Guidance on MoJ Qualifying Criteria

2018 Update

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Preamble

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

a) Interprets key terms in the revised qualifying criteria ('**QC**') document ('**QCD**') published by the Ministry of Justice ('MoJ') on 25 October 2016; and
b) Will approach the audits of MROs registered on MedCo or applications to register with Medco as against the QC.

The aim of this document is to clarify the approach that MedCo take to the interpretation of the QC and to assist MROs in understanding the QC and what is required to meet them. This allows a consistent approach to be adopted during audit. It should be noted that the Guidance is not intended to cover all possible scenarios by which the QC can be met. If an MRO can demonstrate that it meets the QC in a manner not specifically covered in this Guidance but which is consistent with the spirit of the Guidance, MedCo will accept this as meeting the QC. It is the QC that need to be met, not the Guidance. The Guidance does however set out what is considered by MedCo to be appropriate to meet the QC and if the MRO chooses to adopt a different approach the onus will be on the MRO to satisfy MedCo that their approach does meet the QC.

The Frequently Asked Questions to Guidance Document ('**FAQ**') at http://www.medco.org.uk/core-documents-help/ supplements this Guidance by providing answers to common queries raised since the Guidance was last updated. The Guidance and FAQ are produced only to indicate how MedCo may interpret the QC in given situations; neither are legal documents and may be revised from time to time.

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 1.14, 2.7 and 2.8 there are no corresponding paragraphs in this Guidance document.

General Principles (to Assess Compliance)

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 may 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) When making its decisions, MedCo considers the extent to which a MRO that fails to meet one or more of the criteria in part or whole can provide evidence of having fully addressed the applicable issues prior to the decision being made.

d) The onus is on each MRO to provide ***sufficient, relevant, reliable and substantive*** evidence ('**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 evidence requirements as follows, with further explanation of their approach set out in the applicable MedCo QC Audit Guide ('**Audit Guide**') and related MedCo Technical Data Aid ('**Technical Data Aid**'):
   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.

e) 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. Where a MRO states that no evidence exists as no such events have occurred (e.g. no complaints), the onus is on the MRO to demonstrate the plausibility of this in light of e.g. how robust its data capture and business processes are.

f) An independent MRO should undertake business development activities and client engagement suited to its business plan. A passive presence on the MedCo Portal will not be considered proactive business development, nor will reacting to the changing numbers of HVN and RB MROs.

g) 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.

h) When evaluating compliance with any criterion (both Tables 1 and 2), unless explicitly stated otherwise (e.g. minimum 12 months data for SLA performance), 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.

i) It is possible that a MRO may fail to meet one or more numerical targets specified directly in the QC or by MedCo e.g. 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, 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 use of the tolerance level is required on no more than 2 occasions per audit. 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).

j) MedCo may apply a tolerance limit to the requirements for non-numerical 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.

k) New applicants seeking to register a MRO with MedCo are expected to demonstrate as part of their new registration audit that they understand the QC and Guidance and that, should their application be accepted, that they would have all the core functions (see 1.1 below) ready to operate from day 1 upon being set to 'live' status on the MedCo Portal. An applicant will not pass a new registration audit if it only intends to starting designing and developing its processes once it has been set to 'live' status.

l) This Guidance may be updated periodically and as required. Users are responsible for ensuring they have access to, and are making reference to, the latest version of this Guidance.

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** (QC 1.1(i)):
   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 multiple 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 for non-core activities paid for on normal commercial terms e.g. not free of charge or for a severely reduced consideration significantly below market rates;
      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) Such structures have not been set up specifically to exploit the random allocation model or in breach of criterion 1.8 (Ethics Policy). The onus will be on the MRO to demonstrate that this is not the case.
   iii. A MRO should receive payments directly from instructing parties and pay medical experts directly i.e. 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.
   iv. To be considered independent, a MRO must have physically different premises with physically separate spaces from other MROs. Where one or more MROs operate from the same building, MedCo will presume that MROs are not independent of each other and the onus will be on the MROs to demonstrate that they are in fact independent, for example by demonstrating that:
      a) They occupy separate floors/office spaces within a single office building that provides for multiple separate occupancies;
      b) They are functionally operated as separate units in terms of business activities and infrastructure e.g. no shared wired IT networks, utility bills or rental agreements; and
      c) There is no interchange of employees between the MROs i.e. indiscriminate use of employees in both units without regard to the segregated functions of such units.

