Table 1 – Minimum Qualifying Criteria

1) 1.13 – Direct Management of a MRO's Panel of Medical Experts

a) If a MRO deals with a company that provides administrative services ('AS company') on behalf of medical experts, will it be considered to be dealing with an intermediary?

Yes, if the MRO does any one of the following (below are examples, list is not exhaustive):

- Outsources core MRO functions to the AS company.
- Sends instructions to the AS company without explicitly naming the medical expert to produce the report on each occasion.
- Receives and acts on requests from the AS company to change which medical expert produces the report.
- Enters into any agreements, contractual, performance or otherwise, with the AS company on behalf of the medical expert rather than with the medical expert.
- Makes payments to the AS company on behalf of the medical expert.
- Deals with the AS company in a manner that indicates that the decision-maker in the relationship between the expert and the AS company is the AS company rather than the expert. The MRO should always know whether it is dealing with the medical expert or AS company.

No, if the MRO deals with the AS company to perform purely administrative duties such as (below are examples, list is not exhaustive):

- Scheduling appointment slots, within the parameters agreed by the MRO and medical expert.
- Submitting reports produced by the medical expert to the MRO.
- Submitting bills for work performed by the medical expert to the MRO.

A payment to a medical expert will likely be considered to be a direct payment, where it is paid to the expert's:

- Personal bank account; or
- Limited company bank account, provided that company is owned by the expert and/or his immediate family, is not a MedCo-registered MRO and only handles work (MedCo or otherwise) for that one individual expert.

The onus is always on the MRO to ensure that it is not dealing with an intermediary.

2) 1.13 – Geographical Coverage

a) What constitutes a fixed as opposed to a mobile consulting room?

The following factors, when taken together, may indicate that a consulting room is fixed; the clinic is:

- Contractually required i.e. specifically stated in the medical expert's contract with the MRO;
- Consistently held at the same time and place and is not set up on an ad hoc basis;
- Frequently held e.g. daily, weekly or fortnightly;
- Located within suitable premises (see separate question below); and

- One or one of a small number provided by the medical expert within a defined and concentrated geographical area.

Other clinic scenarios are likely to be considered to be mobile consulting rooms.

MedCo reserves the right to consider alternative factors and individual circumstances when considering whether a clinic is fixed or mobile.

It is possible for the same medical expert to provide a number of fixed and mobile clinics. In such instances, the onus is on the MRO to distinguish between those postcode areas where the expert provides fixed or mobile clinics.

b) Which postcode areas are urban and which are rural?

MedCo assesses this using the Office for National Statistics (ONS) usual resident population density measure (persons per hectare). The data below is from the 2011 census where postcode areas with densities of 4.0 and below are considered rural. Please check the ONS website for the latest data.

Postcode Area	Density (Persons per hectare)	Postcode Area	Density (Persons per hectare)	Postcode Area	Density (Persons per hectare)
AL - St Albans	8.1	HD – Huddersfield	8.0	RM - Romford	17.7
B - Birmingham	14.7	HG – Harrogate	1.5	S - Sheffield	7.4
BA – Bath	2.4	HP - Hemel Hempstead	4.9	SA - Swansea	1.3
BB - Blackburn	4.9	HR – Hereford	0.9	SE - London SE	73.8
BD - Bradford	4.4	HU – Hull	4.7	SG - Stevenage	3.1
BH - Bournemouth	5.7	HX - Halifax	5.5	SK - Stockport	5.2
BL – Bolton	12.5	IG – Ilford	36.2	SL - Slough	9.0
BN - Brighton	7.3	IP - Ipswich	1.6	SM - Sutton	39.6
BR - Bromley	20.8	KT - Kingston upon Thames	15.7	SN - Swindon	2.1
BS – Bristol	8.1	L - Liverpool	16.0	SO - Southampton	4.4
CA – Carlisle	0.6	LA - Lancaster	1.3	SP - Salisbury	1.4
CB - Cambridge	2.3	LD - Llandrindod Wells	0.2	SR - Sunderland	18.5
CF – Cardiff	6.7	LE - Leicester	4.2	SS - Southend-on-Sea	13.5
CH - Chester	6.7	LL - Llandudno	1.0	ST - Stoke-on-Trent	4.3
CM - Chelmsford	3.6	LN - Lincoln	1.2	SW - London SW	83.5
CO - Colchester	3.1	LS - Leeds	8.5	SY - Shrewsbury	0.6
CR - Croydon	26.6	LU - Luton	8.8	TA - Taunton	1.5
CT - Canterbury	5.3	M - Manchester	30.1	TD - Galashiels	0.5
CV - Coventry	4.5	ME - Medway	6.1	TF - Telford	2.6
CW – Crewe	3.3	MK - Milton Keynes	3.7	TN - Tonbridge	2.6
DA - Dartford	16.2	N - London N	77.9	TQ - Torquay	2.4
DE – Derby	4.1	NE - Newcastle upon Tyne	2.4	TR - Truro	2.1
DH - Durham	4.3	NG - Nottingham	4.4	TS - Cleveland	5.8
DL - Darlington	1.1	NN - Northampton	3.5	TW - Twickenham	29.7
DN - Doncaster	2.7	NP - Newport	3.0	UB - Southall	28.0

