Response to the Ministry of Justice Consultation on Revisions to the Medical Reporting Process for Road Traffic Accident Claims

5th October 2023

INTRODUCTION

MedCo is the “Protocol” mandated system used to facilitate the sourcing of medical report providers in claims brought under the Ministry of Justice RTA Small Claims Pre-Action Protocol or the Pre-Action Protocol for Low Value Personal Injury Claims in Road Traffic Accidents.
MedCo’s duties are to;

- implement Government policy;
- ensure the independence of medical reporting through a random but fair search and selection process;
- provide accreditation for medical experts;
- ensure the quality of medical legal reports.
- provide training updates to medical experts (e.g. the necessity for comments on the causation of all injuries).

The MedCo system is governed by a Board comprised of an independent Executive Chair, three independent non-executive directors and nine non-executive “representative” directors nominated by the following organisations:-

- Association of British Insurers,
- Gibraltar Insurance Association,
- Forum Of Insurance Lawyers,
- British Medical Association,
- Chartered Society of Physiotherapy,
- Association of Medical Reporting Organisations,
- Law Society,
- Association of Personal Injury Lawyers,
- Motor Accident Solicitor Society

MedCo does not influence or comment on Government policy or the Civil Procedure Rule making process. However, it regularly liaises with the Ministry of Justice in order to assist with the implementation of any relevant policy and rule making process.

RESPONSE

CHANGES TO MEDCO QUALIFYING CRITERIA

Question 1: **The wording and/or the rationale of QCs 1.1, 1.3, 1.6, 1.7, 1.8, 1.9, 1.14, 1.15 and 1.16 have been revised. Do you agree with the proposed changes, and do you have any suggestions to further update and improve these QCs?**

Reply: In the proposed rationale to QC 1.1 there is an amendment that reads "*Organisations which (in the opinion of the MedCo audit team and ratified by the Board) do not meet this definition will be identified and remedial action will be required."* MedCo are concerned that the proposed drafting suggests the opinion and decision rests with the external third party audit team rather than the MedCo Audit committee. It is suggested the wording be amended to refer to the Audit Committee rather than the audit team.

In the proposed rationale to QC 1.8 there is reference to the MedCo Ethics policy with a direct link to the current website location. MedCo are concerned that the use of a direct link, whilst helpful, will mean each time an update is made to the Ethics policy the link in the rationale will no longer work. It is suggested that wording is used to let readers know a copy of the ethics policy can be found on the MedCo website – www.medco.org.uk. Alternatively, MoJ commit to updating the published QC document each time MedCo make a change to the content or location of the document.

In the proposed rationale to QC 1.14 there is reference to the registration page of the MedCo website for MROs with a direct link to the current website location. MedCo are currently in the process of updating the MedCo website therefore this link may change. It is suggested that wording is used to let readers know registration information can be found on the MedCo website – www.medco.org.uk. Alternatively, MoJ commit to updating the future QC document once the new registration for MROs website address is known.

In the proposed rationale to QC 1.15 there is reference that says MROs must provide to MedCo the data set out at:-

https://www.medco.org.uk/media/1301/casesdataupload-v26-may-2021-template.xlsx.

The link takes the user to the template for use with bulk csv uploads and therefore is not the correct documentation.

The requirements for case data upload, including the data fields, are set out in the MedCo Data Validation Rules document and is referenced in the MRO User Agreement. The MedCo Data Validation Rules document can be found using the link below.

https://www.medco.org.uk/media/1317/medco-data-validation-rules-v60.pdf

However, please note MedCo are concerned that the use of a direct link, whilst helpful, will mean each time an update is made to the MedCo Data Validation Rules the link will no longer work. It is suggested that wording is used to let readers know a copy of the MedCo Data Validation Rules can be found on the MedCo website – www.medco.org.uk. Alternatively, MoJ commit to updating the future QC document once MedCo supply the new link for the website location.

In the proposed rationale to QC 2.7 there is reference to the registration page of the MedCo website for MROs with a direct link to the current website location. Details of fees are published in the MedCo Charging Policy and is updated annually. Whilst a direct link can be provided there is a concern it will need updating annually. In addition, MedCo are currently in the process of updating the MedCo website therefore the exact link for the charging policy is not yet known. It is suggested that wording is used to let readers know details of the MedCo Charging Policy can be found on the MedCo website – www.medco.org.uk. Alternatively, MoJ commit to updating the future QC document when the new location of the Charging Policy is known and thereafter on an annual basis.