b) What constitutes "**properly staffed and resourced**" (QC 1.1(ii)) 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 clinical and non-clinical quality assurance role (see 1.13(e)(ii)) 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. MedCo considers activities set out at paragraph (d) below 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 trading, having undertaken relevant training to provide MRO services.
f) Remain up-to-date with relevant medico-legal reporting matters and practices arising from relevant government, regulatory, industry or medical professional bodies.
g) 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.
h) 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 MRO1 has been selected but does not have the resources to produce the report, so engages (directly or otherwise) with MRO2 who completes it on MRO1's behalf, and that report is then submitted to MedCo as if MRO1 had done the work itself – this service may be reciprocated if MRO2 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.
i. A new entrant MRO yet to produce the report volumes needed to be self-sustaining, may be deemed to have a solid financial base where it can demonstrate that it has sufficient financial backing from an owner or third party (e.g. bank) in this period. MedCo deems this maximum time period and self-sustaining volume threshold as those set out at 1.4(f)(i).
e) Staffing models based on a high proportion (i.e. 50% or more) of secondee staff from other MROs or non-MRO organisations that service multiple MROs.

c) **Direct management:**
i. Terms used in the QC rationale for criteria such as "core functions", "third party ownership model" and "fully functioning" are considered to relate more to QC 1.1(iii) than QC 1.1(i) or (ii). MedCo's interpretation of these terms is set out in paragraphs (d) and (e) below; and
ii. In relation to the specific parts of QC 1.1(iii):
a) See the Guidance on all sections of 1.13;
b) As for (a) above and see Guidance on payment of experts at 1.3;
c) See the Guidance for the appointments process at 1.13(e)(c);
d) See the Guidance for quality assurance at 1.13(e)(b) and complaints at 1.9; and
e) See the Guidance for ethics at 1.8 and the applicable MRO User Agreement.

d) The **core functions** of a MRO are considered as a minimum to be those covered by QC 1.1, 1.8, 1.13, 1.16 and 2.2, as interpreted by MedCo in this Guidance. **Non-core activities** include e.g. accounting, legal, compliance, HR and IT infrastructure.

e) MROs may be part of a "**common third party (individual and/or corporate) ownership model**" ("CTPOM") already existing or, by exception, newly formed (e.g. MRO acquired as a byproduct of a larger transaction) as long as they are also "**fully functioning**" i.e. the fact that the MRO is part of a CTPOM is incidental to its ability to operate as a fully functioning MRO and if it lost access to any non-core resources provided by that CTPOM, 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;
      i. A specific exception to this is set out at 1.1(e)(ii)(d)(ii); and
   c) Acquisitions, where the organisations have taken account of the following three factors:
      i. Notice to MedCo: Adequate notice should be provided to MedCo where there is any change of control of a MRO, which will enable MedCo to consider whether the MRO will continue to meet the requirement to be independent in accordance with QC 1.1(i) post-completion of the acquisition;
      ii. Post-acquisition structure: The combined entity is expected to operate:
         a) Either as a single MRO on the MedCo Portal from the date at which it has legal control over the acquired entity;
         b) Or as a separately configured and branded unique, fully functioning business entity, with separation remaining uninterrupted pre-, during and post-acquisition; and
      iii. MedCo's Ethics Policy: The acquisition must not undermine confidence in the MedCo service or the Government's stated policy objectives.

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; and
   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:
      i. 'Executive' includes (but is not limited to) those with the ultimate or material decision-making authority at the MRO i.e. depending upon the size and ownership of the MRO:
         a) Directors of the MRO registered at Companies House, whom have legal and fiduciary duties to fulfill, and their equivalents. The latter includes, where the MRO is a subsidiary of a larger organisation, those managers in the larger organisation to whom the MRO's senior managers report into; or

b) Those managers of the MRO (i.e. senior managers) whom report directly into an Executive Director or equivalent and whom manage the MRO on a day-to-day basis.

ii. A single common director in a CTPOM in a large group (as defined by the EU Accounting Directive https://www.accountingweb.co.uk/business/finance-strategy/audit-exemption-thresholds-set-for-change) is acceptable, but only if that director is appointed purely for the parent entity's financial reporting and corporate governance purposes and can demonstrate no business or operational involvement with any MRO in the CTPOM structure. MedCo will presume that any common director has a business or operational involvement in those MROs and the onus will be on the MRO to demonstrate to the contrary. Evidence of appropriate engagement can comprise e.g. a shareholder agreement that limits the parent entity's rights and those of its appointed directors and how that is executed.

f) The QC refers to "shells". A **shell** is interpreted by MedCo as a MRO that is unable to demonstrate that it meets the minimum standards i.e. Table 1 QC, in particular 1.1 (Definition of a MRO):

i. Should an existing MRO be unable to meet these minimum standards, then the fact that it has been trading as an independent MRO previously does not exempt it from the requirement to meet the minimum standards.

ii. MedCo presumes that the following MROs are shells, with the onus on the MROs affected to demonstrate to the contrary:

a) Where a MRO (whether with high volume, national status or not) 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;

b) Sharing best practices is encouraged e.g. where a MRO identifies such practices in another MRO and applies those principles to its own business and method of operating. Replication of another MRO's practices, especially if they are not best practices and extensive, however, is indicative of being a shell e.g.:

i. Where the processes, documentation and procedures for QC 1.13 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 are not fully functional and do not directly manage their panel of medical experts;

c) 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.

