Ministry of Justice

# Revisions to the Medical Reporting Process for Road Traffic Accident Claims

## Government Response

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# Revisions to the Medical Reporting Process for Road Traffic Accident Claims

Government Response

**Response to a consultation carried out by the Ministry of Justice.**

**This information is also available at:**

**https://consult.justice.gov.uk/civil-law/rta-medical-reporting-consultation/**

# Contents

# Introduction and contact details

This document is the post-consultation response to the *'Revisions to the Medical Reporting Process for Road Traffic Accident Claims'* consultation paper. This consultation sought input from medical experts, medical reporting organisations, the legal profession and insurers or anyone else with an interest in the medical evidence reporting process.

It will cover:

- the background to the consultation exercise;
- a summary and overview of the responses received, broken down by industry sector;
- a detailed response to the specific questions raised in the consultation document; and
- details of the outcomes and next steps regarding the issues contained within the consultation.

Further copies of this report and the consultation paper can be obtained by contacting the:

Personal Injury Policy Team
Civil Justice and Law Policy Division
Ministry of Justice
Post point 5.25
102 Petty France
London SW1H 9AJ

Email: whiplash-reform-team@justice.gov.uk

Copies of this report are also available to download at:

https://consult.justice.gov.uk/civil-law/rta-medical-reporting-consultation/

Alternative format versions of this publication can also be requested from the Personal Injury Policy Team by emailing your request to:

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.

# Background

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 robust, transparent consumer protection procedures in place is key to this commitment.

A consultation paper, 'Revisions to the Medical Reporting Process for Road Traffic Accident Claims' was published on 18 July 2023. It invited comments from interested stakeholders on several issues of relevance to those who commission and/or provide medical reports used in support of RTA-related personal injury claims valued up to £5,000.

The consultation period ran for 12 weeks and closed on 10 October 2023. This report summarises the responses received, along with information on the decisions taken and the next steps in relation to implementing outcomes related to the policy proposals consulted upon.

An Impact Assessment was not produced in relation to this consultation as the changes proposed did not require the production of such. MoJ analysts did, however, consider all available data before recommendations/proposals for change were made.

A Welsh language version of this response paper can be found at:

https://consult.justice.gov.uk/civil-law/rta-medical-reporting-consultation/

A list of respondents is attached at **Annex A** of this response document.

# Summary of responses

1. A total of **49** organisations and individuals responded to the consultation paper. Of these, responses were received from:

| Respondent sector | Number of responses | Percentage |
|---|---|---|
| Administration Agencies | 1 | 2% |
| Claimant Solicitors | 3 | 7% |
| Claimant Representative Bodies | 2 | 4% |
| Cross Sector Representative Bodies | 2 | 2% |
| Defendant Solicitors | 3 | 7% |
| Defendant Representative Bodies | 2 | 4% |
| Direct Medical Experts | 12 | 24% |
| Judicial Representative Bodies | 1 | 2% |
| Indirect Medical Experts | 2 | 4% |
| Compensators | 3 | 7% |
| Medical Representative Bodies | 2 | 4% |
| Other | 2 | 4% |
| Tier 1 Medical Reporting Organisations | 9 | 19% |
| Tier 2 Medical Reporting Organisations | 5 | 10% |
| **Total** | **49** | **100%** |

2. Consideration has been given to the responses provided by stakeholders to the policy proposals included in the consultation document. Overall, opinion was sought on in several areas, including on:

    - revised qualifying criteria for medical reporting organisations (MROs) and rules for medical experts who accept direct instructions (DMEs);
    - the number and type of MROs and/or DMEs ‘offered’ to both represented and unrepresented claimants when they search for a provider on the MedCo Portal;
    - the growing use of unauthorised administration agencies by DMEs and how this can be effectively overseen;
    - the level of fixed recoverable costs available for medical reports; and

- changes to improve the quality of medical reports and on how reports for claimants with legal representation are sourced.

3. The following sections of this government response provide a more detailed look at the submissions made by stakeholders to the specific questions asked. Analysis of the responses made to each proposal is provided, which notes the views of each sector of the industry.
4. Also included alongside each topic area is an overview of the Government's response and information on next steps following consideration of the answers, data and evidence provided.

# Responses to specific questions

## Part 1: Changes to MedCo Qualifying Criteria

5. Part 1 of the consultation document considered updates and amendments to the three MedCo Qualifying Criteria (QC) tables. These are:
    - Table 1 covering the QC for all MROs wishing to register with MedCo;
    - Table 2 covering the additional QC for MROs wishing to be classified as tier 1 MROs; and
    - Table 3 covering the specific QC for all MROs undertaking unrepresented claimant work.
6. The purpose of these QC is to ensure that MROs registered 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.
7. These QC also guard against business failures which could adversely affect the medical experts who undertake work for MROs. They also ensure that claimants and/or their representatives receive a good service when seeking a medical report.
8. These QC were last reviewed and updated in 2020 prior to the implementation of the whiplash reform programme in May 2021. Now that these reforms have had time to bed in, and data on monthly claims volumes has settled, it is an appropriate time to review the QC again to ensure they remain up to date for the post-reform landscape.
9. MoJ considered and recommended several revisions to all three sets of QC, which were set out in the consultation document. The following section summarises the responses received by question.

| | |
|---|---|
| **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?**<br><br>**Please explain your reasoning.** |

**Analysis of responses:**

10. Overall, **36** responses were received in response to this question, with **31** respondents agreeing with the suggested revisions, broken down as follows:
    - 1 x AA;

- 2 x claimant solicitors;
- 3 x compensators;
- 1 x compensator representative body;
- 2 x cross-sector representative bodies;
- 3 x defendant solicitors;
- 1 x defendant representative body;
- 3 x DMEs;
- 2 x medical representative bodies;
- 9 x Tier 1 MROs; and
- 4 x Tier 2 MROs.

**Summary of key points made in support of proposals included in question 1:**

11. Points made by stakeholders agreeing with the proposed revisions covered by question 1 can be summarised as follows:
    - The majority of these respondents, across sectors, agreed with the amendments to table 1, with a general view that they are minor and uncontroversial, and that they build on rather than substantially change the existing QC;
    - The continuing inclusion of a clear ban on identified shell companies being able to register with MedCo was welcomed by some respondents on the basis that this is key to ensuring the MRO allocation process is independent;
    - Updating the MedCo "Guidance on MoJ Qualifying Criteria" to reflect any changes arising from the consultation was suggested by multiple respondents;
    - Replacing the current MRO fee structure with a nominal membership fee for each tier, supported by a pay as you go scheme based on the number of instructions per MRO, was also suggested; and
    - Several helpful technical suggestions to clarify both the wording around how MedCo committees are described and how to link to items on the MedCo website (QC's 1.8, 1.14, 1.15, 2.7) were also made.
12. A further **5** respondents disagreed with the revisions to the QC in Table 1, this breaks down as:
    - 4 x DMEs; and
    - 1 x Tier 2 MRO.

**Summary of key points made against the proposals included in question 1:**

13. Of the five respondents that answered 'no' to the proposed amendments covered by Q1, two offered supporting comments and these were criticisms that the:

- Reforms do not address the problems with the medical reporting process; and
- Wording of QC 1.1 regarding common ownership of MROs is not adequate.

**Government response:** Having considered the feedback provided by respondents and noted the large body of support for the revisions to QCs 1.1, 1.3, 1.6, 1.7, 1.8, 1.9, 1.14, 1.15 and 1.16, these have been accepted and will be implemented in revised QC.

MoJ will also work with and support MedCo to ensure all weblinks included in QC Table 1 are accurate and that, where required, relevant MedCo guidance is provided and/or updated to reflect the new QC.

The new revised QC will come into force in 2025.