Question 2: **We have considered the required capacity included in QC2.2 for MROs seeking to apply for high volume national status and propose it is reduced from 40,000 medical reports per annum to 28,000. Do you agree, and if not, at what alternative level do think this should be set?**

Reply: MedCo considers that there should be a change and have supplied data to assist MoJ in reaching their decision.

Question 3: **We have considered the number of active medical experts required by MROs seeking to apply for high volume national status which is included in QC2.2 and propose it is reduced from 225 to 175. Do you agree, and if not at what level do think this should be set?**

Reply: MedCo considers that there should be a change.. The higher threshold increases the risk that MROs recruit less known / less experienced experts to meet the quota rather than identifying those experts that optimise the quality of service received by claimants. MedCo have supplied the MoJ with data to assist the decision.

Question 4: **MoJ believe the requirement for a tier 1 MRO to have an active expert in 80% of regions should remain unchanged. Do you agree?**

Reply: MedCo agrees with retaining this metric. 80% does not seem unreasonable for an MRO to demonstrate a national presence, and in our experience does not seem to be overly onerous or drive bad practice.

Question 5: **The wording and/or the rationale of QCs 3.2, 3.3, 3.4, 3.5, 3.7 and 3.8 have been revised. Do you agree with the highlighted changes, and do you have any suggestions to further update and improve these QCs?**

Reply: In the proposed rationale to QC 3.8 there is reference to the registration page of the MedCo website for MROs with a direct link to the current website location. Details of fees are published in the MedCo Charging Policy and is updated annually. Whilst a direct link can be provided there is a concern it will need updating annually. In addition, MedCo are currently in the process of updating the MedCo website therefore the exact link for the charging policy is not yet known. It is suggested that wording is used to let readers know details of the MedCo Charging Policy can be found on the MedCo website – www.medco.org.uk. Alternatively, MoJ commit to updating the future QC document when the new location of the Charging Policy is known and thereafter on an annual basis.

One further area to consider could be 3.3 d): *"Operates from substantive, standalone, physical, and professional business premises".*

This is not something that the MoJ insists upon for Tier 1 and Tier 2 MROs, with smaller Tier 2's now generally tending to operate from home. This may restrict the ability of certain MROs to sign up for unrepresented claimant work.

Further, the rationale for this states that a suitable premises would include residential homes that are *"adapted to include private consulting rooms equipped to an equivalent standard to medical facilities"*. For an MRO, it

would not usually be carrying out an examination on site (it will appoint an independent medical expert to perform the examination off site), so therefore, why is *"medically equipped"* necessary in that context?

AMENDED DME RULES

Question 6: **Do you agree with the proposed changes and/or additions to DME rules 1 to 6, and/or do you have any suggestions to further update and improve these rules?**

Reply: Agreed

REVIEW OF THE MEDCO "OFFER"

Question 7: **Do you agree with the proposed change to the MedCo offer for represented claimants as set out at paragraph 20?**

If not, please explain what you believe the offer should be set at along with your reasoning for this and any supporting evidence.

Reply: MedCo has supplied data to assist the MoJ with this decision.
MedCo would consider taking control of making future changes to the offer if the MoJ provides the relevant algorithm and sets agreed parameters that MedCo can work with. This would be more proactive and reduce the time it takes to respond to changes in the market.

Question 8: **Do you agree with the proposal not to change the MedCo offer for unrepresented claimants as set out at paragraph 21?**

If not, please explain what you believe the offer should be set as along with your reasoning for this and any supporting evidence.

Reply: No comment. MedCo has supplied data to assist with this decision.

USE OF ADMINISTRATION AGENCIES BY DMEs

Question 9: **Have you in the past, or are you currently, using the services of an administration agency? If so, what specific administration services do they provide you with?**

Reply: No.

Question 10: **Do you agree that administration agencies should be assessed/audited by MedCo to ensure they are operating to agreed common standards?**

Reply: Yes.