g) QC 1.1(iii)(e) makes it clear that MROs should not operate in a way contrary to the Government's stated policy objectives. As such, MROs should accept instructions from Users that have selected them via the MedCo Portal. However, MedCo considers there to be two instances where a MRO can refuse an instruction from a User and this would not undermine the Government's policy objectives:

i. These instances are where:

a) To accept the instruction would result in the MRO breaching another QC e.g. 2.2.4; or

b) There is a demonstrably untenable relationship between the MRO and Instructing Party e.g. significant commercial dispute or legal proceedings have commenced.

ii. In such instances, the MRO should inform the User in writing that it is rejecting the instruction and the reason for this, so that the User is able to comply with its own obligations to MedCo i.e. provide the reason (with supporting evidence) for making a second selection for the same instruction. Failure by the MRO to complete these formalities would be considered a breach of MedCo's Ethics Policy – the same would apply to the User in respect of its compliance with MedCo's Ethics Policy.

1.2 – Direct Financial Links

a) MROs should declare all potential direct financial links per the MoJ's revised statement (http://www.medco.org.uk/media/1210/moj-revised-statement-on-direct-financial-links-december-2016.pdf) 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 could fall within the definition of a direct financial link as set out in the MRO 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);
   ii. Breached the User Agreement (see warranties section) and
   iii. Undermined MedCo's confidence in the MRO's ability to self-declare all its direct financial links.

1.3 – Payment of Experts on Set Credit Terms

a) MROs are expected to demonstrate this via standard contractual terms and adequate financial records e.g. "aged creditors'" listings.

b) MROs are encouraged to apply the Prompt Payment Code (http://www.promptpaymentcode.org.uk/) when paying medical experts.

c) Where payment terms deviate significantly from the Prompt Payment Code or experts are paid only after the MRO has itself been paid by the Instructing Party, a rebuttable presumption will exist that such payments may be contingent (1.3), medical experts may not be directly managed appropriately (1.13) or be sufficiently independent (1.13 & 2.2.1) 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";
   iii. State that the beneficiaries are any MedCo-registered expert that has been instructed by the MRO to produce a MedCo report for it; and
   iv. 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) - (iii) above, but not (iv) 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) Any financial instrument obtained must be issued by an authorised firm in order for MedCo to accept that QC 1.4 has been met. Authorised firms include:
   i. All authorised insurers (including insurers at Lloyd's) authorised to write business in Class 15: suretyship;
   ii. Banks authorised to accept deposits in the UK, including those authorised in the EU or with appropriate "passports" to conduct business within the UK; and
   iii. Payment institutions (e.g. escrow agents) either registerd with, or authorised by, the Financial Conduct Authority.

e) MedCo does not consider that money deposited in solicitors' client accounts complies with the QC.

f) 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 by meeting 1.4(a)(i) - 1.4(a)(iii) only i.e. not 1.4(a)(iv):
      a) This exception does not apply where a new MRO acquires the business of an existing MRO in part or in whole, as the MRO's period of operation is then deemed to be continuous;
   ii. All other MROs can only satisfy this criterion through meeting 1.4(a)(i)-(iv); and
   iii. Where MROs exist (including new MROs i.e. (i) above) that are connected by any form of group ownership (including that of a common third party (individual and/or corporate) ownership model where the individual MROs are fully-functioning and independent entities) this criterion can only be satisfied through meeting 1.4(a)(i)-(iv). This is because the effect of cross-guarantees and other financial links within group structures can reduce the certainty of medical experts not being paid by 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 ICO's overview of the General Data Protection Regulation (GDPR), which takes effect from 25 May 2018 – https://ico.org.uk/for-organisations/data-protection-reform/overview-of-the-gdpr/ and related links, particularly under the "What's New" tab;
   ii. Demonstrating that the MRO has prepared for the implementation of GDPR e.g. by taking the actions recommended by the ICO in its "Preparing for the GDPR – 12 steps to take now" document - https://ico.org.uk/media/1624219/preparing-for-the-gdpr-12-steps.pdf and any subsequent guidance the ICO might publish;
   iii. Completing the ICO's Getting ready for the GDPR checklists for data controllers or data processors as appropriate – https://ico.org.uk/for-organisations/resources-and-support/data-protection-self-assessment/getting-ready-for-the-gdpr/;
   iv. Documenting its own information security risk assessment; and
   v. 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. In such situations the onus is on the MRO to demonstrate that its information security controls are appropriate and 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. Further guidance with examples is available from The Institute of Risk Management's and Trasparency International UK's Bribery Risk Guide at https://www.theirm.org/media/2218767/IRM-TI-UK-Bribery-Guide-A5-V6-Low-Res-proof.pdf; 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 User 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 an equal or 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.

