Ministry of Justice

Revisions to the Medical Reporting Process for Road Traffic Accident Claims

A Ministry of Justice Consultation

18 July 2023

About this Consultation

To:	This consultation is aimed at medical experts, medical reporting organisations, the legal profession and insurers and all those with an interest in the medical evidence reporting process.
Duration:	From 18/07/23 to 10/10/23
Enquiries (including requests for the paper in an alternative format) to:	**Personal Injury Policy Team** Post point 5.23 Ministry of Justice 102 Petty France London SW1H 9AJ Tel: 020 3334 3157 Email: whiplash-reform-team@justice.gov.uk
How to respond:	Please send your response by 10 October 2023 to: **Personal Injury Policy Team** Post point 5.23 Ministry of Justice 102 Petty France London SW1H 9AJ Tel: 020 3334 3157 Email: whiplash-reform-team@justice.gov.uk
Response paper:	A response to this Consultation exercise is due to be published in January 2024 at: https://consult.justice.gov.uk/civil-law/rta-medical-reporting-consultation

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Foreword

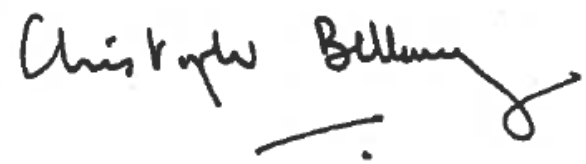
The Government remains committed to engaging with interested stakeholders from across all sides of the PI and medico-legal sectors and the publication of this consultation document is an important part of that engagement.

The medico-legal sector has continued to change and evolve over the years since 2014 in response to Government reform. However, since the introduction of the most recent measures to tackle the number and cost of whiplash claims in May 2021, there has been both a reduction in claims volumes and changes in claimant behaviour.

These changes are attributable not just to the whiplash reforms but also to the societal impacts of the Covid-19 pandemic and associated lockdown measures. Those operating in the sector have adapted to these pressures and altered their working practices over the last two years. This has resulted in better customer service operations and greater use of technological solutions to reduce the operational costs associated with the processing of medical reports.

The industry continues to provide services to both represented and unrepresented claimants seeking good quality medical reports in support of their claims through the Official Injury Claim (OIC) service. However, the Government understands that there have been increasing financial pressures on the sector over the last two years following the implementation of the whiplash reforms and the more recent wider economic conditions.

Therefore, we have decided that it is an appropriate time to consult on a number of medico-legal reporting issues related to the MedCo process, fixed cost medical reports and the implementation of the OIC service. This consultation seeks input, submissions and evidence on these important issues from all stakeholders with an interest in the provision of good quality independent medical reports.



Lord Christopher Bellamy KC
Parliamentary Under Secretary of State for Justice

Executive Summary

The Government first implemented fixed recoverable costs for medical reporting in 2014 and this was followed by the establishment of the MedCo process in 2015. In late 2019 MoJ confirmed changes to the MedCo process[1] to ensure that all those who chose to provide medical reports to both represented and unrepresented claimants following the implementation of the whiplash reforms were competent to do so.

MedCo's remit was expanded to encompass the provision of all medical reports for RTA-related personal injury claims up to a value of £5,000. New qualifying criteria and rules for Medical Reporting Organisations (MROs) and Direct Medical Experts (DMEs) wishing to provide medical reports to unrepresented claimants were also introduced. These changes were designed to ensure that medical report providers were efficient and well-run, with effective and transparent consumer protection policies and procedures.

Further changes restricted the provision of medical reports for unrepresented claimants to physiotherapists, GPs and Accident and Emergency consultants only. Additionally, the fixed cost medical report (FCMR) regime was extended to cover all medical reports for RTA-related personal injury claims up to a value of £5,000 (although no changes were made to the level of the available FCMRs).

Finally, a new MedCo 'offer' was developed and implemented for unrepresented claimants seeking a medical report via the new OIC service. These changes to MedCo's scope, along with the new offer, were important in ensuring that the provision of medical reports following the implementation of the whiplash reforms continued to be dealt with in an efficient and effective manner.

In addition, on 31 May 2021, as part of its commitment to tackling the continuing high number and cost of whiplash claims, the Government also implemented the measures in Part 1 of the Civil Liability Act 2018[2]. These important reforms introduced a fixed tariff of compensation for whiplash injuries and a ban on the use of pre-medical offers to settle such claims. An additional measure to increase the small claims track limit for road traffic accident ('RTA') related personal injury ('PI') from £1,000 to £5,000 was also taken forward at this time.

The Government also worked with industry to develop the OIC service which provides a platform which enables claimants to take forward their claims following the implementation of the Government's whiplash reforms. The OIC is operated on behalf of

1 https://consult.justice.gov.uk/civil-law/future-provision-of-medical-reports/

2 https://www.legislation.gov.uk/ukpga/2018/29/part/1/enacted

the Ministry of Justice by the Motor Insurers' Bureau (MIB) and enables claimants to start, progress and settle their own claim with or without professional representation. OIC is a free service which is also open to represented claimants whose claims are progressed on OIC by professional users.

This consultation seeks input from interested stakeholders on several areas related to the implementation of these various reforms and on the impacts of other wider societal and economic factors affecting the medico-legal sector.

Ministry of Justice
18 July 2023

Introduction

We are seeking stakeholder input on several issues of relevance to those who commission and/or provide medical reports used in support of RTA related PI claims valued up to £5,000.

In support of this, MoJ has considered feedback and data from a range of stakeholders, including MedCo and OIC, and have reviewed several different aspects of the existing medico-legal reporting process. This consultation document sets out these areas and proposes updates and revisions to established parts of the system as well as seeking input on solutions to issues identified since implementation of the reforms. Specifically, we are seeking views on:

- revised MRO qualifying criteria and DME rules;
- the MedCo 'offer' for both represented and unrepresented claimants;
- use of administration agencies by DMEs and how this can be effectively overseen;
- the level of the fixed cost medical report regime; and
- changes to improve the quality of medical reports and how medical reports for represented claimants are sourced.

A list of key consultees is attached at Annex A. This list is not exhaustive, and responses are welcome from all stakeholders with an interest in the development of good quality independent medical evidence. Revised MedCo MRO qualifying criteria tables are attached at Annex B and updated rules for DMEs are attached at Annex C of this document.

This consultation will close at midnight on 10 October 2023 and a response and next steps document will be published in January 2024.

Changes to MedCo Qualifying Criteria

1. The Government remains committed to the provision of good quality independent medical evidence for road traffic accident (RTA) related personal injury claims valued up to £5,000. Ensuring that those who provide medical reports to both represented and unrepresented claimants are competent, efficient and have well run, transparent consumer protection procedures in place is key to this commitment.

2. The MedCo Qualifying Criteria (QC), therefore, remain as important as ever as they ensure that medical reporting organisations (MROs) already registered, as well as those wishing to register, with MedCo are properly constituted businesses. This means that MROs have satisfactory systems and sufficient resources in place to operate to the minimum required standards for both business-to-business operations and, where applicable, as an MRO to unrepresented claimants.

3. These QC were last reviewed and updated in 2020 prior to the implementation of the whiplash reform programme in May 2021. The changes were to review and refresh the drafting of the existing QC and to add a new set related to providing medical reports to unrepresented claimants. Now that these reforms have had time to bed in, and data on monthly claims volumes has settled, it is helpful to review the QC again to ensure they remain up to date for the post-reform landscape.

4. MoJ has considered the current QC and have recommended revisions all three sets i.e., for both tier 1 and tier 2 MROs, the specific QC tier 1 MROs[3] and the additional QC for all MROs undertaking unrepresented claimant work. Most of these changes are minor amendments to update links to guidance and to tighten the drafting of the existing QC and in general are not materially different to the previous version.

5. However, the tier 1 QC does contain requirements which directly relate to claims volumes and the numbers of experts required to cope with such. These are areas which have been impacted by Covid-19 and the implementation of the whiplash reforms, and so it is sensible to review these. Between April 2019 to March 2020 (pre pandemic) the average number of claims registered on Claims Portal was around 56,000[4]; this compares to the current combined level of Claims Portal and OIC claims of around 32,000 per month.

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[3] Tier 1 MROs are organisations who process high volumes of medical reports and who operate at a national level across England and Wales. Tier 1 MROs must be audited against specific high volume national (HVN) QC to reflect this. Tier 2 MROs process lower volumes of reports and generally operate within smaller geographical areas.

[4] Prior to 31 May 2021, RTA-related personal injury claims valued up to £25,000 were processed via Claims Portal. Post reform claims valued up to £5,000 are progressed through OIC whilst claims between £5,000 and £25,000 continue via Claims Portal.

6. MoJ has considered this point and propose that this reduction in claims volumes is reflected in the appropriate QC where it is relevant. Therefore, in reviewing the QC we have proposed some more significant updates to QC 2.2 in Table 2 in relation to the requirements to be a tier 1 MRO. These QC relate to the capacity to deal with high case volumes and to the number of active medical experts on an MROs panel.

7. Currently, the QC require tier 1 MROs to demonstrate the capacity to process 40,000 medical reports PA and to have 225 active experts on their panel. Having looked at the claims volume data and completed some additional scenario modelling MoJ is of the view that this figure should be reduced. However, these QCs are designed to be challenging and any revised figure needs to be robust enough to ensure market integrity and protect against distortion in the tiers.

8. Therefore, taking all relevant factors into account, MoJ proposes that the volume of reports QC be revised down from 40,000 to 28,000 and that the number of active experts QC be revised down from 225 to 175.

9. Like the claims volume and number of experts issues (paragraphs 7-8 above), there is an argument that the requirement to have contracted medical experts in 80% of postcodes (QC 2.2) should also be amended downwards. However, postcode data is used to denote national or regional coverage, therefore MoJ is not convinced it is appropriate to also amend this, but we are interested in feedback on this point.

10. We are interested in the views on these specific proposals and respondents should therefore review the revised QC set out in Tables 1, 2 and 3, attached at **Annex B** of this document. All changes made to these QC have been highlighted in the annex for ease of reference. However, the key changes are summarised below:

Summary of changes to Qualifying Criteria Table 1 (All MROs): QC 1.1, 1.3, 1.6, 1.7, 1.8, 1.9, 1.14, 1.15 and 1.16 - Drafting changes have been made to update the links to guidance provided and to tighten up drafting. For example, the wording relating to the use of ‘shell companies’ and the definition of an MRO in QC 1.1 has been clarified.

Summary of changes to Qualifying Criteria Table 2 (Tier 1 MROs): QC 2.2 - Drafting change to tighten up drafting and proposed change to the required capacity to process 40,000 medical reports per annum to 28,000. Proposed change to the number of contracted, active medical report providers from 225 to 175. **QC 2.7:** Drafting change to update links to guidance.