The assessment or audit of Administration Agencies has merit as they represent a key part of the claimant experience and interaction. However, there are challenges that need to be considered:

Administration Agencies operate on behalf of DMEs, and DMEs are not currently subject to their own qualifying criteria (unless they are carrying out unrepresented claimants work). DMEs should be accountable for the performance of third parties supporting their activity, so common standards could potentially start with this responsibility and oversight.

Clarity regarding what administrative agency support would be in scope as some DMEs use the facilities of administration agencies, without using the full administration service. The level of interaction will vary. Further, it can be difficult to distinguish between an administration agency and other administration services used by DMEs – such as clinic resources or directly employed staff. This is indirect work too but is likely to be different to an agency. As such, the entities and coverage of any audit scope would need very careful consideration and definition.

Without clarity regarding the DME role and responsibility, and what is considered to be an administrative agency, establishing agreed common standards and an associated audit programme will be challenging.

MedCo is happy to assist the MoJ with defining the difference between secretarial services and Administration Agencies and the principles for auditing such agencies.

Question 11: **Do you think administration agencies providing services to DMEs should undertake audit interviews with MedCo on a voluntary basis?**

Reply: No.

Take up on a voluntary basis is likely to be limited, particularly among those agencies that poorly perform, and especially if the outcomes of the audit have consequences. Our comments in Q10 response are also relevant - even if the audit is voluntary.

Question 12: **Do you think that administration agencies should be audited against specific qualifying criteria, similar to that used to audit MROs on MedCo?**

Reply: Yes.

Administration Agencies are an outsourced function delivering services on behalf of the DME. As such, whilst qualifying criteria similar to those for MROs would be difficult to define (particularly given the challenges outlined in Q10 regarding the variety of different support models), they would be necessary.

Any definition of an Administrative Agency would need to be clarified so that they can be distinguished from an MRO and do not rule out the use of, for example, secretaries etc. MedCo is happy to liaise with MoJ in this respect.

Question 13: **Do you agree that DMEs should only be allowed to contract with administration agencies who are authorised by MedCo?**

Reply: Yes.

Despite the challenges already referred to above MedCo considers that Administration Agencies should be required to register with MedCo and be subject to auditing of any relevant qualifying criteria and/or MedCo rules.

However, it should be noted that, given the variety of services offered by administrative support, this is likely to be a significant administration burden for MedCo as some of the support providers are globally significant outsourced providers, but others are very small and Medco would be responsible for 'accrediting' all of them.

Question 14: **Do you have any other comments or suggestions in relation to the use of administration agencies by DMEs?**

Reply: As an alternative to requiring Administration Agencies to register with MedCo having specific DME criteria that includes clear criteria on the outsourcing of services would be a good first step.

Question 15: **Do you have any comments or suggestions on the level of MedCo audit or membership fees administration agencies should pay?**

Reply: To make the registration of Administration Agencies (AAs) successful, there would need to be a supporting enhancement to the MedCo IT system that allows an AA to register and go through a robust due diligence and audit process, pay fees and agree user agreements and possibly declare financial link declarations on an annual basis. To support this additional resources will be required by MedCo. This would all come at a cost, therefore funding of the AA process design, system changes and resources must be agreed. .

Should the government wish to bring AA under the scope of MedCo, then it is suggested that a cost benefit analysis be undertaken to look at the development and ongoing operational costs and the size of the market to determine fees.

Review of Fixed Cost Medical Reports

Question 16: **Do you agree that the fixed cost medical reports regime relating to the RTA and Small Claims protocols as described in Part 45.19 of the CPR should be increased in line with the SPPI inflationary measure?**

Reply: No comment

Question 17: **What is your assessment of the financial impact on potential savings from the Government's whiplash reforms from increasing the applicable FCMRs in line with the SPPI inflationary measure?**

Reply: No comment

Official Injury Claim: medical report process

Question 18: **Do you agree that changes to the MedCo Accreditation process would help to highlight and embed the specific medico-legal requirements included in paragraphs 7.8 of the RTA PAP and 7.9 of the RTA Small Claims PAP?**

Reply: The medico legal requirements of paragraphs 7.8 of the RTA PAP and 7.9 of the RTA Small Claims PAP are currently included within the following MedCo training modules:

- Accreditation
- Civil Law and Procedure Part 2
- Medical report writing Refresher and Update
- Causation and the Civil Liability Act

MedCo is willing to review the feedback, assess the training need and include further modules to help highlight and embed the medico legal requirements of paragraphs 7.8 of the RTA PAP and 7.9 of the RTA Small Claims PAP as required.