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;
   ii. Co-operates with MedCo's processes, including the applicable audit process and escalation procedure, published on MedCo's website at http://www.medco.org.uk/core-documents-help/;
   iii. 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; and
   iv. Takes pro-active action to identify and address any issues under standard 4 of MedCo's Ethics Policy, particularly where they relate to controlling shareholders, directors or senior management.

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;
   ii. Demonstrating that the Ethics Policy has been incorporated into its day-to-day operations e.g. by conducting a risk assessment or gap analysis of its activities against each standard; and
   iii. Where potential actions might contravene the Ethics Policy, that these have been fully evaluated as to whether or not they breach it (see (d) 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:
         i. Companies under common control that do not operate independently from one another as required by QC 1.1;
         ii. "Standalone" MROs each operated/controlled by different members of the same family;
         iii. MROs with a similar profile in close proximity to one another; and
         iv. 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 (core) role, accountable for the MRO's overall compliance with the QC and MRO User 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 (non-core) 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 MRO User 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 non-core Compliance Officer role (but not the core Responsible Officer role) could be performed at a group level. 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.

1.11 – Restriction on Providing Medical Evidence

a) MedCo interprets conflicts of interests in line with the applicable ethical guidance of the: HCPC (http://www.hcpc-uk.org/aboutregistration/standards/standardsofconductperformanceandethics/) and GMC (http://www.gmc-uk.org/guidance/ethical_guidance.asp).

b) MedCo interprets related parties as including e.g. the expert's existing patients (including any patients seen within 12 months of receipt of the instruction), family members, business associates and friends (i.e. more than acquaintances).

c) A MRO can satisfy this QC requirement if:
   i. Its contract with a medical expert contains a provision that requires the expert to disclose to it any conflicts of interests or related party relationships that arise from the receipt of an instruction;
   ii. Where the MRO suspects a potential conflict of interests, it queries this with the expert; and
   iii. Should a conflict arise, it reallocates the relevant instruction to an alternative medical expert.

1.12 – Directors and Officers

a) Directors (as registered at Companies House, as defined by either s250 or s251 of the Companies Act 2006 or equivalent in a non-corporate structure e.g. partner) and Officers (i.e. company secretary and any managers appointed by the MRO as officers) should have the checks set out below performed as part of the recruitment process, and annually thereafter, and assess the results to ensure that no bankruptcies or fraud convictions exist:
   i. Credit reference checks e.g. via Experian, Equifax or Call Credit including understanding whether historic bankruptcy / fraud indicators may be underlying factors behind any low credit scores;
   ii. Searches (https://www.gov.uk/search-bankruptcy-insolvency-register) on the UK's bankruptcy and insolvency registers; and
   iii. Searches (https://www.gov.uk/search-the-register-of-disqualified-company-directors) for disqualified company directors.

b) QC 1.12 strictly applies only to Directors and Officers. However the rationale for QC 1.12 makes clear the MoJ believe that those exercising control via ownership should also be of appropriate character. MROs are invited to consider similar checks as above to owners or shareholders, at the time that they invest and annually thereafter in order to ensure that they can meet the requirements of the Ethics Policy, 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:
   a) The MRO **cannot delegate** part or all of the expert management process to:
      i. Other MROs, whether MedCo-registered or otherwise;
      ii. Intermediaries, whether medical agencies or other third party service providers, and whether external or fellow group companies;
      iii. Administrative companies unless it is for purely administrative duties arising from the MRO's direct interaction with the expert, such as:
         a) Scheduling appointments slots within parameters agreed by the MRO and medical expert;
         b) Submitting reports produced by the medical expert to the MRO;
         c) Submitting bills for work performed by the medical expert to the MRO; and
         d) Uploading completed reports to the MedCo Portal; or

iv. Automated software, unless the software is directly managed by the MRO i.e. it:
    a) Has been developed in-house; or
    b) 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; or
v. Any other arrangement that creates a disconnect between the MRO and the medical expert.

b) **Contractual arrangements** between an MRO and a medical expert for the purposes of assessing RB status are interpreted to be all of the following respectively:
    i. They must be direct arrangements between a MRO (organisation) and a named medical expert (individual). Any other arrangement 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); and
    iii. 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.

c) **Active** for RB status is as per 1.13(e)(d)(iv).

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 e.g. sample review reports; and
            b) Should be added to its panel or not e.g. uses appropriate venues for consultations;
        iv. How it assesses whether medical experts meet the above criteria.
    b) Not instructing experts until recruitment checks (GMC/HCPC registration, MedCo accreditation, ICO registration, insurance etc.) have been satisfactorily completed and a contract is in place;
    c) Executing the above process and retaining evidence thereof;
    d) 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
    e) Avoiding such poor practices as:
        i. Relying upon MedCo, another MRO, intermediary, administrative company or third party organisation to have interviewed and/or performed all the appropriate checks on a potential recruit and his/her operating clinics so that it does not have to; and
        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 GMC / HCPC registration, MedCo accreditation and ICO registration (which must cover medico-legal reporting) 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 appropriate insurance policies (which must cover medico-legal reporting of the medical experts on its panel.