Summary of changes to Qualifying Criteria Table 3 (Unrepresented Claimant Work): QC 3.2, 3.3, 3.4, 3.5, 3.7 and 3.8 - Drafting changes have been made to update the links to guidance provided and to tighten up drafting. For example, the wording on widening the scope of MedCo in QC 3.4.1 has been updated to reflect the implementation of the reforms.

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?**
Please explain your reasoning.	
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?**
	Please explain your reasoning.
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?**
	Please explain your reasoning.
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?**
	Please explain your reasoning.
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?**
	Please explain your reasoning.

Amended DME Rules

11. The QC were developed to ensure that MROs are well run organisations with the resources, processes and customer service capability to provide medical reports. However, MROs are not they only source of medical report provider and claimants may also source reports from Direct Medical Experts (DMEs).

12. In line with the new criteria for MROs (detailed at paragraph 7 above), we believe it is important that the MedCo rules for DMEs undertaking work for unrepresented claimants are also revised to ensure consistency with the standards applied to MROs working for them. MoJ have, therefore, also reviewed and enhanced these rules to reflect, where appropriate, the revised MRO Table 3 QC. These rules will ensure that DMEs continue to operate to a good standard consistent with the requirements which apply to MROs.

13. Most of these changes update links to guidance and to tighten and enhance the drafting of the existing rules. The revised rules for DMEs are attached at **Annex C** to this document. All changes made to the rules have been highlighted in the annex for ease of reference. However, the key changes are summarised below:

Summary of changes to DME Rules: Unrepresented Claimant Work:

Rules 1, 2, 3, 4, 5 and 6:

Drafting changes have been made to all rules to tighten up drafting of the rules and include additional rationale. The links provided to helpful guidance have been checked and updated where necessary and additional links to useful information have also been added. For example, a link to applying for basic DBS certification has been added to help DMEs who need to undertake this process.

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?** **Please explain your reasoning.**

Review of the MedCo 'Offer'

14. The term 'offer' is used to describe the number and mix of MROs or DMEs presented to authorised users of the MedCo service when searching for a medical report provider. The number of MROs or DMEs presented for selection via the 'offer' is set by the Government. There are currently two 'offers' in operation, one for represented claimants and one for unrepresented claimants.

15. The current 'offer' for represented claimants was revised on 6 April 2020 and is set at **two x tier 1 and five x tier 2 MROs or seven DMEs**. A new offer for unrepresented claimants was introduced on 31 May 2021 as part of the whiplash reform programme implementation and is set at **two x tier 1 and two x tier 2 MROs or five DMEs**.

16. It has been three years since the represented 'offer' was last reviewed and approaching two years since the 'offer' for unrepresented claimants was introduced. Therefore, MoJ has decided it is now an appropriate time to review both 'offers' to take account of the impact on the market of the implementation of the whiplash reforms on 31 May 2021.

17. In assessing the 'offer' there are two overriding considerations to keep in mind. The Government's overarching policy intention to enhance and maintain independence in the provision of medical reports must be balanced against the competition requirements for a functional market.

18. Since the represented claims 'offer' was last reviewed in 2020, when there were **11 tier 1 and 40 tier 2 MROs**, there has been a decline in the number of MROs registered with MedCo. This means that as of 31 March 2023, there were **10 tier 1 and 28 tier 2 MROs** authorised and operational on MedCo. Of these, **8 tier 1 and 18 tier 2 MROs** have also opted to provide medical reports to unrepresented claimants making claims via OIC.

19. In reviewing the 'offers' MoJ has considered data in several areas including, but not limited to, the number of MROs in each tier, their geographical coverage and the impact this has on presentation and selection over a period of time. Data on the geographical spread of the registered MROs was compiled using declared postcode data. Considering current tier volumes and whether they operate nationally or regionally, MoJ analysts have considered the available data and have calculated appropriate alternative offer ratios.

20. Having considered all the relevant data, including the reduction in the number of MROs currently operational in the market, MoJ proposes that the 'offer' for represented claimants should be amended as shown below. Revising the 'offer' as proposed ensures that there continues to be fair competition both within and between each MRO tier and that a sufficient choice of DMEs is available for selection by claimant representatives.

Proposed 'offer' for represented claimants:

- **two** tier 1 MROs; and
- **six** tier 2 MROs; and
- **seven** DMEs.

21. In addition, having reviewed the available data, MoJ has concluded that there have been no material changes to the market in this area and proposes that no changes are made to the current MedCo offer for unrepresented claimants and it should remain as shown below.

'Offer' for unrepresented claimants:

- **two** tier 1 MROs; and
- **two** tier 2 MROs; and
- **five** DMEs.

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 as along with your reasoning for this and any supporting evidence.**
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.**

Use of Administration Agencies by Direct Medical Experts

22. MedCo became aware of the use of Administration Agencies (AAs) by DMEs in late 2019. Since then, the number of DMEs utilising the services of AAs has increased, particularly following the implementation of the whiplash reforms on 31 May 2021.

23. These changes required DMEs to adhere to new rules[5] on back-office support when providing medical reports to unrepresented claimants. To meet these new requirements, which are tested through an audit interview with MedCo, some DMEs decided to engage the services of an AA.

24. AAs are being used to support DMEs in producing both MedCo and non-MedCo related medical reports, and they are likely to have been operating prior to the launch of MedCo in 2015. The services provided by AAs can vary considerably with many providing clients with help on straightforward secretarial tasks. However, others may be effectively operating as unauthorised MROs and there is no specific framework in place which can be used to audit the services and assess the quality, robustness or appropriateness of the business models being utilised.

25. MedCo have subsequently analysed the data available to them to help identify AAs operating in the sector and several types have been identified. These AAs appear to be offering different types of service including organisations which:

    - deal with all types of general administrative and/or secretarial work across various sectors (not just medical reporting);
    - were formally registered MROs – some of which have been suspended/terminated from MedCo after failing audits;
    - initially planned to register as MRO but decided to scale back the services they provide to reduce costs; and
    - provide bespoke software and IT support.

26. MedCo has undertaken work to understand the operation of AAs in the medico-legal market, identifying several practices which are of particular concern. These include:

    - payments being made to the AA rather than directly to the DME;
    - AAs performing specified MRO activities such as validation, quality assurance and direct contact/liaison with claimants and/or solicitors;

5 https://www.gov.uk/government/publications/medco-new-rules-and-audit-process-for-direct-medical-experts

- Medical report instructions being received centrally by an AA and then being allocated to DMEs;
- AAs conducting financial transactions using factoring arrangements; and
- AAs becoming directly involved in the writing of medical reports.

27. Taken together, these concerns can lead to the conclusion that some AAs may in effect be operating as unauthorised MROs. If they are in fact operating in this way, logic also dictates that they should be held to the same standards and criteria as existing MROs registered on the MedCo system.

28. MedCo's inquiries into this area have highlighted individuals offering administration services working with small groups of experts. However, without an agreement in place with, or audit by, MedCo, ensuring that such individuals and/or AAs are operating in accordance with the guidelines is difficult. Confirming that the AA/DME arrangement is properly controlled by the DME can also be challenging.

29. Additional data could be obtained by auditing all registered DMEs to identify those using AAs and then seeking information from them on how they operate. Consideration would, though need to be given to the MedCo resources required to implement this solution and an audit fee would also be payable by those audited.

30. Despite this, MedCo have taken several steps to tackle this issue, including the production of best practice guidance on interacting with AAs. They have also identified DMEs who utilise AAs and sought explanations of the arrangements in place, along with copies of any formal agreements made. This has enabled MedCo to undertake fact finding visits and make a reasoned assessment of how some of the AAs involved are operating in practice and to identify any areas of concern.

31. MedCo have noted an increase in the use of AAs since the implementation of the whiplash reforms on 31 May 2021, particularly by DMEs registering to provide medical reports to unrepresented claimants. With this uptick in use by DMEs we agree that the area of third-party administrative support requires investigation.

32. Given the concerns set out above, MoJ would like to seek evidence and input from stakeholders in relation to the use of AAs. This includes on the following options to tackle the highlighted concerns in this area. We would be interested in stakeholder views on these options, which are:

- **Option 1 -** auditing by MedCo of all registered DMEs to identify those using AAs and how they operate, before action to tackle any concerns is taken;
- **Option 2 -** AAs entering voluntary agreements with MedCo to allow fact finding visits and audit interviews (subject to the payment of an audit fee);

- **Option 3 -** require all AAs to register on MedCo and be audited against a new set of QC for indirect service providers (subject to payment of appropriate membership/audit fees); and
- **Option 4 –** do nothing at the current time and continue to monitor to assess whether there is an impact on the quality of service provided to claimants from those DMEs choosing to work with an AA.

33. As noted above, **option 1** (auditing all active DMEs) would generate useful information on the administration arrangements of DMEs and the operating practices of AAs. However, this would likely be resource intensive for both MedCo and for the DMEs to carry out. It would also take a lengthy period to schedule and complete audit interviews for the circa 450 operational DMEs, meaning any action required to address the concerns identified could be significantly delayed.

34. **Option 2** is reliant on good will and co-operation from AAs. This would likely result in good organisations co-operating and adjusting their business models to fit with MedCo requirements. However, AAs wanting to exploit the process would likely not engage with a voluntary scheme and so overall this option would be of limited help.

35. **Option 3** provides the most certainty that active AAs would operate correctly to a good standard. However, it would be imperative to get the QC correct and set the membership fee at an appropriate level. The potential consequences of changes to the market and/or behaviours of MROs following any change would also need to be considered. Feedback from respondents on such consequences would be welcome.

36. There is also **option 4** - do nothing at this stage and continue to monitor the impact AAs are having on the market. This would require MedCo to continue to investigate and interview DMEs utilising the services of an AA, and to monitor the quality of reports provided to ensure they remain at a satisfactory level. However, doing nothing would also preserve the status quo and could leave some DMEs at a disadvantage as compared to those using AAs.

37. If either of **options 2 or 3** are taken forward, amendments to the DME rules and new audit/qualifying criteria will be required to implement them. Restricting DMEs to only contracting with MedCo approved AAs would also be a necessary requirement. In addition, a new set of QC would also be needed to audit AAs against.

38. We would suggest that these new QC ought to align closely with the current Table 1 requirements for all MROs. There will need to be some differences, but these QC cover the basic principles of operating a sound business that are necessary for ensuring AAs are well run with good standards of service.