Question 19: **Do you agree that changes to the MedCo Accreditation process or additional guidance and/or training material would be beneficial to medical experts?**

If so, please explain what changes or types of material would be most useful along with reasoning to support your position.

Reply: The Accreditation and CPD programmes are managed by MedCo's Education and Training Committee and is an ongoing process.

The Committee are responsible for maintaining the Accreditation and Continuous Professional Development (CPD) frameworks; and any associated issues raised by all MedCo user types on a daily basis, as authorised by the MedCo Board.

All experts are required to complete an initial 35-hour training course as part of the registration process, followed by an annual requirement for CPD currently set at 6 hours.

The Committee monitor experts through the CPD programme and regularly adds new modules as required to ensure the programme remains fit for purpose. Topics for new courses are highlighted through changes to legislation, case law, general feedback, feedback from compensators, issues highlighted from quality assessment reviews and queries from experts on frequently occurring issues and/or mistakes which emphasize a knowledge gap.

The Committee also run an annual CPD survey for medical experts and MROs to help them review the previous CPD period. The survey seeks views on the training approach including likes and dislikes, the annual CPD time commitment, module content and the topics covered and is also used to shape and prepare accreditation and CPD on an ongoing basis.

The most recent survey for the 2022/2023 MedCo academic year (01 June to 31 May) received a total of 23 responses. The results showed that the current online training approach is preferred, and experts who responded agreed that the current annual requirement of 6 hours appeared to be appropriate.

Results summary

- *Most respondents think 6 hours CPD appears to be appropriate.*
- *Most respondents think the CPD meets their needs (65%).*
- *Most respondents prefer online training (78%).*

The latest updates to the CPD programme included a new module published on 01 June 2023 addressing Causation and associated Case Law updates as well as covering topics related to the Civil Liability Act; and in March 2023 an annual *expert witness* module on legal practice and case law.

Question 20: **Do you agree that claimants and/or their representatives must wait for the at-fault compensator to confirm their decisions on liability/causation before instructing their selected expert?**

Please explain your reasoning for or against this proposal along with any evidence in support of your position.

Reply: No comment

Question 21: **Do you believe that changes to the RTA Small Claims Protocol would also be necessary to underpin either of the proposals provided in questions 19 and 20 above?**

Please explain your reasoning for or against this proposal along with any evidence in support of your position.

Reply: Any changes to Court Rules/Protocols that impose any additional mandatory requirement to be implemented to MedCo's accreditation programme is likely to incur a cost to in relation to changes to the MedCo training system and associated materials.

Question 22: **Do you agree that the process for sourcing medical reports for represented and unrepresented claimants should be the same?**

Please explain your reasoning for or against this proposal along with any evidence in support of your position.

Reply: Yes - particularly as currently the majority of claimants accessing the OIC Portal are represented. Therefore, it would make sense to align the processes.

In the event claimants' representatives are required to use the OIC system to source medical reports, MedCo's view is that professional users must be provided with an API similar to that offered to unrepresented claimants but costs and funding of the development will need to be set out and agreed.

Question 23: **Do you have any additional suggestions for how data collection on the medical reporting journey for represented and unrepresented claimants could be improved?**

Reply: If represented claimant reports are uploaded, like they are for unrepresented claimants to the OIC Portal, it could give MedCo clearer and more accurate data and visibility of cases where the data has not been uploaded by the MRO / DME.

Further, if the formal instruction is sent to medical report providers via OIC (as it is for unrepresented claimants), then this will reduce the manual process, where MedCo is relying on the instructing party to email the selected medical report provider to perform the examination. In which case human/deliberate errors where selections are emailed to a party that was not selected on the MedCo Portal would be reduced.

Equality issues

Question 24: **What impact would implementing the changes (where such are proposed) in this consultation document have on protected characteristic groups, as defined in the Equality Act 2010?**

Reply: No comment