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. Whilst commercial terms are matters for MROs and medical experts to agree, the onus will be on the MRO to demonstrate that they do not work to impair the independence of the medical expert's opinion in breach of QC 1.8 and 1.13 and that the MoJ's policies as set out in the preamble to the QC are not being undermined by its actions;
      ii. 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 e.g. for poor performance and for subsequent actions e.g. removing them from the panel or restoring them should it be satisfied that those issues have been addressed; and
      iv. **Removing** individual medical experts from its panel promptly as required e.g. retirement, death, emigration, cease to practice, medical registration withdrawn, MedCo accreditation expired and poor performance.

   b) Conducting **Quality Assurance** on the reports it produces, (see also QC 1.1(iii)(d)). The QC refers to MROs producing medical reports of a certain **quality**. MedCo interprets this standard of quality as comprising both clinical and non-clinical quality:

      i. **Clinical quality** involves the MRO defining and implementing suitable processes that cover:
         a) Setting, implementing (e.g. via contractual requirements) and monitoring (e.g. via client satisfaction surveys) a minimum appointment time for its experts to perform patient clinics, with supporting rationale as to the appropriateness of this minimum time. Guidance from appropriate medical bodies e.g. https://www.bma.org.uk/news/2016/august/doctors-set-out-safe-working-levels-plan-for-general-practice and related developments should be considered when setting a minimum appointment time;

         b) The provision of suitable locations for consultations. MedCo considers that at all times the best interests of the claimant must be considered and locations must be confidential, private, safe, secure and be regarded as a professional environment. If in any doubt, MROs should refer medical experts back to their own regulator and published medical best practice to seek guidance;

         c) Reviewing the quality of medical reports produced by its medical experts e.g.:
            i. Sample reviews of the initial reports of newly appointed medical experts and following up any issues; and
            ii. Trend analysis for signs of potential concerns about clinical matters in existing panel members' reports e.g. all injuries identified and length of recovery times.

iii. Examples of potential concerns in addition to the above include:
  a) Absence of an mechanism of injury being described;
  b) Inconsistent findings e.g. examination normal but psychological issues described;
  c) Relevance of health factors to the accident unclear;
  d) Justification for referral to one or more specialists unclear;
  e) Opinion and prognosis not provided for all injuries relevant to the accident; and
  f) Commenting on matters beyond the scope of the medical expert's expertise.

d) Its CMO. 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. The individual concerned:
    a) Satisfies all the 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 as a CMO 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 status 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.

ii. **Non-clinical quality** involves the MRO defining and implementing suitable processes that cover:
  a) Checking that each report meets at least those standards 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);
  b) Trend analysis for signs of potential concerns about non-clinical matters regarding existing panel members' reports e.g. number of reports returned for amendment by instructing parties; and
  c) The MRO's own performance and expert SLA requirements e.g. turnaround times.

c) Effective **appointment capacity** monitoring and planning, (see also QC 1.1(iii)(c)), 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 in advance to fully ad hoc i.e. contact medical experts for availability as and when needed;
  ii. Capacity planning conducted on an ad hoc basis is more suited to smaller RB MROs, whilst block booking in advance is more suited to HVN MROs (see 2.2.2(a)); and
  iii. Capacity planning should allow for lost appointments e.g. "no shows" and cancellations.

d) **Geographical** planning, so that:
   i. Instructing parties have a credible selection choice from the MROs presented by the MedCo Portal to service an instruction, meaning a MRO can only claim geographical coverage in postcode areas where it has an active marketing presence i.e.:
      a) Demonstrable engagement with at least two instructing parties in each postcode area e.g. via business development / account management meetings, marketing campaigns (email, post or telephone) and terms of business.
      b) Where the MRO engages with a multi-office instructing party through a centralised co-ordinated relationship, the MRO is deemed to be actively marketing to all the postcode areas covered by those offices in that arrangement.
      c) Having a website and a presence on the MedCo Portal constitute passive marketing and neither is considered to be active marketing.

   ii. It has sufficient numbers of medical experts operating consulting rooms in the geographical regions that it purports to serve (and does not claim coverage otherwise), to:
      a) Provide sufficient choice and convenience of appointment slots for the claimant;
      b) Offer a quality service in terms of venue, length of appointment and dependability; and
         i. Avoid any need to stockpile instructions (stockpiling occurs where a clinic is only scheduled when a MRO has enough instructions to make it financially viable); and
         ii. Reduce the need for experts to crisscross the country providing a high number of small ad hoc clinics to situations where it is in the claimants' interests to do so.