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| **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?**<br><br>**Please explain your reasoning.** |

**Analysis of responses:**

14. In total, **37** responses were received in response to question 2, with **26** respondents agreeing with the proposed revisions. These were from the following sectors:

- 1 x AA;
- 2 x claimant solicitors;
- 3 x compensators;
- 1 x compensator representative body;
- 3 x defendant solicitors;
- 1 x defendant representative body;
- 5 x DMEs;
- 1 x medical representative body;
- 5 x Tier 1 MROs;

- 3 x Tier 2 MROs; and
- 1 x other.

**Summary of key points made in support of the change proposed in question 2:**

15. Stakeholder comments include the following:
    - Any reduced figures in QC2.2 to reflect the changed claims landscape should also remain sufficiently challenging to maintain market integrity and to avoid unnecessary distortion in the volume of operators in each of the MRO tiers;
    - The proposed changes are fair in light of a reduced number of claims but must ensure that claimants continue to receive a quality service;
    - The volumes in QC 2.2 should be kept under review to allow early identification of any adverse outcomes or unintended consequences from the changes, and the volume requirements should be re-examined if required;
    - The proposed changes strike the right balance between reflecting the reduced number of claims and the need to maintain a competitive environment with challenging QC for MROs seeking high volume national status; and
    - There should be a suitable distinction between T1 MROs and T2 MROs and if the data demonstrates that the proposed amendment will not adversely impact the ratio between the MRO tiers, then the change is considered appropriate.
16. **11 stakeholders** disagreed with the proposed changes to QC2.2. These break down as follows:
    - 1 x claimant solicitor;
    - 1 x cross-sector representative body;
    - 2 x DMEs;
    - 1 x medical representative body;
    - 4 x Tier 1 MROs; and
    - 2 x Tier 2 MROs.

**Summary of key points made against the change proposed in question 2:**

17. Of the stakeholders that answered ‘no’ to the proposed amendments to QC2.2, the following comments were made in support of their position:
    - The reduction in claims volume capacity required under QC2.2 should directly reflect the overall drop in claims volumes since the implementation of the whiplash reforms and the revised figure should therefore be for capacity to process between 20,000 and 24,000 reports;

- To provide the market with more certainty MoJ should commit to regular reviews of the claim volumes and the associated QC requirements every 1 to 2 years;
- It was noted that there should be greater use of DMEs because MROs have a monopoly which should be reduced; and
- The revised figures are just designed to make it easier for new T1 MROs to be created and the reduction should be to no more than 35,000 claims.

**Government response:** More than two thirds of responses to this question agreed with the proposal to reduce the capacity requirement in QC2.2 from processing 40,000 medical reports a year to 28,000. MoJ acknowledge that this figure is not directly proportional to the drop in claims overall since the last review of the QC in 2020.

However, as noted at paragraph 7 of the consultation the purpose of this criterion is twofold: to ensure that existing tier 1 MROs can be fairly audited in regard to their capacity to produce reports, and also to ensure that the tier 1 QC remain a challenging standard to be met by any MROs applying for tier 1 status in the future.

MoJ have therefore decided to proceed with the proposed change to QC2.2, and the volume requirement will be reduced from 40,000 to 28,000. This is to safeguard market integrity and ensure that tier 1 MROs have the appropriate resources and capacity to meet their obligations.

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| **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?**<br><br>**Please explain your reasoning.** |

**Analysis of responses:**

18. **38** responses were received in response to this question, with **23** respondents agreeing with the further revision to QC2.2 regarding the number of active experts required. These were:

- 1 x AA;
- 2 x claimant solicitors;
- 3 x compensators;

- 1 x compensator representative body;
- 3 x defendant solicitors;
- 1 x defendant representative body;
- 4 x DMEs;
- 1 x medical representative body;
- 3 x Tier 1 MROs;
- 3 x Tier 2 MROs; and
- 1 x other.

**Summary of key points made in support of the change proposed in question 3:**

19. Stakeholder comments include the following:
    - Agreement with the proposed change to lower the required number of medical experts to account for the decrease in overall claims volumes;
    - The proposed change is fair considering the reduced number of claims but claimants continuing to receive a good quality service must be ensured;
    - It is preferable to maintain a smaller group of experts whose evidence is of high quality, but the issue should be kept under review in case volumes change again; and
    - Any reduced figures regarding active experts under QC2.2 should also remain sufficiently challenging to maintain market integrity and to avoid unnecessary distortion in the volume of operators in each of the MRO tiers.
20. However, **15 respondents** disagreed with the proposed change. These can be broken down as follows:
    - 1 x claimant solicitor;
    - 2 x cross-sector representative bodies;
    - 3 x DMEs;
    - 1 x medical representative body;
    - 6 x Tier 1 MROs; and
    - 2 x Tier 2 MROs.

**Summary of key points made against the change proposed in question 3:**

21. Of the stakeholders that answered ‘no’ to the proposed amendments to QC2.2, the following comments were made in support of their position:
    - The reduction in the number of required active medical experts required under QC2.2 should directly reflect the overall drop in claims volumes since 2020/21

and the revised figure should therefore be for a requirement to maintain a list of around 160 active experts rather than the proposed 175;

- Consideration should be given to better defining what an 'active' expert is as there is some confusion in the market;
- A lower number could lead to an increased workload on busy medical experts;
- Changing the number will result in some MROs removing experts from their list meaning they could potentially miss out on work;
- The number of experts is irrelevant as what matters is the quality of their reports;
- The change will lead to an increase in the usage of 'hired gun' experts by MROs;
- Not requiring Tier 2 MROs to maintain a list of active experts is unfair; and
- A further 10% reduction is required to account for additional experts exiting the market.

**Government response:** Around two thirds of the stakeholders who commented on question 3 agreed with the suggested change to reduce the list of active experts that MROs were required to maintain from 225 to 175. As with question 2 MoJ acknowledge that this figure is not directly proportional to the drop in claims overall since the last review of the QC in 2020.

However, as stated previously, paragraph 7 of the consultation notes that the QCs for tier 1 MROs are designed to be challenging. They ensure that existing tier 1 MROs can be fairly audited regarding their capacity to have enough active experts available to provide the reports they are commissioned to produce. They also ensure that the tier 1 QC remain a challenging standard to be met by tier 2 MROs applying for tier 1 status in the future.

Therefore, MoJ have decided to proceed with the proposed change to QC2.2 in regard to the list of active experts a tier 1 MRO is required to maintain, and the requirement will be reduced from 225 experts to 175. This again acts to safeguard market integrity and ensure that tier 1 MROs have the appropriate resources and capacity to meet their obligations.

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| **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?**<br><br>**Please explain your reasoning.** |

**Analysis of responses:**

22. Overall, **39** responses were received in response to this question, with **38** respondents agreeing with the revision. These were as follows:

- 1 x AA;
- 3 x claimant solicitors;
- 3 x compensators;
- 1 x claimant representative body;
- 2 x cross-sector representative bodies;
- 2 x defendant representative bodies;
- 2 x medical representative bodies;
- 3 x defendant solicitors;
- 6 x DMEs;
- 9 x Tier 1 MROs;
- 5 x Tier 2 MROs; and
- 1 x other.

**Summary of key points made in support of the proposal in question 4:**

23. Stakeholder comments in favour of the proposal to not change the requirement to have active experts in 80% of (post code) regions in England and Wales including:

- Agreement that 80% is a reasonable requirement to enable the claimant to have choice and without the need to travel further than necessary;
- Tier 1 MROs should set a gold standard for service and this requirement supports this and helps to differentiate between tier 1 and tier 2 MROs;
- The request that there is a formal review of the use of remote examinations; and
- Further thought should be given to the use of regions. For example, coverage could be defined by active experts per county instead.