39. In terms of membership and/or audit fees to be paid if **options 1, 2 or 3** are taken forward, this would not be an area for Government to comment and is for MedCo to

consider. It would though, be helpful if respondents would provide input on what they think these fees should be. Any responses received in this area will be passed on to MedCo for consideration in the event options 1,2 or 3 are progressed.

40. In terms of answering the questions below, we would like to confirm that by AA we are referring to organisations who are contracted by DMEs to provide administrative services in relation to the provision of MedCo medical reports.

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?** **Please provide details of any services provided.**
Question 10:	**Do you agree that administration agencies should be assessed/audited by MedCo to ensure they are operating to agreed common standards?** **Please explain your reasoning.**
Question 11:	**Do you think administration agencies providing services to DMEs should undertake audit interviews with MedCo on a voluntary basis?** **Please explain your reasoning.**
Question 12:	**Do you think that administration agencies should be audited against specific qualifying criteria, similar to that used to audit MROs on MedCo?** **Please explain your reasoning.**
Question 13:	**Do you agree that DMEs should only be allowed to contract with administration agencies who are authorised by MedCo?** **Please explain your reasoning.**
Question 14:	**Do you have any other comments or suggestions in relation to the use of administration agencies by DMEs?** **Please explain your reasoning.**
Question 15:	**Do you have any comments or suggestions on the level of MedCo audit or membership fees administration agencies should pay?** **Please explain your reasoning.**

Review of Fixed Cost Medical Reports

41. In 2014, the Government introduced a fixed cost medical reports (FCMRs) for initial medical reports used in support of soft tissue injury claims, to tackle the rising cost of medical evidence and to support the MedCo reforms. These changes were made through amendments of the Civil Procedure Rules (CPR), specifically to Part 45[6].

42. The following were introduced in relation recoverable disbursements:

> Initial report from a MedCo accredited medical expert: **£180**.
>
> Additional reports (where justified) from:
>
> (i) Consultant Orthopaedic Surgeon (inclusive of a review of medical records where applicable): **£420**;
>
> (ii) Consultant in Accident and Emergency (A&E) Medicine: **£360**;
>
> (iii) General Practitioner (GP) registered with the General Medical Council: **£180**; or
>
> (iv) Physiotherapist registered with the Health & Care Professions Council: **£180**;
>
> (c) obtaining medical records: no more than **£30** plus costs from the records holder limited to **£80** in total for each set of records required. Where records are required from more than one holder the FRC applies to each set of records required;
>
> (d) addendum report on medical records (except by Consultant Orthopaedic Surgeon): **£50**; and
>
> (e) answer to questions under Part 35: **£80**.
>
> Where appropriate, VAT may be recovered in addition to the cost of obtaining a fixed cost medical report or medical records.

43. The £180 FCMR for initial reports is intended to cover both payment to the medical expert and the cost of organising the medical examination, and all current MedCo medical reports are covered by this regime. As noted above, there are some additional costs included in the CPR which apply to secondary specialist reports by GPs, physiotherapists, A&E consultants and orthopaedic surgeons but there are no regimes in place at present for other experts, such as dentists and psychologists.

44. When consulting on and setting this figure in 2014, the Government considered a range of factors such as the level of work required to arrange and conduct an examination and to write and return a report. Also considered were industry agreed

6 https://www.justice.gov.uk/courts/procedure-rules/civil/rules/part45-fixed-costs#rule45.19

guidelines published by the Association of Medical Reporting Organisations (AMRO), which provided a rate of £250 for initial soft tissue injury reports.

45. In addition, the Government considered the impact on the costs of medical reports from the introduction of the ban on referral fees through section 56 of the Legal Aid, Sentencing and Punishment of Offenders Act 2013[7]. Following the introduction of this Act a noticeable increase in the cost of initial medical reports was identified in MROs not signed up to the AMRO agreement.

46. On 31 May 2021 the MedCo regime was extended from just soft-tissue injury claims to cover all road traffic accident-related personal injury medical reports for claims valued up to £5,000. This extension ensured clarity and certainty as to cost, as well as a consistent approach for both compensators and claimants regarding all claims affected by the implementation of the whiplash reforms.

47. However, given this extension and the fact that eight years have passed since the introduction of FCMRs, it is now appropriate to review the level they are currently set at. As noted at paragraph 44 above several factors were considered when setting the levels currently in use and these remain valid today.

48. The continuing functioning of around 40 MROs in this market is indicative that the £180 FCMR for an initial report does still cover the level of work required. This includes arranging/conducting an examination and writing and returning a report to the claimant and/or their representatives. However, it is likely that reduced volumes of claims and outside factors such as inflation and its subsequent impact on the cost of living means that the margins for MROs and DMEs have been reduced.

49. MoJ analysts have reviewed the different costs available to assess the potential inflationary impacts since they were first introduced in July 2014 using the Services Producer Price Index (SPPI)[8]. This is consistent with the approach taken by MoJ in relation to the recent wider review of fixed recoverable costs in the Fast Track.

50. The following provides an overview of a potential new set of FCMRs based on this analysis and revised by 1.183% using the SPPI and rounded to the two nearest significant figures:

[7] https://www.legislation.gov.uk/ukpga/2012/10/section/56/enacted

[8] The SPPI is primarily a suite of individual price indices that provide information on price change for a range of service industries. The SPPI is published by the Office of National Statistics and captures quarterly changes in the price received for services provided by UK businesses to other UK businesses and Government.

Initial report from a MedCo accredited medical expert: **£210**.

Additional reports (where justified) from:

(i) Consultant Orthopaedic Surgeon (inclusive of a review of medical records where applicable): **£500**;

(ii) Consultant in Accident and Emergency (A&E) Medicine: **£430**;

(iii) General Practitioner (GP) registered with the General Medical Council: **£210**; or

(iv) Physiotherapist registered with the Health & Care Professions Council: **£210**;

(c) obtaining medical records: no more than **£35** plus costs from the records holder limited to **£95** in total for each set of records required. Where records are required from more than one holder the FRC applies to each set of records required;

(d) addendum report on medical records (except by Consultant Orthopaedic Surgeon): **£59**; and

(e) answer to questions under Part 35: **£95**.

Where appropriate, VAT may be recovered in addition to the cost of obtaining a fixed cost medical report or medical records.

51. The main argument against extending the current FCMR regime is that it could have a negative impact through increased costs to compensators who ultimately fund the reports. Therefore, before a decision is taken on whether to implement higher FCMRs it is also necessary to take account of the overall financial impact of such an increase on the sector. We would welcome input on this point.

52. Whilst we are seeking views from stakeholders on reviewing the existing FCMRs, it should be noted that there is no intention at this stage to amend the regime for additional specialist reports not already included in CPR Part 45.19.

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

Official Injury Claim: medical report process

53. Medical reports are an important part of the claims procedure and support the negotiated settlement process by explaining the type and extent of injuries suffered. However, they must also provide an independent opinion on a claimant's injuries of sufficient quality to assist the court if the parties fail to settle at the pre-action stage.

54. The implementation of the whiplash reforms changed the process for bringing and settling an RTA-related personal injury claim valued up to £5,000. The reforms and the introduction of the OIC process enabled unrepresented claimants to take control of their claim and seek their own medical report at the appropriate stage.

55. Now that these changes have been in force for two years, we believe it is right to look at how this innovative new system has worked in practice. This section is therefore a call for evidence on issues related to the new medical reporting process.

56. In doing this, MoJ has considered feedback from range of sources including industry stakeholders - such as those representative groups on the MoJ OIC Advisory Group[9] - along with data from OIC and MedCo. This has led to the identification of several issues relating to the timing of instructions being sent, the content of reports produced and a gap in the data available on represented claims.

Data available on the OIC Medical reporting process

57. For both unrepresented and represented claimants there is data from MedCo which can be used to map their user journeys. This data shows the time taken between the accident, a liability decision being received, a medical report provider being selected, and an examination being scheduled/completed (Table 1 below).

Table 1: MedCo Data (Feb 22 – Feb 23)

	Days between accident and search	Days between search and selection	Days between selection and examination	Days between examination and report date	Total number of days taken
Unrepresented claims average:	49	5	19	3	**76**
Represented claims average:	39	0	36	3	**78**

9 https://www.gov.uk/government/collections/official-injury-claim-advisory-group

58. The data shows that represented claimants select an expert more quickly than unrepresented claimants but take slightly longer overall to reach the completed report stage. This faster selection of a provider is likely due to claimant representatives' greater familiarity with the medical reporting process and with the report providers available through MedCo.

Medical Report Upload Times

59. However, the situation is different for the second stage of the process covering the time taken between the initial report being completed and the report then being checked and uploaded onto OIC. For unrepresented claimants the time taken to upload a report following an examination and the time taken to check for errors and accept and disclose the report can be monitored by combining MedCo and OIC data.

Table 2: OIC Data

	Selection date to upload date	Upload date to check medical date	Check medical date to first offer
Unrepresented claims average:	**21 days**	**18 days**	**19 days**

60. As table 2 above shows, for unrepresented claimants we can see when the medical report provider completes and uploads the report into OIC for factual checks. Once this is complete, we can also monitor the time taken to disclose the report to the at-fault compensator and for an initial settlement offer to be received.

61. For represented claimants, however, no specific data is available from OIC on the stages between the liability decision being made and communicated to the claimant representative and when the report is uploaded onto OIC and subsequently disclosed. The available high-level data shows that the time taken between these stages is longer for represented claims, but no detailed information is available to help us understand why this is the case.

62. This difference in the relative availability of data on represented and unrepresented claimants' medical journeys relates to the different way represented claimants source reports. Represented claims follow a separate process for checking, uploading to OIC and disclosing the medical report.

63. Unrepresented claimants use the OIC system to contact MedCo and source a provider. The selected expert or MRO will then ensure the completed report is checked for factual errors and will upload it onto OIC which allows the claim to continue. For represented claimants their professional representatives are responsible for contacting MedCo, sourcing a provider, and then checking and uploading the report back onto OIC.

64. The decision to continue with the pre-reform process for represented claimants was taken following discussions with the Civil Procedure Rule Committee sub-group supporting this work, as it was felt to be the logical option at the time the rules and new PAP were being developed. However, we now consider that it is time to look at this again.

Data Gap

65. The links between MedCo and OIC allow for unrepresented claims to be monitored from start to finish. Data is obtainable at each stage allowing checks to ensure the process is working properly, and that claims are not being held up unnecessarily. This joined up process also enables areas for improvement to be identified and actioned efficiently by both MedCo and OIC.

66. However, as the medical process for represented claims is effectively dealt with outside of the OIC process, tracking the data in the same way is not currently possible. This means that we're unable to fully monitor whether different claimants are having different experiences. We would welcome feedback from respondents in this area to identify specific issues to be tackled and/or improved.