   iii. Population density differences are accounted for between urban and rural areas i.e. one medical expert may constitute sufficient coverage for a low density rural location but not for a high density major metropolitan area. MedCo assesses population density by postcode area using the Office for National Statistics' ('ONS') usual resident population density measure (persons per hectare) and considers densities of 4.0 and below as rural postcode areas. Population densitites by postcode area are set out in the FAQ.

   iv. A MRO can claim geographical coverage in a postcode area (see 2.2.3 (a)) where:
      a) The MRO has an active marketing presence (see above);
      b) The MRO has sufficient medical experts under contract to service the demand in that area i.e. 3 per urban postcode area and 1 per rural postcode area;
      c) Each expert above produces at least one report from one or more venues within that postcode area year-on-year;
         i. Where a MRO expands into a new postcode area, this provision does not apply during the first 12 months from when it first claimed coverage on the MedCo Portal;
      d) At least 60% of expert consultations are at fixed, and not mobile, consulting rooms:
         i. It is possible for the same medical expert to operate from fixed and mobile consulting rooms. In such instances, the onus is on the MRO to distinguish between them;
         ii. Where it is unclear if a venue is fixed or mobile, it is likely to be considered mobile;
         iii. Factors indicative of a fixed consulting room include, but are not limited to, it being used as a clinic (i.e. the expert holding consecutive appointments in the same consulting room) and the clinic being:
            a) Consistently held at the same time and place;
            b) Frequently held e.g. daily, weekly or fortnightly for an urban postcode area and fortnightly or monthly for a rural postcode area;
            c) Available for MedCo and non-MedCo medico-legal appointments for one or more MROs / instructing parties); and
            d) Of such duration that an expert could not hold more than 2 clinics (i.e. at different locations) per day;

iv. The designation of 'fixed' and 'mobile' may be calculated on the above basis using one of two data sets:
   a) The MRO's own data; or
   b) Industry-wide data pooled and maintained up-to-date by AMRO on behalf of multiple MROs, provided that access to this data is available to all MedCo-registered MROs (whether members of AMRO or not) on the same terms and for a not-for-profit fee.

e) By definition, a RB MRO should rarely be in a position to provide national coverage (i.e. of 80% or more of all postcode areas) on a substantive basis. In such situations, the onus will be on the MRO to demonstrate that its coverage claimed on the MedCo Portal is appropriate.

f) **Independent** means that the medical expert:
   a) 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;
   b) 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
   c) 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.

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

1.15 – Upload Anonymised Case Data

a) MROs are required to upload data for all their MedCo cases. The QC specifies that MedCo will define the time period for providing the required data. MedCo has set this out within its SLAs – see SLA 7 in Appendix 1.

b) Allowances for error and system problems are built into the timescale metric. A MRO that uploads case data daily or weekly and checks that the upload was successful has time to correct any errors or system problems and still meet the SLA:
   i. MROs may not exclude cases from the SLA 7 calculation unless their upload is prevented by system errors with the MedCo Portal, where these errors affect all MROs' uploads and persist for at least 14 consecutive calendar days. Such errors, and the allowances to be made when calculating SLA 7, are determined by MedCo and not by individual MROs.
   ii. HVN MROs should note the normal recovery time for disaster recovery set out in QC 2.4.

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 five 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;
   iv. Data security, so that claimants' sensitive personal data is adequately protected at all times; and
   v. MedCo compliance, to ensure that areas of deficiency are addressed promptly.

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:
   i. 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; and
   ii. Monitoring performance against the SLAs on a monthly basis would be considered best practice.

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

Table 2 – Additional Qualifying Criteria

a) MedCo considers that the overriding 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.

b) Minimum quantities set out in the QC e.g. 40,000 reports pa and 250 experts are considered absolute and not pro-rateable; time periods not stated in the QC are pro-rateable where expressly stated.

c) Where a RB MRO seeks to be recategorised to HVN status. MedCo will take into account evidence which demonstrates the MROs ability to achieve HVN status. Relevant evidence will cover but is not limited to following factors:
   i. The extent to which it meets and exceeds the Minimum QC;
   ii. The extent to which it meets the Additional QC, given the volume of reports available to it;
   iii. Its reputation and standing amongst instructing parties, which reflects the need for HVN MROs to provide confidence to Users that they can operate to the minimum standards at high volumes; and
   iv. The extent to which realistic, practical operational factors in meeting the QC have been considered e.g.:
      a) Its business plan should demonstrate that the MRO is familiar with the practical implications and challenges of running a high volume, national MRO or equivalent. Demonstration of such knowledge, specifics and precision would support an applicant's case.
      b) For a MRO to switch from producing low volumes of reports to high volumes within 12 months whilst also maintaining high quality standards requires exceptional skill and experience. The onus will be on the MRO to demonstrate that it is properly staffed and resourced to deliver this scale of change;
      c) Its ability to leverage its non-MedCo business (if any) to assist it in meeting the Additional QC;
      d) The extent to which it meets the spirit of the QC and Guidance, for example an applicant that applies at the earliest possible time (i.e. after 2 years trading) and has only aspired to that point to meet the minimum critiera , rather than building towards meeting the additional criteria, is less likely to demonstrate credibility and a track record of delivery.