24. **One** respondent disagreed with the proposal noting that:

- 175 experts are not enough to cover the whole country and many agencies are using one off clinics to cover low workload areas. The use of clinics should be encouraged, and MROs could focus on covering 75% of the UK with the highest workloads and arrange separate clinics for the remaining 25%.

**Government response:** Given the almost universal support for the proposal to not change the requirement for MROs to have an active expert in 80% of regions, MoJ will make no change to this specific QC.

Regarding some of the suggestions made, we would note that the decision to reintroduce a ban on remote examinations following the lifting of Covid restrictions was taken by the MedCo Board. The MoJ supports this position which is in line with general medical opinion on the assessment of soft tissue injuries. It is also worth noting that the use of remote examinations remains allowable in certain specific situations and guidance can be sought from MedCo if an expert considers a remote rather than a face-to-face examination may be appropriate.

The point made about consideration of using alternative means to designate regions has also been noted. However, at this stage we consider that the use of postcodes allows for more targeted coverage than use of an alternative such as regions or counties.

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| **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?**<br><br>**Please explain your reasoning.** |

**Analysis of responses:**

25. **32 responses** were received in response to this question, with **30** respondents agreeing with the revision. This can be broken down as follows:

- 1 x AA;
- 1 x claimant solicitor;
- 2 x defendant solicitors;
- 5 x DME;
- 3 x compensators;
- 1 x cross-sector representative body;
- 2 x defendant representative bodies;
- 2 x medical representative bodies;
- 9 x Tier 1 MROs; and
- 4 x Tier 2 MROs.

**Summary of key points supporting the amendments to QC table 3 in question 5:**

26. Stakeholder comments included the following:

- Agreement that the suggested revisions are reasonable, on basis that they are minor and uncontroversial, with the amendment in relation to the prompt answering of queries particularly welcomed;
- The suggestion that MROs who fail to pay the audit fee within the stipulated time should have their MedCo registration automatically terminated. This is on the basis of saving MedCo resources and encouraging MROs to take sufficient steps to be ready for their audit;
- The links to pages on the MedCo website can change when documents are updated so there was the suggestion that the QC merely directs users to the website where they can then navigate to the appropriate section; and
- QC 3.3 d) regarding the types of premises allowed might be too restrictive, and consideration could be given to bringing this in line with the general requirements for MROs dealing with represented claimants.

27. **Two** respondents disagreed with the proposed amendments to table 3, these were:

- 1 x DME; and
- 1 x Tier 2 MRO.

**Summary of key points made against the amendments to QC table 3 in question 5:**

28. One respondent opposed the changes to QC table 3, noting that MROs and DMEs have been audited, and the QC work and don't require amending.

**Government response:** Support for the proposed amendments to QCs 3.2, 3.3, 3.4, 3.5, 3.7 and 3.8 was nearly universal. Therefore, MoJ will proceed with the amendments proposed. The comment made regarding QC 3.3 d) is noted. This QC was not one of those amended and has been in place since the introduction of Table 3 in 2021. The purpose of Table 3 is to set QC for those who wish to provide services to unrepresented claimants; as such they are in places stronger than the general QC to provide additional protections to these claimants and this is one such area. However, MoJ does acknowledge that the wording of the supporting text to QC 3.3 could benefit from some clarification. Therefore, MoJ will discuss this with the MedCo Audit Committee and Board with a view to agreeing amended text to clarify the requirements under QC3.3 d).

## Part 2: Amended DME Rules

29. The DME rules are designed to reflect the MRO QC and have been developed to ensure that DMEs operate effectively with suitable systems, processes and customer service capabilities to provide medical reports. We believe it is important that the rules for DMEs undertaking work for unrepresented claimants also continue to be consistent with the standards applied to MROs.

30. This is why we sought input from medical stakeholders on a set of revisions and enhancements to 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.

31. Most of the proposed changes were updated links to guidance and tweaks to wording to tighten and enhance the drafting of the existing rules. However, it is important to check these changes with experts and to seek additional input on potential areas for improvement.

32. The following section of this response document provides a summary of the responses received from stakeholders to the proposed amendments included in question 6. It also provides information of next steps in relation to changes to be made to the QC framework and the implementation timetable of these changes.

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| **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?**<br><br>**Please explain your reasoning.** |

**Analysis of responses:**

33. **36** responses were received in response to this question, with **31** respondents broadly agreeing with the revisions to the DME rules. These responses came from the following sectors:

- 1 x AA;
- 3 x compensators;
- 1 x cross-sector representative body;
- 2 x defendant representative bodies;
- 2 x medical representative bodies;
- 3 x defendant solicitors;
- 7 x DMEs;
- 7 x Tier 1 MROs;

- 4 x Tier 2 MROs; and
- 1 x other.

**Summary of key points made in support of the changes proposed in question 6:**

34. Stakeholder comments include the following:

- Several respondents agreed that the proposed amendments were fair and reasonable and that it was important that DMEs operated to best practice standards, which the rules ensure;
- One respondent suggested that there should be a standard leaflet created to ensure that claimants can obtain a good understanding of the medico-legal process;
- The rules related to the use of sub-standard examination facilities could be tightened;
- A further respondent agreed with the proposed rules but suggested that, for consistency, the DBS requirements should be the same for DMEs and MROs regarding the current MedCo audit guidance; and
- It was also suggested that the rules should reflect that DMEs will be subject to an audit interview arranged by the MedCo audit committee and that the rationale to rule 2 should be amended to reference oversight by the audit committee and that the last sentence of the 'additional rationale' should be amended by replacing the word 'consistent' with 'of consistently good quality'.

35. A further **5 respondents** disagreed, and these were as follows:

- 1 x cross-sector representative body;
- 2 x DMEs;
- 1 x Tier 1 MRO; and
- 1 x Tier 2 MRO.

**Summary of key points made against the changes proposed in question 6:**

36. Comments provided by these stakeholders included:

- Rule 1 b) should be amended to state that an expert should have a good understanding of their role and duties as an expert witness;
- Rule 1 c) should be amended to clarify whether PI is their area of expertise. For example, do they have relevant qualifications, knowledge, skills and experience necessary for the role they undertake in providing an assessment and giving an opinion on the case;
- The rules create unnecessary bureaucracy and costs for DMEs; and

- The rules do not go far enough, as many DMEs effectively operate as MROs and should pay higher fees and be audited as Tier 2 MROs.

**Government response:** Given that the vast majority of responses agreed with the proposed changes to improve the DME rules, the Government will work with MedCo to implement them with some minor tweaks to update the text around the role of the audit committee.

We note the additional comments made in relation to DBS consistency and amendments to rules 1 b) and 1 c) about testing the competency of experts. We will consider these points further and discuss in more detail with MedCo whether additional action should be taken in these areas.

In terms of whether a leaflet explaining the medico-legal system to claimants should be produced, the MoJ agree that this would be helpful, but we are unable to provide legal advice. We do, though, recommend that the medical and expert witness representative bodies active in the sector collaborate with each other to produce an agreed document which could be shared with their members as appropriate.

## Part 3: Review of MedCo 'Offer'

37. The MedCo 'offer' is the name given to the process for generating the number and mix of MROs or DMEs presented to authorised users of MedCo when they conduct a search for a medical report provider. The number of MROs or DMEs presented for selection via the 'offer' is set by the Ministry of Justice and there are currently two 'offers' in operation, one for represented and one for unrepresented claimants.

38. 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.

39. In reviewing and/or amending the 'offer' there are several considerations to keep in mind. These include the need to maintain competition law requirements whilst ensuring a functional market where MROs and DMEs are presented with an equal chance of selection, along with enhancing and maintaining independence in the provision of medical reports.

40. In reviewing the two '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 time. Data on the geographical spread of the registered MROs was compiled using declared postcode data. MoJ analysts considered the available data and calculated appropriate alternative offer ratios. We sought stakeholder input on these through questions 7 and 8.