67. Plugging data gaps will provide greater insight into how the process works in practice and in our view enable required changes to be made to improve outcomes for all claimants. A more efficient process will support access to justice for claimants and will support our commitment to improving claims journey for all who undertake it. In addition, further information and insight will help inform future evaluation exercises of the impacts of the reforms on unrepresented claimants and professional users.

Information to be included in Medical Reports

68. Stakeholder feedback has also been provided to MoJ and MedCo which highlights other areas where action may be required. These include medical reports where there has been no reference to the defendant's version of events where, in line with Part 7.9 of the RTA Small Claims Protocol[10], that should have been considered by the medical expert.

69. In addition, the level of information being provided on the cause and the impact on amenity of specific non-whiplash injuries could also be improved. In particular, more information could be provided as to whether ancillary injuries are separate from, or related to, a whiplash injury and on the degree to which both the whiplash and/or any non-whiplash injuries impact the amenity of the claimant.

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10 https://www.justice.gov.uk/courts/procedure-rules/civil/protocol/pre-action-protocol-for-personal-injury-claims-below-the-small-claims-limit-in-road-traffic-accidents-the-rta-small-claims-protocol#7

70. A lack of a clear opinion in the medical report on required issues, such as the defendant's version of events and/or causation and amenity, can delay settlement discussions and adversely impact on the claimant. MedCo has already issued a reminder to experts about this requirement[11], but we are interested in views on what impact this has had and whether further action should be taken to help facilitate improvements in this area.

71. Several recent court judgments have referenced similar issues and reinforce the need for additional information to aid the court in these areas, including in the Court of Appeal (Rabot v Hassam and Briggs v Laditan[12]). Amendments to reflect the CoA's judgment are being made to the OIC guidance for claimants on dealing with overlapping injuries and to clarify the standard instructions to medical experts generated by the system.

72. Such clarity supports the settlement process and would also greatly assist in those cases where the parties fail to agree and must seek resolution via the courts.

Liability decisions and the timing of instructions

73. Looking at combined data from OIC and MedCo suggests that these issues may be related to how and when instructions are being sent to medical report providers. The data shows that claims made by unrepresented claimants are, in general, proceeding normally with no significant hold ups in the process.

74. However, there are indications that some claimant representatives are issuing instructions to medical report providers prior to the receipt of liability/causation decisions from the at-fault compensator. This can be demonstrated by looking at data. For example, MedCo data shows that the average time between accident and the search for a medical report provider is similar for represented (39 days) and unrepresented claimants (49 days) but other data points provide a different view.

75. The mode[13] time taken between the accident and search for unrepresented claimants is 14 days, but for represented claims it is only 1 day (table 3). If you then look at the data from OIC on liability admissions, we can see that the average time taken for a liability decision to be made for unrepresented claimants is 13 days and the average time for represented claims is 18 days (see table 4 below).

11 https://www.medco.org.uk/news-and-updates/instructions-to-medical-report-providers-and-commenting-on-the-defendant-s-version-of-events/#:~:text=Paragraph%207.9%20of%20the%20Pre,part%20of%20their%20quality%20checks.

12 https://caselaw.nationalarchives.gov.uk/ewca/civ/2023/19

13 The 'mode' is the number which appears most frequently when calculating an average.

Table3: MedCo Data

	Days between accident and search	Days between search and selection
Unrepresented claims mode:	**14**	**0**
Represented claims mode:	**1**	**0**

Table 4: OIC Data

	Days to decide liability
Unrepresented claims average:	**13**
Represented claims average:	**18**

76. These two data points together suggest that requests for a medical report are being made prior to the receipt of a liability decision from the compensator. If this is the case, this has the potential to impact on the quality of the evidence produced, the time taken to finalise the evidence and the final outcome for the claimant. Where liability is denied (in full or part) or causation challenged, the need to then amend the instructions to the report provider and provide the defendant's version of events, or for the compensator to challenge a gap in the medical report at a later point, add times to the process for represented claimants.

77. It is probable that this is being done for multiple claims at once for efficiency reasons, but not waiting for this decision is likely to be a key cause of one or more of the issues outlined above. Ensuring that instructions issued in relation to represented claims are issued at the appropriate time, when the relevant information on causation and liability can be included, would likely result in more accurate medical evidence and therefore better outcomes for the claimant.

Aligning the medical report process for unrepresented and represented claimants

78. The Government wishes to explore aligning the processes for obtaining medical reports so that all claims follow the current unrepresented claimant route. This would mean that represented claimants would also obtain their medical reports via a link embedded in the OIC system with the report provider responsible for the fact checking and uploading of the completed report.

79. Aligning the process so that both represented and unrepresented claimants follow the same route would allow for more effective monitoring. It would also better support the process for technical improvements to be rolled out for both claimant types at the same time.

80. As a result, claimant representatives would need to use OIC to source medical report providers rather than use MedCo directly. It would also require the report provider to upload the report onto OIC once they have completed it so that it can be made available for fact checking and/or disclosure. This would smooth out the current two-tier approach and would allow for more detailed analysis of the medical reporting stages for both represented and unrepresented claimants.

81. We would be interested in stakeholder feedback on this proposal and on whether there are other alternative solutions to improving data and analysis in this area.

82. Options to improve performance in this area could include:

- **Option 1** - ensuring better knowledge by professional user claims handlers in relation to when instructions for medical reports should be issued;
- **Option 2** - improved training and guidance for experts on covering causation, the defendant's version of events and amenity impacts arising from non-whiplash injuries;
- **Option 3** - amending the process for represented claims to ensure that a claim cannot proceed to the medical reporting stage until the liability decision has been made and communicated to claimants and their representatives (this is already the case for claims brought without legal representation);
- **Option 4** – aligning the medical reporting process to ensure that both unrepresented and represented claimants followed the same user journey. This option builds on option three above, as unrepresented claimants already need to wait for a liability decision before moving to the medical reporting stage. It also ensures that data gaps are plugged and provides a consistent process for the provision of medical reports for both claimant types.

83. For options 1 and 2 the improvements suggested could be made via updates to MedCo Accreditation modules and through general awareness raising activities. MedCo and OIC have already co-operated to provide helpful information for claimants on arranging a medical examination which has been published via OIC's new 'Help Hub'[14]. However, we would be interested in stakeholder views on whether additional guidance and/or training material would be helpful.

84. Regarding option 3 it should be noted that implementing such a change would not preclude claimants or their representatives from contacting an appropriate medical report provider to assess general availability. It would, however, restrict their ability to formally issue instructions to their selected provider before liability/causation

[14] https://www.officialinjuryclaim.org.uk/help-hub/

decisions are made (which would still be required to be made within the deadline provided for in the Small Claims PAP).

85. Option 4 would mean that technical changes, to the OIC service and amendments to the Pre-action Protocol underpinning it, would be needed, but overall, we believe this would be beneficial to the process. It would allow for better quality data which in turn would help identify and facilitate improvements to the OIC claimant medical reporting journey. This data would also highlight where consideration of the rules underpinning OIC is required to ensure they work consistently and as intended.

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?

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

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.

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.

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.

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.

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?

Equality issues

Background

86. The core issues for this consultation document relate to improvements to the medico-legal process for claimants affected by the implementation of the Government's whiplash reform programme. Section 149 of the Equality Act 2010 ("the Act") requires Ministers and the Department, when exercising their functions, to have 'due regard' to the need to:

- eliminate unlawful discrimination, harassment, victimisation and any other conduct prohibited by the Act;
- advance equality of opportunity between different groups (those who share a relevant protected characteristic and those who do not); and
- foster good relations between different groups (those who share a relevant protected characteristic and those who do not).

87. In carrying out this duty, Ministers and the Department must pay "due regard" to the nine "protected characteristics" set out in the Act, namely: race, sex, disability, sexual orientation, religion and belief, age, marriage and civil partnership, gender reassignment, pregnancy and maternity.

88. Through this consultation the Government has sought input from stakeholders on a range of proposals to improve the efficiency and quality of the medical reporting process and to increase the level of fixed recoverable costs available in respect of this work.

Direct Discrimination

89. The proposed improvements to the medical reporting process will apply to and benefit all claimants equally. Our assessment therefore is that the proposals are not directly discriminatory within the meaning of the Equality Act 2010.

Indirect Discrimination

90. No changes are being proposed which are likely to result in indirect discrimination within the meaning of the Act to affected stakeholders. Any changes made as a result of this consultation are unlikely to result in anyone with a protected characteristic being put at a particular disadvantage compared to someone who does not share the protected characteristic.

91. However, the Government does not collect comprehensive information about personal injury claimants in relation to protected characteristics. This means that making direct comparisons between different protected groups can be difficult which may affect our understanding of the potential equality impacts of the proposals made.

92. Claimants with particular religious or other beliefs or those who identify with specific gender identities or sexual orientations may feel restricted in the type of medical report provider they can choose from. However, but this risk may be mitigated by the proposed inflationary increase to the fixed recoverable costs, if such increase results in increased market choice.

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?

Please explain your reasoning.

Part 5: Statistics

Current volume of RTA related PI claims

93. There were around **367,000** RTA related Personal Injury claims made in 2022/23 in England and Wales[15]. Of these, around **312,000** were estimated to be whiplash related.

Current volume of claims supported by MedCo reports

94. There were around **268,000** searches on the MedCo system in 2022/23. **84%** of these searches resulted in the selection of an MRO, around **14%** in the selection of a DME and around **4%** in no selection.

Volume of represented/unrepresented claimants

95. Around **544,000** claims have been made using the OIC service since its launch on 31 May 2021. Of which around **493,000** claims were represented, and around **51,000** claims were made by unrepresented claimants.

Current number and type of authorised users

96. There are currently around **1,300** operational Authorised Users on MedCo system.

Current numbers of MROs

97. There are currently **38** operational MROs registered with MedCo, of which **10** are tier 1 high volume national providers and **28** are lower volume tier two providers.

Current numbers of indirect and direct medical experts

98. There are currently **86** operational indirect medical experts and **414** operational direct medical experts.

[15] Based on Compensation Recovery Unit performance data

Questionnaire

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? Please explain your reasoning.
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? Please explain your reasoning.
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? Please explain your reasoning.
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? Please explain your reasoning.
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? Please explain your reasoning.
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? Please explain your reasoning.
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 as along with your reasoning for this and any supporting evidence.

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.

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?

Please provide details of any services provided.

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

Please explain your reasoning.

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

Please explain your reasoning.

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

Please explain your reasoning.

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

Please explain your reasoning.