DT - Dorchester	1.3	NR - Norwich	2.2	W - London W	94.3
DY – Dudley	6.9	NW - London NW	69.1	WA - Warrington	8.8
E - London E	81.7	OL - Oldham	12.4	WC - London WC	100.8
EC - London EC	80.4	OX - Oxford	2.6	WD - Watford	13.8
EN – Enfield	15.3	PE - Peterborough	1.6	WF - Wakefield	10.6
EX – Exeter	1.1	PL - Plymouth	1.9	WN - Wigan	14.7
FY - Blackpool	17.3	PO - Portsmouth	7.5	WR - Worcester	2.3
GL - Gloucester	2.2	PR - Preston	5.4	WS - Walsall	9.8
GU - Guildford	4.5	RG - Reading	4.0	WV - Wolverhampton	7.0
HA - Harrow	42.6	RH - Redhill	3.8	YO - York	1.1

c) What venues are appropriate to use for consulting rooms, whether fixed or mobile?

For medical experts to assess patients, MedCo considers that at all times the best interest of the claimant must be considered and locations must be confidential, private, safe and secure and be regarded as a professional environment. Subject to the right to periodical review, currently it considers the following venue types as examples but not an exhaustive list:

i. Best practice: Medical facilities e.g. clinics, GP practices and other medically equipped centres.
ii. Acceptable: Hotel conference / meeting rooms / offices equipped to an equivalent standard to medical facilities that are confidential, private, safe and secure and home visits (eg elderly/vulnerable patients).
iii. Inappropriate: Hotel bedrooms, other offices / commercial premises, private residences and via webcams or other means whereby the medical expert is remote from the patient.

If in any doubt, medical experts should refer back to their own regulator and published medical best practice to seek guidance.

3) 1.16 – Minimum Standards and Service Levels

a) How often should performance against SLAs be monitored?

That is up to each MRO to decide, but a minimum of monthly would be considered best practice.

b) Why does SLA 2 not take into account instances where solicitors / claimants specifically request a delay in appointments?

There are two measures for SLA 2. The first includes such delays and the second excludes them. Where a MRO can demonstrate both that it meets the second measure and does not meet the first due specifically to a high level of Instructing Party requests, it may be deemed to meet SLA 2. MedCo however will consider the circumstances of each case etc.

c) What is the appropriate basis to calculate SLAs 1 and 2?

A worked example follows, based on 10 cases with the following characteristics:

- 7 – no delay requested by solicitors: 4 within SLA and 3 outside SLA
- 3 – delay requested by solicitors: 1 within SLA and 2 outside SLA

- SLA days is a variable, depending upon SLA number and whether part a or b

Worked examples:
- SLA 1a (all instances): 50% i.e. (4+1)/10, where SLA days = 25 business
- SLA 1b (excluding delays): 57% i.e. (4/7), where SLA days = 20 business
- SLA 2a: calculated as 1a, except SLA days = 35 business
- SLA 2b: calculated as 1b, except SLA days = 25 business

d) Where can the information be found to calculate SLA 8?

The onus is on each MRO to review the details of poor performance published by the appropriate medical professional bodies e.g. GMC, HPCP and MedCo; identify whether any poor performers are on its medical expert panel; and if so, identify how many reports those experts produced for the MRO in the past 12 months. This will enable the MRO to calculate this SLA and assess the effectiveness of its own internal quality assurance processes.

Table 2 – Additional Qualifying Criteria

4) 2.2 – Operational Capability

a) Do the minimum numbers e.g. of medical experts (250) or medical reports pa per urban (16) and rural (4) areas reduce in proportion where less than 40,000 reports are produced pa?

No.

b) What method should be used for calculating the "less than 15 miles" distance an injured party has to travel to attend an appointment with a medical expert?

Any journey that the injured party would normally be able to take (e.g. by public or private transport) to get to the appointment is acceptable. Methods with a propensity to generate theoretical travel distances (e.g. "as the crow flies") are not appropriate. Google maps is an example of a tool that can be used to assess / measure these distances.

General Disclaimer:

The Answers to FAQs ("answers") listed above are provided strictly for guidance purposes only and are intended to be read in conjunction with the MedCo Guidance on the MoJ Qualifying Criteria. The answers are produced in response to queries that have been raised since the Guidance was produced. At all times, MRO must comply with the Qualifying Criteria. The answers are produced only to indicate how MedCo may interpret the Qualifying Criteria in given situations; they are not a legal document and may be revised from time to time.