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| **Question 7:** | **Do you agree with the proposed change to the MedCo offer for represented claimants as set out at paragraph 20?**<br><br>**If not, please explain what you believe the offer should be set as along with your reasoning for this and any supporting evidence.** |

**Analysis of responses:**

41. In total, **39** responses were received in response to this question, with **24** respondents agreeing with the suggested revision to the offer. These were:

- 2 x claimant solicitors;
- 3 x compensators;
- 1 x claimant representative body;
- 2 x defendant representative bodies;
- 1 x medical representative body;
- 2 x defendant solicitors;

- 6 x DMEs;
- 2 x Tier 1 MROs;
- 4 x Tier 2 MROs; and
- 1 x other.

**Summary of key points made in support of the revised offer proposed in question 7:**

42. Stakeholder comments include the following:

- Several respondents agreed and noted that it is important that there continues to be fair competition within and between each MRO tier, and that a sufficient choice of DMEs is available for selection;
- Support for the offer but noting that the overall number of MROs in the market can have an effect on the percentage of times each MRO is shown on an 'offer.' This should be monitored and the 'offer' revisited if there is a significant change in numbers;
- Support for the revised offer on the basis that more Tier 2s in the 'offer' will increase competition;
- No objection in principle but a query of the increased number of Tier 2 MROs included in the revised 'offer'; and
- The suggestion that it may be sensible to set the 'offer' as a percentage to be reviewed on a yearly basis, rather than be a set number. This could ensure randomness is retained without the need for consultation. A set algorithm for MedCo to work with would be more practical and reduce the time it takes to respond to changes in the market.

43. Overall, there were **15 responses received which** disagreed with the proposed changes to the 'offer'. These were:

- 1 x AA;
- 1 x claimant solicitor;
- 2 x cross-sector representative bodies
- 1 x medical representative body;
- 2 x DME;
- 7 x Tier 1 MROs; and
- 1 x Tier 2 MRO.

**Summary of key points made in opposition to the revised offer proposed in question 7:**

44. Stakeholder comments against the revised offer included:

- The ‘offer’ should be changed so that users are presented with a selection of the nearest report providers to an inputted postcode irrespective of whether they are a Tier 1 or Tier 2 MRO or a DME;
- The ‘offer’ should not change as increasing the number of Tier 2 MROs is unfair, although the number of MROs should be monitored, and the question returned to if change is detected;
- The number of both Tier 1 and Tier 2 MROs in the ‘offer’ should be reduced and the number of DMEs increased;
- There shouldn’t be a randomised ‘offer’ process and lawyers should be allowed to choose their preferred provider;
- The change is not reflective of the number of MROs in the market, and it provides an advantage to Tier 2 MROs despite Tier 1 MROs paying a higher MedCo registration fee;
- The changes are anti-competitive and would result in in Tier 1 MROs either exiting the market or switching status to Tier 2; and
- There should be a formal review mechanism embedded within the rules to allow MedCo to adjust the offer based on a formula linked to the number of active MROs on each tier, subject to regular reviews as the current process is too inflexible.

**Government response:** Overall, most stakeholders supported the revised offer of **2 x Tier 1 MROs, 6 x Tier 2 MROs and & 7 DMEs**. Although it is noted that respondents from both T1 and T2 MROs raised similar concerns that the new ‘offer’ provides an unfair advantage to the other group. It was also suggested that the revised ‘offer’ is anti-competitive.

However, as noted in the consultation document the proposed ‘offer’ has been specifically calculated to reflect the changes in the numbers of operational MROs and to ***ensure*** effective and lawful competition both between and across the tiers and provide all MROs with an equal opportunity for selection by users of MedCo.

The revised ’offer’ will be implemented in 2025. MoJ will continue to work with MedCo to monitor both the ‘offer’ and the impact it has on the market. We will return to this issue again if the data indicates there has been a significant shift in the number of operational MROs/DMEs.

We also note the comments relating to changing the way the ‘offer’ is calculated and the suggestions that this should be something MedCo controls. However, there are policy considerations related to the ‘offer’ which are outside of MedCo’s operational remit. Because of this, MoJ will continue to oversee the calculation of the ‘offer’ using data provided by MedCo.

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| **Question 8:** | **Do you agree with the proposal not to change the MedCo offer for unrepresented claimants as set out at paragraph 21?**<br><br>**If not, please explain what you believe the offer should be set as along with your reasoning for this and any supporting evidence.** |

**Analysis of responses:**

45. In total, **37** responses were received in response to this question, with **31** respondents agreeing that the 'offer' for unrepresented claimants should not be changed. These were from the following sectors:

- 3 x claimant solicitors;
- 3 x compensators;
- 1 x claimant representative body;
- 1 x cross-sector representative body;
- 2 x defendant representative bodies;
- 2 x medical representative bodies;
- 2 x defendant solicitor;
- 8 x DMEs;
- 5 x Tier 1 MROs; and
- 4 x Tier 2 MROs.

**Summary of key points made in support of the proposal included in question 8:**

46. The following comments were received from stakeholders who supported the proposal:

- Several respondents from across the sector agreed that there is no need to amend the 'offer' at this stage because there has been no material change to the number of unrepresented claimants since the original offer set; and
- One respondent noted that leaving the 'offer' unchanged is acceptable for now but they would prefer it to be set at 2 x Tier 1 and 3 x Tier 2 MROs.

47. A further **6** respondents disagreed with the proposition, these were:

- 1 x AA;
- 1 x cross-sector representative body;
- 1 x DME; and
- 3 x Tier 1 MROs.

**Summary of key points made in opposition to the recommendation to not revise the 'offer' for unrepresented claimants as detailed in question 8:**

48. Stakeholder comments included:

- Two stakeholders opposing the change noted that they believe that the same offer should apply to both represented and unrepresented claimants; and
- A further comment was made about whether randomisation was necessary for unrepresented claimants and that a 'taxi-rank' system should be employed, or claimants should be allowed to select whoever they wished.

**Government response:**

Given the level of cross sector support for the current 'offer' for unrepresented claimants, the 'offer' for unrepresented claimants will remain unchanged.

MoJ will, however, continue to work with MedCo to monitor the impact it has on the market. We will return to this issue again if the data indicates there has been a significant shift in the number of operational MROs/DMEs in this area.

# Part 4: Use of Administration Agencies by Direct Medical Experts

49. The use of Administration Agencies (AAs) by DMEs became prevalent in late 2019, with the number of DMEs utilising their services increasing following the implementation of the whiplash reforms on 31 May 2021. Rule changes on back-office support were introduced at this time which required DMEs to be audited when providing medical reports to unrepresented claimants. In response to these changes some DMEs decided to engage the services of an AA.

50. As was noted in the consultation document, AAs are being used to support DMEs in producing both MedCo and non-MedCo medical reports, and their services can vary considerably. Some provide clients with low-level secretarial help whilst others may be effectively operating as unauthorised MROs. There is currently no specific framework in place to audit or assess the quality, robustness or appropriateness of the business models being utilised by AAs operating in the medico-legal sector.

51. Therefore, this segment of the consultation was focussed on those who have experience of using the services of AAs in the production of medical reports. We were seeking responses from DMEs (the main users of AAs), but contributions were also welcomed from all with an interest. Seven questions were asked in the consultation on varying areas associated with the use of AAs by DMEs.

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| **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?**<br><br>**Please provide details of any services provided.** |

**Analysis of responses:**

52. Overall, **30** stakeholders answered this question with **25** respondents stating they did not use AAs and **5** DMEs confirming they have used/are using an AA. **8** respondents provided comments, including on the types of service provided by AAs. These were:

- 1 x AA;
- 1 x claimant solicitor;
- 4 x DMEs;
- 2 x Tier 1 MROs; and
- 1 x judicial representative body.