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

Please explain your reasoning.

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

Please explain your reasoning.

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?

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

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?

Please explain your reasoning along with any supporting evidence.

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 Parts 7.8 of the RTA PAP and 7.9 of the Small Claims PAP?

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

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.

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.

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.

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.

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?

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?

Please explain your reasoning.

About you

Please use this section to tell us about yourself

Full name	
Job title or capacity in which you are responding to this Call for Evidence exercise (e.g. member of the public etc.)	
Date	
Company name/organisation (if applicable):	
Address	
Postcode	
If you would like us to acknowledge receipt of your response, please tick this box	☐ (please tick box)
Address to which the acknowledgement should be sent, if different from above	

If you are a representative of a group, please tell us the name of the group and give a summary of the people or organisations that you represent.

Contact details/How to respond

MoJ contact details

Please send your response by 10 October 23 to:

Personal Injury Policy Team
Ministry of Justice
Post point 5.23
102 Petty France
London SW1H 9AJ
Tel: 020 3334 3157
Email: whiplash-reform-team@justice.gov.uk

Complaints or comments

If you have any complaints or comments about the Consultation process, you should contact the Ministry of Justice at the above address.

Extra copies

Further paper copies of this Consultation can be obtained from the address above, and it is also available on-line at https://consult.justice.gov.uk/civil-law/rta-medical-reporting-consultation.

Alternative format versions of this publication can be requested from:

whiplash-reform-team@justice.gov.uk

Publication of response

A paper summarising the responses to this Consultation will be published in approximately three months' time. The response paper will be available on-line at: https://consult.justice.gov.uk/civil-law/rta-medical-reporting-consultation.

Representative groups

Representative groups are asked to give a summary of the people and organisations they represent when they respond.

Confidentiality

By responding to this Consultation, you acknowledge that your response, along with your name/corporate identity will be made public when the Department publishes a response to the Consultation in accordance with the access to information regimes (these are primarily the Freedom of information Act 2000(FOIA), the Data Protection Act 2018 (DPA), the General Data Protection Regulation (GDPR) and the Environmental Information Regulations 2004).

Government considers it important in the interests of transparency that the public can see who has responded to Government Consultations and what their views are. Further, the Department may choose not to remove your name/details from your response at a later date, for example, if you change your mind or seek to be 'forgotten' under data protection legislation, if Department considers that it remains in the public interest for those details to be publicly available.

If you do not wish your name/corporate identity to be made public in this way then you are advised to provide a response in an anonymous fashion (for example 'local business owner', 'member of public'). Alternatively, you may choose not to respond.

Impact Assessment

The changes proposed in this consultation document do not require the production of a full Impact Assessment. Where required MoJ analysts have considered the available data and made recommendations/proposals for change.

Welsh Language

The policy proposals included in this document do not affect MoJ services in Wales. A Welsh language version of the executive summary and question set included in this Consultation Document is also available on https://consult.justice.gov.uk/civil-law/rta-medical-reporting-consultation.

Consultation principles

The principles that Government departments and other public bodies should adopt for engaging stakeholders when developing policy and legislation are set out in the Cabinet Office Consultation Principles 2018 that can be found here: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/691383/Consultation_Principles__1_.pdf

Annex A: List of Consultees

The following list is not exclusive, and submissions are welcome from all stakeholders with an interest in medico-legal reporting:

All Medical Reporting Organisations registered on MedCo

All direct medical experts registered on MedCo

All indirect medical experts registered on MedCo

All authorised users registered with MedCo

The Law Society

The Forum of Insurance Lawyers

The Association of Personal Injury Lawyers

The Association of British Insurers

The Motor Accident Solicitors Society

The Association of Consumer Support Organisations

The Chartered Society of Physiotherapy

The British Medical Association

The Gibraltar Insurance Association

The Personal Injury Barristers Association

The British Insurance Brokers Association

Annex B: Revised MRO Qualifying Criteria

Table 1: Minimum Qualifying Criteria for all MROs Registered with MedCo

All MROs applying for inclusion on the MedCo system must meet (and on an ongoing basis must continue to meet) each of the criteria in Table 1 (below) in order to achieve and retain MRO status on MedCo. All MROs will be audited by MedCo against these criteria:

Minimum Qualifying Criteria for all MROs	Qualifying Criteria Rationale
1.1 All Medical Reporting Organisations (MROs) wishing to register on the MedCo system must provide documented assurances that their organisation meets the terms below. MRO Definition: For the purposes of registration and remaining registered on MedCo, an MRO is defined as: "an organisation whose principle function is to provide medico-legal reporting services, and which is: (i) independent (ii) properly staffed and resourced; and (iii) directly and solely responsible for all work associated with receiving instructions via the MedCo portal; and instructing a medical expert to provide an initial medical report".	The practice of MROs registering shell companies with MedCo undermines the Government's policy principles of independence, fair competition and public confidence in MedCo. As such, MROs identified as ~~S~~shell companies are not allowed to be registered on the ~~MedCo~~ system. It is however, acknowledged that some MROs may fall under a common third-party ownership model. This does not automatically equate to shell company status and each case will be decided on its merits. MedCo will ~~continue to~~ monitor for breaches of this policy and will investigate and take action to remove any MROs identified as ~~'~~shell companies~~'~~. ~~This definition has been developed to provide clarity as to what functions an MRO providing medico-legal reports on the MedCo system should undertake.~~ ~~It is acknowledged that some MROs may fall under a common third-party ownership. However,~~ MROs must be fully functioning entities in their own right and must have a principal function of providing medical reporting services. MROs should not outsource the core functions or significant areas of the MRO role to third party service providers. The MRO definition provides clarity as to what functions an MRO providing medico-legal reports on the MedCo system should undertake.

Minimum Qualifying Criteria for all MROs	Qualifying Criteria Rationale
Each MRO must: a) establish and maintain the direct management and control of a panel of MedCo accredited experts; b) employ staff in-house with responsibility for managing the instructions received from authorised users and for directly undertaking all administrative work associated with the commissioning of reports from MedCo accredited experts on their own panel, including managing the invoicing, direct payment of experts and debt collection processes; c) manage the appointments process for claimants (including identifying appropriate dates, times and venues for medical examinations, and processing cancellation and rescheduling of appointments); d) oversee and quality assure (clinically and non-clinically) the report production process and have systems in place to effectively manage any complaints from instructing parties; and e) comply fully with the MedCo User Agreement, including its Ethics Policy, and operate in a way which is not contradictory to the Government's stated policy objectives.	The direct management and control of experts by MROs includes MROs making payments direct to experts and not third-party providers. It is central to the policy underpinning random allocation that the MRO receiving the instruction subsequently carries out the work. This definition, in conjunction with other criteria, will provide customer reassurance regarding quality of service. An MRO should be fully resourced and accountable, and not be a clearing house with some/all of its functions outsourced to a linked (parent) or another organisation. It must have sufficient employees and resources available to it to service all accepted instructions to a minimum accepted standard of service to instructing parties. Compliance with this definition will be assessed by MedCo as part of the formal MRO audit process. This will be in accordance with: • the terms set out in the MedCo User Agreement; • guidance published by MedCo; and • instructions and/or recommendations provided by the MoJ, including the terms of any Memorandum of Understanding agreed between the MoJ and MedCo. 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. Failure to meet the definition could lead to removal from the system. This includes MROs that fail to provide MedCo, within timescales defined by MedCo, with all such documentary evidence and/or additional information as MedCo may reasonably request for the purpose of determining whether or not an MRO meets the qualifying criteria. For the avoidance of doubt a key intention of these qualifying criteria is to restrict and control the deliberate establishment of "shell" MROs which undermine the Government's policy of independence through random allocation of medical report providers~~isation~~.

Minimum Qualifying Criteria for all MROs	Qualifying Criteria Rationale
1.2 Obligation to declare all direct financial links. In order to achieve and retain MRO status, an organisation is required to sign and comply with the declaration contained in the revised MoJ Statement on Financial Links. Signatories to this declaration must keep it up to date at all times. In addition, as a minimum all organisations are required to sign this declaration upon registration as an MRO, and thereafter they must re-sign the declaration on an annual basis (or as and when required in accordance with the MedCo Data Contributor Agreement).	The Government has consistently stated its commitment to tackling the issue of direct financial links between those who commission reports and those who produce them. In order to ensure this public policy objective is delivered, MROs are required to declare all those individuals and organisations to which they have a direct financial link, as required in the MoJ Statement on Direct Financial Links. This document is included as a schedule in the MedCo User Agreement which is provided to and signed by MROs when they register with MedCo.
1.3 Commitment to pay medical experts direct, on set credit terms irrespective of the outcome of the case.	MROs must commit to and demonstrate the ability to pay medical experts direct and within payment terms agreed with their medical experts. These payment terms must not include any element of contingency based on a particular outcome of the case. This provision removes any suggestion that the medical expert has an interest in the outcome of the case and is consistent with paragraph 88 of the "Guidance for instruction of experts in civil claims[16]" produced by the Civil Justice Council, which ~~came into force~~was published on 01/12/14.
1.4 A financial instrument of at least £20,000 demonstrating that the MRO has sufficient funds available to remunerate medical experts from whom it has commissioned medical reports in the case of failure of the MRO.	The availability of sufficient financial resources is required to ensure that medical experts are protected in the event of a failure of an MRO. Obtaining this financial instrument is also a disincentive to the establishment of "shell" MROs which undermine the random allocation model.
1.5 Evidence of a minimum of £1m for professional indemnity insurance and £3m for public liability insurance.	If an MRO mismanages a case (e.g. misses a limitation date or court deadline) then the claimant and the claimant's representative might suffer significant

[16]https://www.judiciary.gov.uk/wp-content/uploads/2014/08/experts-guidance-cjc-aug-2014-amended-dec-8.pdf

Minimum Qualifying Criteria for all MROs	Qualifying Criteria Rationale
	financial loss. Therefore, a minimum level of Public Liability cover is required for MROs. On the same basis, if a claimant sustains any loss or injury during the course of the medico-legal process, the MRO must have appropriate insurance cover to mitigate any losses arising from a claim. The level of insurance included in this criterion is a reflection of the premiums that the industry currently pays.
1.6 Compliance with all relevant regulatory requirements in relation to information security, including all duties imposed under the Data Protection Act (DPA) 2018[17] and any additional relevant ~~European~~ legislation such as the ~~EU~~ UK General Data Protection Regulation[~~18~~].	MROs, irrespective of their size, handle sensitive information (often medical in nature). Therefore, this requirement will ensure that all MROs can demonstrate that they have all the necessary systems, controls and checks in place in relation to information security. This provision includes within its scope all an MRO's outsourced or external suppliers to whom data is transferred or that are able to access it including e.g. externally hosted applications (case management or report writing software), appointment booking platforms and administrative agencies. The MRO is responsible for ensuring that the data it transfers or enables access to, is processed in accordance with regulatory requirements and cannot delegate this responsibility~~it~~. This will give confidence to instructing parties that MROs registered with MedCo all adhere to a consistent minimum standard in relation to data processing and management and, if necessary, that they can demonstrate compliance if audited. Additional information on data protection can be found at the following: https://www.gov.uk/data-protection https://ico.org.uk/for-organisations/guide-to-data-protection/guide-to-the-general-data-protection-regulation-gdpr/