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. Any RB MRO aspiring to HVN status that meets the exemption requirements for statutory audits should arrange with its external auditor for a statutory audit to be undertaken and the issued audited accounts to be available as part of its MedCo re-categorisation audit;
   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) **Unlinked source** means an entity with no direct financial links to the MRO.

b) 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.

c) For a MRO that has not previously produced 40,000 MedCo and non-MedCo 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. This business plan must address specifically:
   i. The MRO's plan to achieve HVN status, demonstrating how its past actions and achievements are consistent with this aim and what its future plans are to realise this. MedCo is likely to consider plans as being more credible where they are:
      a) Specific rather than generic e.g. tangible actions with owners and deadline dates;
      b) Indicative of a medium-long term business view rather than being short-term or opportunist i.e. where the plan for the next 12 month horizon is an integral part of a longer term strategy that has already realised the development of the MRO from e.g. inception / a small MRO to e.g. a medium / large RB MRO; and
      c) Forward-looking rather than backward-looking i.e. past performance is relevant only in the context of how that enables future performance;
   ii. Any inorganic growth strategies e.g. acquisitions of MedCo and/or non-MedCo medicolegal businesses (see 1.1(e)(i)(c));
   iii. Growth in its MedCo and non-MedCo businesses;
   iv. The growth required to consistently produce 40,000 medical reports pa from its current position. The focus is not growth in numbers of reports per se, but the rate of growth as that is integral to managing capacity, which tends to be implemented successfully through a series of step changes rather than linearly. The plan should cover recognition of these step changes and how each would be managed. The greater the capacity gap between 40,000 reports and the current state, the more challenging capacity management becomes, which should be reflected in the plan;
   v. How that growth will arise i.e. why claimant representatives would select it over other MROs in the required additional volumes (reductions in the number of HVN MROs is not a valid explanation, as the MRO has no knowledge of potential additions to HVN status). This supports credibility of the above capacity management plan and 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.
   vi. Its historic growth rate; and
   vii. That its **operational functions** (see para below) are sufficiently robust and scaleable per QC 2.2 (bullet 1, subsection ii), which MedCo assesses in terms of performance against the MedCo SLAs (see 2.2.5) and MoJ SLAs (see 2.2.3).

d) Demonstrating that **operational functions** are sufficiently robust and scaleable involves the MRO:
   i. Already performing or having performed within the past 4 calendar years at levels:
      a) Either substantially above a combined volume of MedCo and non-MedCo reports at 4,000 per annum (10% of the HVN requirement), below which MedCo deems it unrealistic for a MRO to be able to meet the Additional QC or for it to be viable to conduct an audit;
      b) Or at the upper end of the MedCo RB spectrum typically in the top 20% of all HVN and RB MROs in terms of the number of MedCo medical reports it produces per annum (published on the MedCo website);
         i. 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 resourcing and appointment capacity plans that set 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 e.g.:
      a) Meeting the MedCo SLAs comfortably and consistently at its current level of volumes, to give confidence that it can maintain these levels if volumes were to sharply increase; 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.

e) 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 1.13(b)(b)(i)-(iii) plus the following **appointment capacity** provisions:
   i. Arrangements must be such that MROs should be 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
   ii. For RB MROs aspiring to HVN status, where instruction volumes are insufficient for them to secure large scale block booking arrangements with experts, they should be able to demonstrate an ability to forward plan and manage adequate appointment capacity on a c.3 month horizon such that they meet all the MedCo efficiency SLAs (see Appendix 1).

b) A MedCo-accredited 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** is where each MedCo-accredited expert produces for the MRO on average:
   a) At least 16 MedCo and non-MedCo medical reports pa, where the expert is either a generalist (e.g. GP) or services an urban area;
   b) At least 4 MedCo and non-MedCo medical reports pa, 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 only 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 up to a three year horizon to allow for fluctuations in instructions year-to-year provided an expert produces at least one report in each 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 possible per medical expert pa is 160, based on 250 medical experts producing 40,000 medical reports. This enables MROs to direct more work to, in their view, better performing experts.

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 **contracted medical expert** is a MedCo-accredited medical expert that is active and with which the MRO has the above contractual arrangements.