**Summary of the key points made in response to question 9:**

- One respondent noted that they were aware of different types of AA, ranging from single people providing typing services to companies with many staff providing a full range of secretarial services such as admin, financial credit

control, marketing, quality reviews and back-office services. There is no simple definition of an AA and any attempt to define/regulate would have unexpected consequences;

- Two respondents noted that they don't use AAs directly but have relationships with AAs used by experts who seem to provide administrative support and deal with queries etc.;
- One respondent said that they use an AA to book appointments and send completed reports to claimants for review;
- One respondent noted that they buy secretarial services from an AA to act as point of contact between the expert and agencies/solicitors, to transcribe directions and to take bookings. The expert noted they arrange examinations (including venue hire) and all professional work in relation to providing a report; and
- Three respondents noted that whilst they do not use the services of an AA if they operate as described it must be appropriate for them to be held to similar standards as MROs. This would maintain the integrity and consistency of the medico-legal process.

**Government response:**

**Question 9** sought input from respondents on whether they had utilised the services of an AA and if so what type of services and support they received. The purpose was to gain a better understanding of the types of AA operating in the market and of the breadth of services thy offer to DMEs.

Feedback on this point was limited but we note that the responses that were received confirmed that there are a variety of AAs operating in the market. They also confirmed that the services provided covered a range of tasks from simple administration services to more complex management functions like those carried out by MROs.

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| **Question 10:** | **Do you agree that administration agencies should be assessed/audited by MedCo to ensure they are operating to agreed common standards?**<br><br>**Please explain your reasoning.** |

**Analysis of responses:**

53. There were **35** responses received to this question with **29** respondents agreeing with the proposal for administration agencies be assessed/audited by MedCo. These were:

- 2 x claimant solicitors;
- 1 x cross-sector representative body;
- 4 x compensators;
- 3 x defendant solicitors;
- 9 x DMEs;
- 2 x medical representative bodies;
- 8 x Tier 1 MROs;
- 4 x Tier 2 MROs; and
- 1 x other.

**Summary of the key points made in support of the proposal made in question 10:**

54. Stakeholder comments made in favour of the proposal included the following:

- Thirteen respondents from across the sector agreed that AAs should be held to the same standards as MROs etc. as they are performing many of the same functions, and also noted that DMEs must demonstrably be in control of the relationship with an AA and MedCo audits would support this;
- Use of AAs is becoming more frequent, and there are concerns that they are not held to the same standards as MROs, and this must be addressed. Audits/assessments by MedCo would help to ensure consistency in this area;
- AAs can provide helpful services to DMEs, but everyone else involved in the medico-legal process must be registered on MedCo and adhere to appropriate rules/QCs, so for consistency AAs should as well. This would allow MedCo to apply sanctions if required to address poor service/behaviours;
- Without MedCo audits potential harms could be allowed to develop unchallenged within the services provided by AAs;
- If this proposal is taken forward, there should be different tiers developed to reflect the differing levels of support services provided by AAs;
- Some AAs are acting as MROs, and this must be investigated and regulated;
- The idea of MedCo assessing/auditing AAs has merit but there may also be challenges to this approach. Clarity is required on the scope of the work an AA is allowed to undertake and what the level of responsibility is for the DME in managing the relationship with the AA to ensure they do not go beyond the scope of providing administration support;
- AAs acting in the role of an MRO for a DME is wrong and any AA and/or DME found to be acting in this way should be removed from MedCo immediately; and

- It is important that claimants are protected, and there are concerns over data protection and potential inappropriate financial links when an AA is involved in the process and regulation of their activities is required.

55. **6** respondents were opposed to the proposal covered by question 10. These were:

- 1x AA;
- 1 x claimant solicitor;
- 1 x defendant solicitor;
- 1 x DME;
- 1 x Tier 2 MRO; and
- 1 x cross-sector representative body.

**Summary of the key points made by those opposed to the proposal made in question 10:**

- Agreement that action is needed in this area but having MedCo audit AAs risks elevating their status to that of MROs. There was preference that DMEs maintain control of the relationship with responsibility for ensuring the behaviours of the AAs used are appropriate;
- It would be helpful to have standard criteria regarding data security and protection for DMEs to use to manage their relationship with an AA, but any rules should not be restrictive and impair an AA's ability to support DMEs; and
- MedCo should be focussed on the quality of medical evidence provided, so if MROs/DMEs are properly audited there is no benefit from also auditing AAs.

**Government response:**

The purpose of **Question 10** was to gauge the views of the sector as to whether AAs operating in the market should be required to conform to an agreed set of operating standards to be assessed by MedCo.

In general, the feedback provided supports the assertion that if AAs are to operate in support of DMEs undertaking MedCo work, they should be assessed/audited by MedCo. A variety of reasons were given for this, but on the whole stakeholders were concerned with issues related to consistency, behaviours, responsibility and fairness.

The government agrees that if AAs are operating as de-facto MROs, logically it is appropriate that they should be held to the same standards, criteria and financial commitments as existing MROs registered on MedCo.

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| **Question 11:** | **Do you think administration agencies providing services to DMEs should undertake audit interviews with MedCo on a voluntary basis?**<br><br>**Please explain your reasoning.** |

**Analysis of responses:**

56. **Overall, 35** stakeholders answered this question, with **8** respondents answering yes, and these were from the following sectors:

- 1 x cross-sector representative body;
- 4 x DMEs;
- 1 x medical representative body; and
- 2 x Tier 2 MROs.

**Summary of key points made in support of the proposal in question 11:**

57. Of the **8** respondents that agreed that AAs should undertake audit interviews on a voluntary basis, the following points were made:

- All organisations, whether MROs or AAs, ought to be audited;
- Audits are required to ensure that the staff working at AAs have the relevant knowledge to provide a good service, especially when working with unrepresented Claimants; and
- A consistent approach is required to have confidence in the process.

58. **27** respondents disagreed with the option of voluntary audit interviews. These are from the following sectors:

- 1 AA;
- 2 x claimant solicitors;
- 1 x claimant representative body;
- 3 x compensators;
- 2 x defendant solicitors;
- 5 x DMEs;
- 1 x medical representative body;
- 7 x Tier 1 MROs;
- 3 x Tier 2 MROs;
- 1 x judicial representative body; and
- 1 x other.

**Summary of key points made by those opposed to the proposal in question 11:**

59. Stakeholder comments included the following:

- The DME should be held responsible and accountable for meeting MedCo requirements, not the AA;
- A respondent stated that they had not seen any evidence of any AA compromising the independence or quality of medical reports;
- **21** respondents expressed the view that any voluntary agreement would be ineffective because any AA exhibiting poor behaviour or standards would simply refuse to be audited; and
- Some respondents expressed concern that some AAs were effectively operating as unauthorised MROs, so urgent mandatory audits are necessary along the lines of those that MROs must undertake.

**Government response:**

Question 11 builds on the previous question and tests whether stakeholders felt that AAs operating in the medico-legal sector should be required to undertake voluntary audit interviews with MedCo. This would be a light touch option to improve and standardise levels of AA service in the sector.

Three quarters of those who responded to this question indicated that they opposed the proposal for AAs to undertake audit interviews on a voluntary basis The MoJ notes and agrees with the majority view that voluntary audits would not be an effective way to ensure compliance with quality and customer service standards. Therefore, the option of audits on a voluntary basis will not be pursued at this time.

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| **Question 12:** | **Do you think that administration agencies should be audited against specific qualifying criteria, similar to that used to audit MROs on MedCo?**<br><br>**Please explain your reasoning.** |

**Analysis of responses:**

60. **In total, 35** respondents answered this question. **30** were in favour of AAs being audited against specific qualifying criteria, and these are broken down over the following sectors:

- 1 x claimant solicitor;
- 1 x claimant representative body;
- 3 x compensators;

- 1 x cross-sector representative body;
- 1 x defendant solicitor;
- 1 x defendant representative body;
- 8 x DMEs;
- 2 x medical representative bodies;
- 6 x Tier 1 MROs;
- 4 x Tier 2 MROs;
- 1 x judicial representative body; and
- 1 x other.