[17] http://www.legislation.gov.uk/ukpga/2018/12/contents/enacted

[~~18~~] ~~https://gdpr-info.eu/~~

Minimum Qualifying Criteria for all MROs	Qualifying Criteria Rationale
	https://digital.nhs.uk/data-and-information/looking-after-information/data-security-and-information-governance/data-security-and-protection-toolkit For organisations wishing to establish, implement, maintain and continually improve an information security management system ISO/IEC 27001/2020 is recommended as best practice. More information can be found here: https://www.iso.org/standard/82875.html ~~https://www.iso.org/standard/54534.html~~
1.7 Commitment to, and compliance with, anti-bribery legislation.	MROs, irrespective of their size, may be susceptible to bribery. Therefore, all MROs are required to demonstrate that they have all necessary systems, controls and checks in place to comply with anti-bribery legislation. Guidance on this issue can be found here: https://www.gov.uk/anti-bribery-policy
1.8 Commitment to, and compliance with, a business ethics policy by the MRO and all individuals controlling it. This includes a demonstrative understanding of the impact that controlling individuals'* behaviour may have on maintaining, monitoring and enforcing the ethics policy. * shareholders (including beneficial owners), directors (including shadow directors) and day-to-day operational management.	Instructing parties need to be reassured that the organisations they instruct (and those controlling them) act ethically on a continuous basis. Also, that they have the means and understanding to effectively monitor and enforce the ethics policy, including following all relevant legislation and industry standards. All MROs must both comply with the ethics policy contained in the MedCo user agreement and implement and follow an appropriate business ethics policy for their business. The MedCo ethics policy can be found here: https://www.medco.org.uk/media/1469/ethics-policy.pdf Helpful guidance for both regulators and businesses on implementing ethical policies can be found here: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/497539/16-113-ethical-business-regulation.pdf In addition, attending the Institute of Business Ethics one-day training course on 'Understanding Business Ethics' should be considered as best practice in this area. More information on this training can be found here: ~~https://www.ibe.org.uk/events-training/ems-event-calendar/understanding-business-ethics-sept.html~~

Minimum Qualifying Criteria for all MROs	Qualifying Criteria Rationale
	https://www.ibe.org.uk/events-training/ems-event-calendar/understanding-business-ethics.html
1.9 Documented, published and functional complaints handling process with a full audit trail of all complaints received and how they have been handled.	It is a consequence of the operation of the MedCo system that instructing parties will have to utilise MROs that they previously may not have ~~chosen~~instructed. As such, and in order to retain MedCo credibility, any MRO must demonstrate that it handles all complaints seriously and in a professional manner. A documented process must be in place and be auditable. A complaint is defined as any expression of dissatisfaction, whether oral or written, whether justified or not, from or on behalf of an eligible complainant about the MROs services including, but not limited to the provision of, or failure to provide, a medico-legal report. It is important to treat complaints seriously as they can highlight problems or areas for improvement in your organisation and handling them well can protect your reputation and prevent future complaints. Helpful guidance and example procedures can be found here: https://www.legalombudsman.org.uk/information-centre/learning-resources/good-complaints-handling/best-practice-complaint-handling-guide/ https://www.england.nhs.uk/wp-content/uploads/2021/09/item7ii-nhs-england-complaints-policy.pdf
1.10 Appointment of a Responsible Officer/Compliance officer.	All MROs must have a single point of contact responsible for demonstrating full and proper knowledge of and compliance with MedCo requirements. This point of contact will be responsible for liaison with MedCo and/or its audit team.
1.11 Restriction on providing medical evidence in any case where a Related Party is involved.	No MRO may provide a medical report in support of a case in which a related party is involved in order to avoid conflicts of interest.
1.12 MROs should not have controlling Shareholders, Directors, Officers or non-equity	MROs must be owned and operated by people of appropriate character.

Minimum Qualifying Criteria for all MROs	Qualifying Criteria Rationale
funders who have been declared bankrupt or convicted of fraud in last 5 years. Where an MRO is financed by material non-equity funding, e.g. loans from individuals, those individuals are covered by this provision unless the MRO can demonstrate that the individuals exert no direct control as a result of their funding.	Directors include shadow directors. Officers include company secretary, chief medical officer and day-to-day operational management. Non-equity funders exclude UK regulated lenders / debt providers e.g. banks, investment management/private equity firms and listed debt securities. The FCA provides helpful information on checks which can be undertaken to cover areas such as identity, employment, finances and educational checks: https://www.ukemployeechecks.co.uk/employee-screening-packages/fca-screening
1.13 Direct management of an MRO's panel of medical experts.	An MRO is responsible for the recruitment, validation and management of the independent MedCo accredited medical experts on its panel. Management includes such processes as contract management, appointment capacity, changes to panel due to suspension/removal/reinstatement, quality assurance (clinical and non-clinical) and geographical coverage. MROs must be able to demonstrate on request that its medical experts comply with all legal and regulatory requirements (including confirmation that every expert providing a report on behalf of that MRO has attained accreditation, and that all on their list retain operational status).
1.14 Payment of the requisite fees for registration with MedCo by the due date.	MROs will only be able to become registered with MedCo upon receipt of the requisite fee, as determined by the MedCo Board. Further information on the registration requirements for MedCo can be found ~~and published~~ at: https://www.medco.org.uk/who-am-i/medical-reporting-organisation-mro/register/ ~~www.medco.org.uk.~~
1.15 Upload of anonymised medical case data and collection of relevant management by MedCo, within a time period defined by MedCo.	In order to underpin effective management of the MedCo system and to monitor its effectiveness, MROs must provide to MedCo the data set out at https://www.medco.org.uk/media/1301/casesdataupload-v26-may-2021-template.xlsx, ~~www.medco.org.uk,~~ including the uploading of medical case data, within timescales defined by MedCo. All data uploads will need to be compliant with the DPA.

Minimum Qualifying Criteria for all MROs	Qualifying Criteria Rationale
1.16 All MROs must demonstrate understanding of their performance in order to monitor, manage and comply with the minimum standards and service levels as defined by MedCo.	In line with the accreditation process for medical experts, it is important that MROs will be able to provide confidence to users of the MedCo system that they operate to the required minimum standards. This will be auditable as part of the MedCo audit process.

Table 2: Additional Qualifying Criteria for High Volume National MROs

The qualifying criteria listed in Table 2 (below) cover the extra requirements needed for an MRO to be reclassified as a high volume, national (HVN) MRO. All MROs seeking HVN status will be audited by MedCo against these additional criteria:

Additional Qualifying Criteria for HVN MROs	Qualifying Criteria Rationale
2.1 Minimum two years of trading history as an MRO providing MedCo compliant medical reports with all audited financial statement qualifications disclosed.	This will give the instructing party confidence in the sustainability of the chosen MRO and provide reassurance in the market that the random allocation model will only produce MROs that have a demonstrable record of delivery. A qualified report does not necessarily mean that there are issues with an organisation's financial health; it can also mean that there was insufficient data provided to form an opinion on aspects of the accounts provided for audit. The specific circumstances relating to instances of insufficient data will be considered but the nature of any specific audit qualifications may result in rejection by MedCo.
2.2 Operational Capability: An MRO must be able to demonstrate that: i. It has the capacity to process at least ~~40~~28,000 independent medico-legal expert reports each year (where instructions are received from an unlinked source). Medico-legal reports, for these purposes, are not restricted to MedCo whiplash reports and may be of another type (e.g. non-soft tissue personal injury reports). If an MRO has not previously processed ~~40~~28,000 independent medico-legal reports, it may be considered to have the requisite capacity if it can provide evidence to demonstrate to the satisfaction of Medco that it nonetheless has the ability to reach	It is important that MROs will be able to provide confidence to users of the MedCo system that they operate to the required minimum standards, this is particularly important for organisations who process a high volume of instructions. This will be auditable ~~as part of the~~by MedCo ~~audit process~~. The requirements as to the number of experts and availability within each region are intended to ensure that there are a sufficiently large number of medical experts available in any particular region. It is accepted that 80% coverage of available postcodes in England and Wales will be considered 'national'. A larger number of experts with whom an MRO has a contractual relationship will mean that there is likely to be a much greater ability for those MROs to offer appointments that are geographically convenient and at a time that suits for those members of the public who require a medical report to be produced. A small number of experts in any region could restrict choice in this respect.

Additional Qualifying Criteria for HVN MROs	Qualifying Criteria Rationale
such capacity within the following 12 months and, to that end, possesses: a) an appropriate business strategy with respect to the growth required to meet that capacity; b) operational functions (including human resources and IT systems) which are sufficiently robust and scalable such that they can demonstrate the ability to deliver the increase in capacity, over the following 12 months without adversely affecting their ability to process and deliver reports of sufficient quality in a proper and timely manner and without adversely affecting their financial stability or profitability; and c) meets (ii) – (v) below. ii. It has contractual arrangements with at least ~~225~~ 175 individual, active, MedCo accredited medical experts who provide MedCo whiplash reports; iii. It has contracted medical experts in 80% of the postcodes in England and Wales and for 80% of its cases the injured party has to travel less than 15 miles to attend an appointment with a medical expert; iv. It has a minimum of five distinct clients, which are not associated organisations with it, and no client represents more than 40% of the total instruction volume (to prevent an	A distinction is made between instructions received from a linked source and an independent source, as an independent source will require a more demanding and challenging service accessed from a free and open market. The requirements for there to be a minimum of five distinct clients, which are not organisations associated with the MRO, and that no client represents more than 40% of the total instruction volume, are requirements for MedCo. These are to ensure that larger MROs have the capacity to deal with a high volume of clients to the required standards.

