appropriately)					
4	Elapsed time from receipt of solicitor / claimant / medical expert enquiry (not complaint) to final response made / despatched by MRO in respect of enquiries received via: - Telephone - In writing or email	 24 hours 48 hours	 90 90	 - -	 - -
5	Elapsed time from receipt of complaint (by parties below) to final resolution agreed by MRO, for complaints made by: - Solicitors or claimants - Medical experts	 20 business days 20 business days	 90 90	 20 days 20 days	 90 90

Guidance on MoJ Qualifying Criteria

No.	Minimum Service Level	High Volume National (HVN) MRO		Regional Based (RB) MRO	
		Standard	% Met	Standard	% Met
Quality (so that MROs perform their quality assurance role effectively over medical experts and claimants receive a fair and accurate report)					
6	Proportion of medical reports produced by the MRO per annum that meet all the minimum report standards as set out by AMRO in its Protocol C (Protocol with Experts – (http://www.amro-uk.co.uk/constitution-protocol)	95%	100	95%	100
7	Elapsed time from despatch of medical report to solicitor / claimant to uploading DPA-compliant, anonymised full medical and management case data to the MedCo Portal	30 days	100	30 days	100
8	Proportion of a MRO's reports in the immediately preceding 12 months that have been produced by medical experts identified by MedCo's EAPR committee or the expert's professional body as producing 1 or more medical reports of an unacceptable standard	Less than 5%	100	Less than 5%	100
Data Security (so that claimants' sensitive personal data is adequately protected at all times)					
9	An ISO27001 (Information Security) certification is in force or in progress, whose scope includes the entire MRO; where the risk assessment is commensurate with the processing of highly sensitive personal data (medical records); and the ISO Assessor finds that performance is: - Number of major non-conformities found at MRO: - Number of minor non-conformities found at MRO:	 Zero Less than 5	 100 100	 - -	 - -
10	The number of claimants in reports issued where sensitive personal data has been inappropriately disclosed in any 12 month period does not exceed the lower of:	40 or 0.1% of claimants	100	40 or 0.2% of claimants	100

Guidance on MoJ Qualifying Criteria

No.	Minimum Service Level	High Volume National (HVN) MRO		Regional Based (RB) MRO	
		Standard	% Met	Standard	% Met
Definitions Applicable to These SLAs					
a	"Instructions" and "reports" mean medico-legal whiplash only instructions and reports. All other types of report should be excluded in measuring performance against these SLAs.				
b	"High volume" is defined based on the numbers of reports produced per annum by each MRO, where all MROs (whether classified as HVN or RB) are ranked in descending order of numbers of reports produced. The minimum level to be high volume is that achieved by the MRO ranked:	Bottom of the top 20% of all MROs (HVN and RB)	-	No minimum volume applies	-
c	The above service standards have to be sustainable over a period of time rather than achievable only at a point in time. The minimum period of sustainability is defined as:	12 months on a continuous basis	100	No minimum time period	-
d	When assessing a MRO's performance against these service standards, no reports or related data can be excluded from the period under consideration for any reason. If any information needed to produce the service level standards is not available, lost or compromised, the residual information available will be considered incomplete and the MRO will be deemed to have failed to meet each service standard affected. Sampling of the available data is not considered an acceptable alternative.				