2.2.3 – MoJ SLAs on 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.105 in England and Wales, and not the postcode district or any other smaller zone.

b) An MRO meets the first MoJ National Coverage requirement (80% of the postcodes), where in 80% of the 105 postcode areas it has 1 contracted MedCo-accredited medical expert with a fixed consulting room in that postcode area, where the requirements stated within 1.13(e)(d) are also met.

c) 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 actual travel distances injured parties may use e.g. public highways measured via e.g. Google maps and not on a theoretical basis e.g. "as the crow flies".
   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.

d) 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 have a contract with the MRO and submit 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 to 12 months' data measured on a rolling monthly basis, 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. Where there is more than one entity that instructs an MRO within a group of companies, the 40% threshold applies to the aggregate instructions made by the group.

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, relevant thresholds and notes 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 five 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;
   iv. Data security, so that claimants' sensitive personal data is adequately protected at all times; and
   v. MedCo compliance, to ensure that areas of deficiency are addressed promptly

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.
   i. Any HVN MRO looking to deliver good or best practice should aim to exceed these standards and service levels.
   ii. Monitoring performance against the SLAs on a monthly basis would be considered the minimum needed.

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 utilise spare capacity within the existing teams / systems to maintain these standards at higher volumes.

2.3 – Financial Instrument

See 1.4 in respect of the type of instrument that is considered likely to be 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 but 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

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 MROs

No.	Minimum Service Level	High Volume National (HVN) MRO		Regional Based (RB) MRO	
		Standard (note ii)	% Met	Standard (note ii)	% Met
Efficiency (so that claimants receive their reports on a timely basis)					
1	Elapsed time from instructions being received to date of appointment (see note i): a) In all instances (includes e.g. "do not attends", reschedules, "no shows"/abandoned & requested delays) b) 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 (see note i): a) In all instances (includes e.g. all in SLA 1(a) above and where supplemental report required) b) 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 after original report has been issued: a) Proportion of reports issued requiring re-work and/or MedCo-related follow-up work b) 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: a) Telephone b) 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 (see note iii): a) Solicitors or claimants b) Medical experts	 20 business days 20 business days	 90 90	 20 business days 20 business days	 90 90

No.	Minimum Service Level	High Volume National (HVN) MRO		Regional Based (RB) MRO	
		Standard (note ii)	% Met	Standard (note ii)	% 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). *Unless automated checks are mandatory fields, MROs should demonstrate checks are made*	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. **NB. SLA7 equates to QC 1.15**	30 calendar days	100	30 calendar days	100
8	Proportion of a MRO's reports in the immediately preceding 12 months that have been produced by medical experts suspended or disciplined by the expert's professional body or MedCo for producing 1 or more medical reports of an unacceptable standard or other inappropriate conduct (excluding suspension for administrative reasons)	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: a) Number of major non-conformities found at MRO: b) Number of minor non-conformities found at MRO:	 Zero Less than 5	 100 100	 - -	 - -
10	a) The number of MedCo-related cases where personal data has been inappropriately disclosed in any 12 month period does not exceed (see note iii): b) Elapsed time from reporting breach (to ICO and/or individual as appropriate) since becoming aware of it	0.05% of cases 72 hours	100 90	0.1% of cases 72 hours	100 90
MedCo Compliance					
11	Number of audit recommendations rated either Red or Amber that have not been given the status of "closed – implemented" by the MedCo Audit Team within 6 months of the final audit report being issued	Zero	100	1	100

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" relate to the first fixed cost medical report for a soft tissue injury claim as defined in the Pre-Action Protocol for Low Value Personal Injury in Road Traffic Accidents from 31 July 2013 only. All other types of report should be excluded in measuring performance against these SLAs.				
b	"High volume" is calculated based on the number of reports produced per annum by each MRO, where all MROs (whether classified as HVN or RB) are ranked by MedCo in descending order of number of reports produced. High volume is defined as being within the top 20% by volume	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 be achievable only at a point in time. The minimum period of sustainability is defined as:	12 months on a continuous basis		As HVN, but waived during first 12 months' trading	
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.				
Notes to the SLAs					

i	• Where a MRO can **demonstrate** that it meets part (b) of the SLA but not part (a) due specifically to a high level of Instructing Party requests to delay booking appointments to enable the injuries sustained to manifest themselves, it may be deemed to meet the SLA. MedCo however will consider the circumstances of each case.
	• Exclusions means the following situations which the MRO can demonstrate with evidence:
	  • Cases that meet all three of the following - delay occurred at the instruction phase of the case; was specifically requested by solicitor or /claimant; and the delay was such that the SLA could not possibly have been met e.g. delays of a few days should NOT be excluded but those for e.g. 4 weeks should be.
	  • Liability becomes contested and the solicitor requests the case be put on hold despite an appointment having been arranged.
	  • The Claimant is ill on the Appointment Date and an alternative must be scheduled post recovery, where the post recovery time is such that it requires a fit note or equivalent.
	  • The Claimant requests an alternative venue and date, as a result of work commitments.				

ii	The standards do not represent average measures, but **actual** measures.				
iii	MRO assertions that no complaints or data breaches have arisen will only be accepted where the MRO can **demonstrate** robust processes to identify and capture these.				