Additional Qualifying Criteria for HVN MROs	Qualifying Criteria Rationale
in-house MRO serving its own commercial ambitions); and v. It has the ability to comply with the SLAs for high volume, national MROs as defined by MedCo.	
2.3 A financial instrument of £100,000 demonstrating that the MRO has sufficient funds to remunerate medical experts from whom it has commissioned medical reports in the case of failure of the MRO.	The availability of sufficient financial resources is required to ensure that medical experts are protected in the event of a failure of an MRO. Payment of this financial instrument is also a disincentive to the establishment of "shell" MROs designed to undermine the random allocation model.
2.4 A documented and tested Disaster Recovery Plan and Business Continuity Plan, including testing schedule and outcomes and fixes, which demonstrate that the MRO can return to normal operation within a maximum of 72 hours.	It is good industry practice for an MRO handling a significant volume of cases to have a documented disaster recovery plan and business continuity plan. Clients currently and typically expect that plans of this nature are in place. Lawyers are likely to require such plans so that, in the event of any significant problems, they can be assured that this will not have a prolonged detrimental impact on their own business and their clients.
2.5 Appointment of Chief Medical Officer.	A retained General Medical Council of Health Care Professionals Council registered CMO would ensure clinical governance and dispute resolution. Whilst not mandatory for all MROs, it is required for those providing high volumes of medical reports and this requirement demonstrates commitment to clinical governance.
2.6 Appointment of nominated Caldicott Guardian.	All NHS organisations and local authorities that have access to patient records are required to have a Caldicott Guardian, i.e. a senior person responsible for protecting the confidentiality of a patient and enabling appropriate information sharing. To ensure claimant data is protected and used legally, ethically and appropriately for the correct purpose only, HVN MROs must also appoint a Caldicott Guardian to provide leadership and informed guidance on complex matters involving confidentiality and information sharing.

Additional Qualifying Criteria for HVN MROs	Qualifying Criteria Rationale
	This is an example of “best practice” and MROs providing medical reports should demonstrate their commitment to the protection of sensitive information through the appointment of a Caldicott Guardian. Further information on the roles and responsibilities of a Caldicott Guardian can be found here: https://www.ukcgc.uk/manual/role
2.7 Payment of the requisite fees for registration with MedCo and onsite audit.	MROs will only be able to become registered with MedCo upon receipt of the requisite fee, as determined by the MedCo Board. Further information on the registration requirements for MedCo can be found at: https://www.medco.org.uk/who-am-i/medical-reporting-organisation-mro/register/ ~~and published at www.medco.org.uk.~~ ~~-~~All high volume, national MROs will be required to undergo an onsite audit of their adherence to the criteria set out in this paper. The report resulting from the audit must be provided to MedCo.
2.8 Demonstrable A2A capability to solicitors.	A2A functionality streamlines the claims process for all stakeholders, including the claimant, making the system efficient and timely and also removing unnecessary costs for both MROs and solicitors.

Table 3: Supplementary Qualifying Criteria for MROs providing unrepresented claimant reports

The qualifying criteria listed in Table 3 (below) cover the requirements for carrying out unrepresented claimant work. All MROs seeking unrepresented claimant compliant status will be audited by MedCo against these additional criteria:

Supplementary Qualifying Criteria for Unrepresented Claimants	Qualifying Criteria Rationale
3.1 MROs opting into unrepresented claimant work must be fully functional organisations which are compliant with all relevant qualifying criteria including that contained in table 1. This includes accepting instructions in relation to both represented and unrepresented claims as an operational norm.	This will give unrepresented claimants confidence that their selected provider consistently operates to high standards, which is necessary given an unrepresented claimants' likely unfamiliarity with the medical report process. MROs should be able to demonstrate adherence to good practice approaches and where weaknesses are identified, they should be few in number, the implications are not material, and they are capable of resolution within a short timescale. Consideration will be given to any MedCo warning letters, suspensions or removals from the system related to any aspect of an MRO's compliance with any other applicable QCs issued within the last three years. This includes both the warnings issued and the MROs response to issues covered.
3.2 Key individuals working for the MRO adhere to the following fit and proper persons criteria: • honest, of good character, credible and with integrity; • competent and capable to perform tasks intrinsic to their job, taking into account appropriate factors such as location and other business interests; • have the qualifications, knowledge, skills and experience necessary for their office; and • have not been responsible for, privy to, contributed to or facilitated any serious	Given the likely imbalance in knowledge, experience and power in the relationship between unrepresented claimants and MROs a 'fit and proper persons' regime is required in the claimants' interests. Evidence may include references from former employers, professional advisers and social media profiles. This requirement is in line with best practice in the NHS and other sectors. For an MRO, key individuals are those with significant control over the MRO strategically, financially and operationally, i.e. shareholders, directors (including shadow directors) and day-to-day management. When the MRO assesses themselves against this QC, they should take into account all their dealings with MedCo or as an MRO in the past 3 years under any registration application in any capacity (including shareholder, beneficial owner, director, shadow director and employee) for any User type, together with equivalent non-MedCo activities. Where concerns arise, the extent to which the

Supplementary Qualifying Criteria for Unrepresented Claimants	Qualifying Criteria Rationale
misconduct/mismanagement in the production of MedCo or non-MedCo medico-legal reports.	MRO/DME acknowledges failings, takes corrective action and demonstrates compliance thereafter are relevant mitigating factors, dependent upon the number, frequency and significance of the relevant concerns. An MRO that fails to demonstrate that it meets this QC will be suspended from conducting unrepresented claimant work, irrespective of their existing tier status or performance against any other QC. Where in doubt, MROs should contact MedCo immediately to discuss any concerns. In the interests of protecting unrepresented claimants, MedCo may suspend a MRO's Business to Claimant ~~2C~~ status whilst any concerns are being investigated.
3.3 Has the resources and structure necessary for operational delivery of the unrepresented claimant service on a consistent and stable basis i.e.: a) **Ability to operate** at times when unrepresented claimants may wish to pursue their claims, which may be outside normal office hours; b) **Ability to operate** ~~across~~ multiple communication channels to cater for different unrepresented claimants' communication preferences and needs (e.g. if vulnerable or not have web access); c) **No key person** involved in the day to day operation of the MRO should work on a temporary, self-employed or consultancy basis; and d) **Operates from** substantive, standalone, physical and professional business premises.	MROs should be able to provide a high level of customer service irrespective of owner availability and employed staff (including director) turnover, holidays and sickness. All key functions, activities and knowledge should be available to the MRO at all trading times. This means that each key function, activity or area of knowledge has to be capable of being performed ~~-~~/ ~~-~~known by more than one person. An appropriate ~~range~~ choice of communications channels should be available to claimants across a range of times, including outside of normal office hours (9-5). This may involve staff being available to take calls before or after these hours or other methods of recording and promptly answering queries being used. The minimum number of channels operated by an MRO should cater for the full spectrum of unrepresented claimants' contact preferences. For example, at least one option from each of the following 3 categories: physical (e.g. letter), audio (e.g. telephone) and electronic (e.g. email, SMS/text, social media and live-chat or similar). The types of premises which would usually be considered inappropriate include residential homes (except those adapted to include private consulting rooms equipped to an equivalent standard to medical facilities), virtual offices, retail space (e.g. above shops), offices of fellow group companies either related to the insurance industry (e.g. GP practices) or not (e.g. property management, car hire), offices of legally separate companies related to the insurance industry (e.g. claims

Supplementary Qualifying Criteria for Unrepresented Claimants	Qualifying Criteria Rationale
	management companies) and general co-working offices hired out on a temporary basis as and when needed. The individual circumstances of each MRO will, however, be considered during their audit. Contact details for the MRO should be specific to the MRO i.e. email/physical address and telephone number; forwarding details e.g. post-office box numbers **are not acceptable**.
3.4 Direct management of the unrepresented claimant experience.	The MRO is responsible for their dealings with unrepresented claimants and will be held accountable for any interactions between the instructing claimant and any outsourced customer service providers. The customer service function should not be outsourced to a third party and MROs should always retain oversight of, and be accountable for, any dealings such providers have with the instructing party. Following the implementation on 31 May 2021 of the whiplash reforms, MedCo's remit has beenis being extended to cover all road traffic accident-related personal injury claims where damages for pain, suffering and loss of amenity are valued at up to £5,000. Therefore, the end-to-end service (receipt of instruction to uploading of report) provided to the unrepresented claimant by the MRO should also cater for non-soft tissue injuries, where appropriate.
3.5 MROs must provide the unrepresented claimant with transparent, accurate, timely and up-to-date information about: a) **its process** for producing the medico-legal report, especially the consultation procedure; b) **what** its and the claimant's roles, responsibilities and rights are in this process; c) **its** contact details and availability by channel;	It is important that all information and communications provided to unrepresented claimants uses easily understandable language and be available in a range of accessible formats. This means that information must be displayed prominently, timely and consistently. It must also be clear and in plain English, with information presented in a straightforward manner with important details clearly highlighted. Additional advice and guidance on writing in plain English can be found here: https://www.plainenglish.co.uk/medical-information.html The communication channels used should be such that no unrepresented claimant can be misinformed no matter how they choose to engage with the MRO, including such channels as website, social media, telephone, letter, email and live-chat or similar.

Supplementary Qualifying Criteria for Unrepresented Claimants	Qualifying Criteria Rationale
d) **its performance** against the service standards specified at QC 3.6; and e) **how** to make complaints about the MRO and to initiate any dispute resolution process.	The onus is on the MRO to manage expectations and make sure that it is clear on the medico-legal report production process, including what the claimant needs to do and when. This includes clearly explaining the unrepresented claimant's rights to challenge the MRO on matters of fact pre- and post-report provision. MROs should inform unrepresented claimants of their performance levels, how to complain if they experience poor service and the details of any dispute resolution process. If MROs fail to address the claimant's complaint to his/her satisfaction, the claimant should have the process for how to report the MRO to MedCo clearly explained to them. Helpful guidance and example procedures can be found here: https://www.legalombudsman.org.uk/information-centre/learning-resources/good-complaints-handling/best-practice-complaint-handling-guide/ https://www.legalombudsman.org.uk/downloads/documents/publications/Guide-Good-Complaints-Handling.pdf https://www.england.nhs.uk/wp-content/uploads/2021/09/item7ii-nhs-england-complaints-policy.pdf
3.6 All MROs must understand, monitor and manage their performance in order to comply with the enhanced standards and service levels as defined by MedCo.	It is important that unrepresented claimants have confidence that those suppliers they select to produce their medico-legal reports operate to the required standards. Monitoring performance will enable MROs to be flexible when accommodating requests made by unrepresented claimants. This will be auditable as part of the MedCo audit process.
3.7 Demonstrates a robust end-to-end claimant customer service capability in terms of medico-legal services offered, resources (people, processes and technology) deployed and the quality of outputs.	Particular customer services skills that should be demonstrable and evident in dealing with unrepresented claimants include: • **Timeliness** i.e. questions answered promptly, issues identified, and problems resolved quickly with specific details given of if/when something will happen; • **Attitude** i.e. unrepresented claimants must be treated with respect, courtesy and professionalism; • **Empathy** i.e., treat others how one would like to be treated;