**Summary of key points made in support of the proposal in question 12:**

61. Stakeholder comments include:

- **5** respondents said that audits of AAs must be mandatory to be effective;
- As with responses to question 11, there are concerns that some AAs are operating as unregulated MROs, and that where this is the case, they should be audited to the same qualifying criteria as MROs;
- While AAs should have to meet specific qualifying criteria, it is important that we can define AAs properly so that appropriate qualifying criteria can be created to cover the different types of AAs; and
- Some respondents qualified their response by stating that if an AA is providing only very minor administrative services, they should be treated differently to those providing services akin to an MRO.

**Summary of key points opposed to the proposal in question 12:**

62. **5** respondents disagreed with the option of AAs being audited against specific qualifying criteria, and these are broken down over the following sectors:

- 1 x AA;
- 1 x claimant solicitor;
- 1 x defendant solicitor;
- 1 x DME; and
- 1 x Tier 2 MRO.

**Summary of key points opposed to the proposal in question 12:**

63. The following comment were made by stakeholders:

- Attempts to regulate AAs which do not fall within the definition of an MRO would not be justified, since MedCo is only intended to regulate MROs/DMEs;
- As with the response to question 11**, 2** respondents indicated that they had not seen any evidence of any AA compromising the independence or quality of reports, and attempts to regulate AAs is therefore not justified; and
- Audits on qualifying criteria would result in increased complexity and cost. Instead, a set of standards ought to be published for AAs to follow, and DMEs should be responsible and accountable for ensuring they are followed.

**Government response:**

Question 12 also builds on the options presented in the earlier questions included on this topic and tests the option of whether AAs operating in the medico-legal sector should be audited against specific qualifying criteria by MedCo. This would be a more robust option to improve standards and levels of AA service.

Responses show that there are concerns across the sector as to exactly how AAs are acting, with several expressing concerns that some may be operating as unauthorised MROs. This view is supported by more than 85% of respondents to this question agreeing that AAs should be audited against specific qualifying criteria.

MoJ agrees that of the three options explored, mandatory audits against agreed qualifying criteria will provide the most certainty that AAs supporting DMEs undertaking MedCo work are operating to agreed minimum standards.

However, the introduction of a single set of AA-specific QC could introduce an unnecessary burden on AAs which only carry out minor secretarial services for DMEs. Therefore, MoJ will work with MedCo to develop a range of QCs which fairly encompass the support activities of different types of AA before changes are made to the necessary Pre-action Protocols, Civil Procedure Rules and Practice Directions.

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| **Question 13:** | **Do you agree that DMEs should only be allowed to contract with administration agencies who are authorised by MedCo?**<br><br>**Please explain your reasoning.** |

**Analysis of responses:**

64. Question 13 requested input from respondents on whether there should be controls on who DMEs could contract with to provide support services. In particular, feedback was sought on the need for AAs to be registered with MedCo.

65. **A total of 37** respondents answered this question. Overall, **31** were in favour of DMEs only being allowed to contract with AAs who are authorised by MedCo. They are from the following sectors:

- 1 x claimant solicitor;
- 1 x claimant representative body;
- 3 x compensators;
- 1 x cross-sector body;
- 1 x defendant solicitor;
- 1 x defendant representative body;
- 8 x DMEs;
- 2 x medical representative body;
- 7 x Tier 1 MROs;
- 4 x Tier 2 MROs;
- 1 x judicial representative body; and
- 1 x other.

**Summary of key points made in support of the proposal in question 13:**

66. Comments made by respondents included the following:

- **7** respondents reiterated comments in the previous two questions regarding the need to ensure that AAs are properly regulated via compulsory rules;
- If DMEs could choose an AA not authorised by MedCo, it would not be possible to ensure that all AAs are operating at the appropriate standard, which would call into question the purpose of auditing the AAs;
- It is important that there is a level playing field for all providers, and since all MROs and DMEs must be authorised by MedCo, it follows that AAs must be authorised as well; and
- Two respondents answered yes, but qualified their answers by saying that where AAs are providing only basic secretarial help and not services similar to an MRO, DMEs should not have to instruct only MedCo-authorised AAs.

**Summary of key points made in opposition to the proposal in question 13:**

67. **6** respondents disagreed that DMEs should only be allowed to contract with AAs who are authorised by MedCo, and these are broken down over the following sectors:

- 1 x AA;
- 1 x claimant solicitor;
- 1 x defendant solicitor;
- 2 x DMEs; and
- 1 x judicial representative body.

68. Stakeholder comments made in include:

- A respondent repeated their reasoning from question 12, which is that attempts to regulate AAs which do not fall within the definition of an MRO would not be justified as MedCo was only intended to regulate MROs/DMEs;
- As per responses from questions 11 and 12, one stakeholder states they have seen no evidence of AAs affecting the independence/quality of reports;
- One respondent reiterated their answer to question 12, which is that audits on qualifying criteria would result in increased complexity and cost and that instead a set of standards ought to be published for AAs to follow, with DMEs responsible and accountable for ensuring they are followed; and
- One respondent also suggested that the additional bureaucracy of this process is not justified. Instead, MedCo should concern themselves more with the quality of the reports.

**Government response:**

This question supports the previous audit-based questions and sought input on whether only MedCo audited AAs should be allowed to contract with DMEs.

In summary, more than four fifths of respondents agreed that DMEs should only be allowed to contract with AAs authorised by MedCo. Many of the comments on this question echoed responses already provided about auditing and authorisation of AAs and objections also repeated those made previously.

The feedback provided in response to this question will be fully considered as part of the process to develop an appropriate QC process for AAs.

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

**Please explain your reasoning.**

**Analysis of responses:**

69. This question sought to catch any further comments on the use of AAs not already captured by the previous questions. Overall, **17** responses were received from the following sectors:

- 1 x AA;
- 2 x claimant solicitors;
- 2 x compensators;
- 1 x cross-sector body;
- 2 x defendant solicitors;

- 2 x defendant representative bodies;
- 3 x DME;
- 1 x medical representative body;
- 2 x Tier 1 MROs; and
- 1 x other.

**Summary of key points made in response to question 14:**

- An expert should be able to choose how much support they wish to have from third party organisations such as AA, if the expert complies with MedCo's requirements;
- Some respondents suggested that DMEs ought to have certain core services that they cannot contract out to AAs, such as booking appointments and quality assurance;
- Several respondents commented that AAs are a useful service that enables the DME to concentrate on preparing reports, and subjecting AAs to audits will likely result in cost increases which would likely be passed on to DMEs;
- Several respondents indicated that DMEs should be required to notify MedCo, on a continuing basis, when they are using an AA;
- There are a range of different services being carried out by AAs and it is important to be able to distinguish and define different services before making any rules to regulate them. For example, between an AA and two experts sharing a secretary, and between an AA and a small MRO;
- One stakeholder said that MedCo's guidance on the use of AAs (dated 24/10/2018) should prepare AAs and DMEs to ensure they are compliant with the rules about MROs, and any DMEs not in compliance ought to be suspended immediately; and
- Several responses reflected comments made to previous questions, such as the importance of ensuring there was a level playing field for all organisations facilitating the provision of medical reports.

**Government response:**

There was some overlap in the answers to this question and previous questions on AAs, which is to be expected. Some stakeholders used this opportunity to emphasise the importance of having a level playing field for those operating in the sector. Some reiterated that while AAs might provide a valuable service, they should have to follow the same rules as MROs. Others pointed out no change is required or that the range of services provided by AAs varies significantly and that the rules need to take this into account.