Supplementary Qualifying Criteria for Unrepresented Claimants	Qualifying Criteria Rationale
	• **Awareness** of the needs of vulnerable claimants and that specific additional actions/services may be required to support their application; • **Ownership** i.e., make sure that the unrepresented claimant does not get bounced around trying to find the right person to help them; • **Active** listening i.e., MROs should not assume to know what the unrepresented claimant wants, but should listen first, then act in response to their specific needs; • **Expertise** i.e., be knowledgeable about the service, say if you do not know the answer and then quickly get the information from someone who does and revert back to the unrepresented claimant; • **Dependability** i.e., do what you say, when you have said you will do it and do not leave it up to the unrepresented claimant to follow up; and • **Be prepared** to follow up regularly with the unrepresented claimant to make sure that everything is proceeding satisfactorily. • **Consideration** should be given to staff training/qualifications on customer services and obtaining external certifications e.g. ISO9001 (2015 and successor versions) to substantiate the above. More information on ISI9001 can be found here: https://www.iso.org/iso-9001-quality-management.html
3.8 Payment of the requisite fees for registration with MedCo and onsite audit.	MROs will only be able to become registered with MedCo upon receipt of the requisite fee as determined by the MedCo Board and published at Further information on the registration requirements for MedCo can be found at: https://www.medco.org.uk/who-am-i/medical-reporting-organisation-mro/register/~~www.medco.org.uk~~. All MROs opting in to undertake unrepresented claimant work will be required to undergo an onsite audit of their compliance with and adherence to the additional criteria set out in this paper for this purpose.

Annex C: Revised DME Rules

The following rules have been developed to enable DMEs to demonstrate that they have can provide a good level of service to unrepresented claimants seeking a medical report. DMEs wishing to undertake this work will be subject to an audit interview with the MedCo audit team. Where appropriate, additional rationale for each rule has been provided below, and further guidance will be provided prior to audit interviews being undertaken.

Rule 1: Fit and Proper Persons

DMEs must adhere to the following fit and proper persons criteria, and ensure that any employee dealing with unrepresented claimants also adheres to these criteria:

a) Be honest, of good character, credible, and must act with integrity;

b) Be competent and capable of performing tasks intrinsic to their role, both in terms of their core medico-legal expert duties and/or related administrative tasks;

c) Have relevant qualifications, knowledge, skills and experience necessary for the role they undertake;

d) Enhanced certification is considered best practice, but basic DBS certification is mandatory for all experts and key staff dealing with unrepresented claimants. A basic DBS certification request can be made here: https://www.gov.uk/request-copy-criminal-record; and

d) Not have been responsible for, privy to, have contributed to or facilitated any serious misconduct or mismanagement in the production of ~~Medco~~ MedCo or non-~~Medco~~ MedCo medico-legal reports.

Additional Rationale: Given the imbalance in knowledge, experience and power in the relationship between unrepresented claimants and DMEs, a 'fit and proper persons' regime is appropriate to protect their interests. In the case of an employee of a DME, evidence that the employee is a fit and proper person may include references from former employers, references from professional advisers, or a review of social media profiles. This is in line with best practice in the NHS[19] and where in doubt, DMEs should contact MedCo to discuss any concerns. It is noted that there are a range of appropriate administrative qualifications available to employees, however DMEs will be responsible for ensuring qualifications claimed by staff are valid and suitable for the role undertaken.

Rule 2: Audits and Accreditation

DMEs will be authorised to undertake unrepresented claimant work only upon satisfactory completion of both:

a) an audit in the form of an assessment interview and/or an onsite audit of their compliance with and adherence to the Rules specific to DMEs including the Rules specific to DMEs authorised to accept instructions from unrepresented claimants. In the event that a DME attending an assessment interview with the Medco Audit Team fails to satisfy the audit criteria, an on-site audit may at Medco's discretion be arranged at a later date, and

b) the Medco Accreditation Training Unrepresented Claimant Module.

Additional Rationale: Passing an assessment interview undertaken by a qualified auditor provides reassurance that the DME understands the roles and responsibilities that they and their staff have in relation to providing services to unrepresented claimants. The ~~new~~ accreditation module will form part of the MedCo accreditation process which is designed to ensure the quality of training undertaken by medical experts undertaking MedCo work remains consistent.

19 https://nhsproviders.org/fit-and-proper-persons-regulations-in-the-nhs

Rule 3: Data Protection

DMEs are required under paragraph 6 of the MedCo Rules to comply with all relevant requirements in relation to duties imposed under the Data Protection Act 2018 (http://www.legislation.gov.uk/ukpga/2018/12/contents/enacted) and any additional relevant ~~European~~ legislation such as the ~~EU~~ UK General Data Protection Regulation (GDPR) ~~(https://gdpr-info.eu/)~~.

DMEs dealing with unrepresented claimants must be aware of and able to demonstrate compliance with all requirements relating to the processing of personal data under Data Protection Legislation and the requirement to treat individuals fairly, including but not limited to the requirements relating to consent. Additional information on the application of the UK GDPR can be obtained from a wide variety of sources including from:

- the Information Commissioner's Office https://ico.org.uk/for-organisations/sme-web-hub/checklists/assessment-for-small-business-owners-and-sole-traders/ ~~: https://ico.org.uk/for-organisations/in-your-sector/health/health-gdpr-faqs/~~ and https://ico.org.uk/for-organisations/uk-gdpr-guidance-and-resources/ ~~https://ico.org.uk/for-organisations/guide-to-data-protection/guide-to-the-general-data-protection-regulation-gdpr/~~

- the National Health Service: https://digital.nhs.uk/data-and-information/keeping-data-safe-and-benefitting-the-public/gdpr ~~https://digital.nhs.uk/data-and-information/looking-after-information/data-security-and-information-governance/information-governance-alliance-iga/general-data-protection-regulation-gdpr-guidance~~

- the Health and Care Professions Council: https://www.hcpc-uk.org/news-and-events/blog/2018/gdpr-and-hcpc-standards-six-months-on/

- the British Medical Association: https://www.bma.org.uk/advice-and-support/ethics/confidentiality-and-health-records/gps-as-data-controllers-under-gdpr; and

- the Chartered Society of Physiotherapy: https://www.csp.org.uk/professional-clinical/digital-physiotherapy/data-ethics-gdpr.

Additional Rationale: DMEs will be assessed against this rule as part of the face-to-face audit process as described in Rule 1. Additional links to sources of helpful information on compliance with the UK GDPR rules have been provided.

Rule 4: Interactions with unrepresented claimants

DMEs must be able to demonstrate timeliness when responding to unrepresented claimants' questions and a commitment to treating such claimants with respect, empathy, courtesy and professionalism. DMEs should also show an awareness of the differing needs of potentially vulnerable unrepresented claimants.

Additional Rationale: Compliance with this rule will demonstrate an understanding of how to engage in a sensitive way with unrepresented claimants and that DMEs and their staff know how to deal with the differing needs of individuals. Consideration could also be given to ensuring staff training/qualifications on customer services and obtaining external certifications e.g., ISO9001[20] (2015 and successor versions).

Rule 5: Resources and Delivery

Whether they employ staff or not, DMEs must demonstrate they have the resources and structure necessary for operational delivery of the unrepresented claimant service on a consistent and stable basis. Including the ability to:

- be contactable at times when unrepresented claimants may wish to pursue their claims, which may be outside normal office hours; and
- operate across multiple communications channels to cater for different unrepresented claimants' ~~communication~~ preferences and needs (e.g. if vulnerable or they do not have web access).

DMEs should have robust end-to-end customer service systems, including sufficient resources (people, processes and technology). DMEs are personally responsible for their dealings with unrepresented claimants and will be held accountable for any interactions they have with the instructing claimant as well as those by their staff or any outsourced customer service providers/administration agencies.

DMEs opting-in to undertake unrepresented claimant work must be compliant with all MedCo Rules. They are also expected to be willing to accept instructions in relation to

[20] https://www.iso.org/iso-9001-quality-management.html

road traffic accident related soft-tissue and (where applicable) non-soft tissue injury claims from represented and unrepresented claimants as an operational norm.

Additional Rationale: Unrepresented claimants may have different working pattern which could restrict their ability to engage with their claim during office hours. DMEs should be able to demonstrate that they have considered this and have sufficient systems or capability in place to ensure that they also receive a good service, including an option of communicating through multiple channels (e.g., email, phone, SMS/text, social media and live-chat applications).

This may require an effective messaging process to be in operation and some responses/conversations may need to be made outside normal working hours. Whilst DMEs are expected to respond promptly, t~~T~~his does not mean ~~however, that DMEs~~they must be available 24/7 or that office phones must always be answered at any time outside normal hours.

Rule 6: Provision of information

DMEs must be able to verifiably demonstrate how they will provide unrepresented claimants with transparent, accurate, timely and up-to-date information, in plain English[21], about:

- their process for producing medico-legal reports, especially the consultation procedure and what the claimant's roles, responsibilities and rights are in this process;
- the contact details and the different communications channels they offer; and
- their service standards and how to make complaints, if necessary, about the DME and how to initiate a dispute resolution process.

Additional Rationale: Unrepresented claimants may not have a good understanding of the medico-legal process or be aware of what they need to do and when they need to do it. It is important that all information and communications provided to unrepresented claimants uses easily understandable language and is available in an accessible format.

[21] https://www.plainenglish.co.uk/medical-information.html

DMEs are responsible for ensuring that an unrepresented claimant understands the process of arranging and attending an examination, including what the claimant needs to do and when. This includes clearly explaining the unrepresented claimant's rights to challenge factual elements of their report as well as other practical considerations such as what the consequences are if they miss their appointment etc.

It is also important that DMEs can demonstrate how they will explain this and that they have an effective complaint handling mechanism in place. If DMEs fail to address the claimant's complaint to his/her satisfaction, the claimant should have the process for how to report the DME to MedCo clearly explained to them. A complaints system does not need to be overly complex, but should be clear, fair and proportionate to the size of the practice[22].

[22] https://www.legalombudsman.org.uk/information-centre/learning-resources/good-complaints-handling/best-practice-complaint-handling-guide/
https://www.legalombudsman.org.uk/downloads/documents/publications/Guide-Good-Complaints-Handling.pdf
https://www.england.nhs.uk/wp-content/uploads/2021/09/item7ii-nhs-england-complaints-policy.pdf