However, nothing provided in response to this question offered new insight into the topic of how AAs work in the market. That said, several of the points provided here are helpful and will be considered alongside those provided in response to other questions.

**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.**

**Analysis of responses:**

70. Whilst MoJ plays no role in setting membership fees for MedCo, it was helpful to include a question on this issue in relation to AAs. As this will provide helpful data to MedCo to support any future considerations in this area. In total, **31** responses were received in response to this question, which are broken down as follows:

- 1 x AA;
- 3 x claimant solicitors;
- 3 x compensators;
- 2 x cross-sector representative bodies;
- 3 x defendant solicitors;
- 1 x defendant representative body;
- 5 x DMEs;
- 1 x medical representative body;
- 7 x Tier 1 MROs;
- 4 x Tier 2 MROs; and
- 1 x other.

**Summary of the key points made in response to question 15:**

- No audits should be carried out on AAs and no fees should be charged;

- Charging AAs fees for audits would cause those costs to be put onto DMEs, which might lead to some DMEs withdrawing from the market;
- Where AAs are operating similarly to MROs, they should be audited at the same level as MROs, and pay the same fees;
- It is important to determine the range of services AAs are providing, as memberships fees must be dependent on the level of work being done, ranging from nominal where only secretarial services are being offered, to MRO levels where the service is equivalent;
- AAs could be charged a percentage of what they are charging experts to run cases; and
- AAs could be charged £10 per medical report upload.

**Government response:**

As noted at paragraph 70 above, MoJ plays no part in the setting of membership and/or audit fees for any individual or organisation on MedCo. Final decisions on such fees are solely the remit of MedCo and the purpose of this question was to seek input and evidence from stakeholders which could aid MedCo in their deliberations regarding appropriate changes.

A range of comments and suggestions have been provided in response to this question. Some respondents urge caution regarding how qualifying criteria for AAs are formulated for reasons relating to cost and lack of certainty on the range of work being carried out by AAs. Others suggested that rather than membership fees, AAs could instead be charged per upload or a percentage of their charge to the DME.

In terms of next steps, more detailed summaries of the comments made will be provided to MedCo to aid any considerations they may have regarding membership and/or audit fees for AAs following the completion of the work to develop appropriate QC.

# Part 5: Review of Fixed Cost Medical Reports

71. In 2014, the Government introduced a fixed cost medical report (FCMR) scheme for the provision of initial medical reports for soft tissue injury claims ahead of the implementation in 2015 of the MedCo reforms. These changes were made through amendments of the Civil Procedure Rules (CPR), specifically to Part 45[1].

72. The following were introduced in relation to 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.

73. 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. Given the passage of time since the introduction of the FCMR, it is appropriate to review the level they are set at.

74. 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). This is consistent with the approach taken by MoJ in relation to the recent wider review of fixed recoverable costs in the Fast Track.

75. The following provides an overview of a potential new set of FCMRs based on this analysis and increased by 18.3% using the SPPI and rounded to the two nearest significant figures:

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

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.

76. The MoJ sought views from stakeholders on these proposed increases and the impact such an increase would have on the potential savings from the Government's whiplash reform programme.

**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.**

**Analysis of responses:**

77. A total of **40** responses were received in response to this question, with **29** respondents agreeing with the proposed increases to FCMR. These were from the following sectors:

- 1 x AA;
- 1 x claimant solicitors;
- 1 claimant representative body;
- 2 x cross-sector representative bodies;
- 2 x medical representative body;

- 9 x DME;
- 2 x indirect medical experts;
- 6 x Tier 1 MROs;
- 4 x Tier 2 MROs; and
- 1 x judicial representative body.

**Summary of key points made in support of the proposed increases to FCMR**:

78. Stakeholder comments include:
    - The proposed increases in line with the SPPI are representative of the level of costs inflation being experienced by the legal services sector;
    - While the proposed increases are welcome, it is the first change in the fees since 2014 and the fees ought to be reviewed more regularly;
    - The increases proposed are vital to ensure that the standard of the medical reports produced remains high, particularly given that experts instructed via MROs only retain a small part of the fee; and
    - There are fewer MROs in the market than there used to be, and this increase is needed to keep the numbers up.
79. However, **11** respondents disagreed with the proposed increases to FCMR. These are broken down as follows:
    - 3 x compensators;
    - 2 x defendant solicitors;
    - 1 x defendant representative body;
    - 2 x DMEs;
    - 2 x Tier 1 MROs; and
    - 1 x Tier 2 MRO.
80. It is important to note, however, that the reasons for objecting to the proposal in question 11 were split between some who do not wish to see any increase, and those who wish to see a more significant one than that proposed.

**Summary of key points made against the proposed increases to FCMRs:**

81. Stakeholders made the following comments:
    - MROs still appear to be profitable and as such, it appears that the level of FCMRs are already set at a reasonable level;

- Any increases to the level of FCMRs would only increase costs and would therefore be to the detriment to MoJ policy of reducing the overall cost of low value in RTA claims;
- Insurance premiums for drivers would increase if the cost of reports were to be increased;
- The number of MROs has decreased in recent years and the proposed increase to the FCMR is insufficient to prevent the trend continuing;
- The proposed increased cost of obtaining an initial report in a whiplash claim (£210) would become disproportionate to the damages awarded for a whiplash injury lasting no more than three months (£240) under the current tariff;
- While an increase to the FCMRs is needed, the SPPI understates the actual increases in the costs of providing reports. The increases proposed are not, therefore, enough to ensure the quality of medical reports remains high; and
- Some DMEs and MROs indicated that in addition to inflation, the requirements for the reports are more complex now than when FCMRs were introduced; the increase in FCMRs therefore needs to be by more than by SPPI.

**Government response:**

Around three quarters of responses agreed the FCMR should be increased as proposed. MoJ acknowledges the concerns held by several respondents who commented that the fee increase ought to be higher, but we consider that the SPPI is the appropriate index to apply to FCMR.

In addition, although significant comment was provided, no specific calculations or evidence was supplied as to why SPPI was an inappropriate measure or why a higher than inflation increase is necessary. This approach is also consistent with the review of fixed recoverable costs in the Fast Track implemented on 6 April 2024.

Therefore, MoJ will move forward with an increase to the FCMR using SPPI as an inflationary measure. Account will also be taken of the passage of time since the figures consulted on were calculated, and revised figures will be published as part of short, targeted consultation on the required secondary legislative changes ahead of implementation in 2025.

**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.**

**Analysis of responses:**

82. Input was also sought from stakeholders on the potential financial impacts of increasing the FCMRs on savings made from the implementation of the whiplash reforms. Overall, **31** comments were received in relation to this question, but only **17** made comments within the scope of the question. In-scope responses received were from the following sectors:

- 1 x AA;
- 2 x claimant solicitors;
- 3 x compensators;
- 1 x cross-sector representative body;
- 3 x defendant solicitors;
- 2 x defendant representative bodies;
- 1 x DME;
- 1 x medical representative body;
- 1 x Tier 1 MRO;
- 1 x Tier 2 MRO; and
- 1 x judicial representative body.

**Summary of key points made in response to question 17:**

83. The following comments were received in response to this question:

- The small increases proposed to the FCMR will make little difference in the context of the reforms as a whole;
- Given the reduction in whiplash claims since the reforms were put in place, the small increase in FCMR should make little difference to overall savings;
- While on the face of it, the proposed increases to the FCMRs are modest and only one part of the costs of running a whiplash injury claim, they are a significant component and will increase the costs of making a claim;
- Several responses stated that until the publication of the Government's report on how the insurance industry has passed on savings from the whiplash reforms through lower insurance premiums, it is difficult to comment on how the proposed increases to FCMRs will affect those potential savings; and
- Several compensators and defendant solicitors stated that insurers are facing significant inflationary pressures already due to factors outside their control, and the proposed increases will likely erode the savings made by the reforms.

84. Several of the out-of-scope responses received expressed scepticism that genuine savings have been passed on, suggesting that insurance companies have profited significantly from the reforms, while insurance premiums have risen steeply. Other comments expressed dissatisfaction with the FCMR system generally. These responses, whilst out of scope of this consultation have however been noted.

**Government response:**

As with responses to the previous question, a wide range of opinions were received. Compensators, defendant solicitors and defendant representative bodies generally warned of potential savings being eroded by any increase in the FCMR and warn of other significant inflationary pressures on the car insurance market.

Responses from other groups differed, but generally indicated that given the significant reduction in whiplash claims since the reforms, and the increase in the Small Claims Track limit from £1,000 to £5,000, the increases to FCMR should be a major cost for compensators.

Overall, evidence or responses provided to this question did not persuade that an inflationary increase to FCMR levels would have a significant impact on savings.

# Part 6: Official Injury Claim: medical report process

85. 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.

86. 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 introduction of the OIC process enables unrepresented claimants to seek their own medical report.

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

**Analysis of responses:**

87. Overall, **32** responses were received in answer to this question, with **24** agreeing that the proposed changes could help. These are broken down as follows:

- 2 x compensators;
- 1 x cross-sector representative body;
- 2 x defendant solicitors;
- 2 x defendant representative bodies;
- 7 x DMEs;
- 1 x medical representative body;
- 6 x Tier 1 MROs; and
- 3 x Tier 2 MROs.

**Summary of key points made in support of changes to the MedCo Accreditation process include the following:**

- Changes are needed as unrepresented claimant instructions provide all relevant information, but instructions from representatives sometimes do not;
- Changes would help but OIC also needs to have a facility added which allows compensators to flag that a defendant's version of events has been provided but not considered by the expert;
- Previous training and reminders have not been sufficient to ensure compliance with the protocol, and MedCo training should be updated to reflect this;

- It would be sensible to reinforce the importance of ensuring instructions are sent at the right time with all relevant information included to improve the overall quality of reports; and
- The protocol provisions are understood but may be being ignored so claimant representatives and medical experts should be audited for compliance and sanctioned where appropriate.

88. A further **8** stakeholders disagreed that changes to the MedCo Accreditation would help embed the relevant pre-action protocol requirements, and they are:

- 2 x claimant solicitors;
- 1 x cross-sector representative body;
- 1 x defendant solicitor;
- 2 x Tier 1 MROs;
- 1 x Tier 2 MRO; and
- 1 x judicial representative body.

**Summary of key points made by respondents disagreeing that changes to MedCo's Accreditation process could help:**

- Shortcomings are unlikely to be remedied by changes to accreditation or additional guidance and could probably best be dealt with by ensuring that a claim could not proceed until liability has been decided and communicated;
- Medical experts should be aware of relevant protocol requirements, but no changes are required to accreditation which already includes material on sections 7.8 of the RTA PAP and 7.9 of the RTA Small Claims PAP, but clearer instructions would be helpful;
- Changes would not help but a clear set of declarations to be made by experts should be included in instructions to enable them to demonstrate their understanding of their obligations; and
- The rules anticipate that a defendant's version of events is unnecessary in most claims, so no changes are needed.

**Government response:**

Three-quarters of the respondents agreed that updated MedCo Accreditation would help to highlight and embed the requirements included in paragraphs 7.8 of the RTA PAP and 7.9 of the RTA Small Claims PAP.

MoJ will work with MedCo to review and refresh the Accreditation process to improve quality and compliance with these rules.

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| **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?**<br><br>**If so, please explain what changes or types of material would be most useful along with reasoning to support your position.** |

**Analysis of responses:**

89. A total of **35** responses were received to this question. **30** stakeholders agreed that changes to the MedCo Accreditation process or additional guidance and or training would be beneficial to medical experts, and these are broken down as follows:

- 3 x compensators;
- 3 x cross-sector representative bodies;
- 2 x defendant solicitors;
- 1 x defendant representative body;
- 8 x DMEs;
- 2 x medical representative bodies;
- 7 Tier 1 MROs; and
- 5 Tier 2 MROs.

**Summary of key points made in favour of changes to the MedCo accreditation process and or guidance/training:**

- Additional guidance on when additional reports and/or psychological reports are justified would be helpful;
- Additional guidance would be helpful to ensure experts are kept up to date with the requirements in the CPR and developments in the assessment of causation and the interpretation by the courts;
- There is a need for a robust accreditation process and continuous improvement, and a range of sanctions should be provided to MedCo to be applied against experts who fail to comply with the requirements of the CPR;
- The existing training has not been updated for some time and is repetitive.
- All experts should have training on the core competences of an expert witness; and
- At present, experts can meet their CPD requirements by taking the same three modules (out of 11 available modules) each year. The requirements ought to be changed so that this is no longer possible.

90. An additional **5** respondents did not agree that changes to the accreditation process or additional training would be useful. These are from the following:

- 1 x claimant solicitor;
- 1 x defendant solicitor;
- 1 x DME;
- 1 Tier 1 MRO; and
- 1 x judicial representative body.

**Summary of key points made against changes to the MedCo accreditation process and or guidance/training:**

- Guidance issued by MedCo previously (footnote 11 in the consultation document) is sufficient and fit for purpose; and
- The current initial and ongoing MedCo Accreditation system is fit for purpose.

91. Comments were also received which are outside the scope of the question. These included suggestions for new rules which require experts to identify each injury and confirm whether the injury is in their opinion an injury covered by the whiplash definition in the CLA. Another comment suggested further rule changes to help ensure MedCo randomisation cannot be circumvented and to ensure that medical records are only obtained and reviewed when necessary.

**Government response:**

This question sought views from stakeholders on whether changes to MedCo Accreditation or additional guidance or training would be beneficial, and around 85% of respondents agreed that it would. The MoJ will work with MedCo to review and refresh Accreditation, training and guidance for experts.

The suggestion made in relation to experts repeating modules for CPD purposes will also be explored further with a view to tightening this requirement.

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

**Analysis of responses**

92. Overall, **43** responses were received to this question, of which **25** agreed 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. These are broken down as follows.

- 1 x claimant solicitor;
- 3 x compensators;
- 3 x defendant solicitors;
- 2 x defendant representative bodies;
- 8 x DMEs;
- 1 medical representative body;
- 3 x Tier 1 MROs;
- 3 Tier 2 MROs; and
- 1 x judicial representative body.

**Summary of key points made in favour of the change proposed in this question:**

- The best way to address shortcomings in many medical reports is to ensure that claimants cannot obtain a medical report until the liability decision has been made;
- This would prevent issues later in the process where information is missing from the report, and it would reduce the need to have the report amended to comply with the protocol;
- The Small Claims PAP requires the representative to tell the expert about any issues with causation/liability, so it makes sense to wait for a decision. This will also protect against threats of non-payment because the report is deemed to be incomplete by the compensator; and
- Waiting for the liability decision will help and won't cause any real delays to the process as the average time for a decision is just 18 days for represented claims and even if it takes longer, the decision must be made within 30 days or liability is automatically deemed to have been admitted in full.

93. A further **18** stakeholders do not agree that claimants should wait until a liability/causation decision is reached. These were from the following sectors:

- 2 x claimant solicitors;
- 2 x claimant representative bodies;
- 2 cross-sector representative bodies;
- 3 DMEs;
- 1 medical representative body;

- 6 Tier 1 MROs; and
- 2 Tier 2 MROs.

**Summary of key points made against the change proposed in this question:**

- Any benefit would only apply to a minority of cases and cause unnecessary delays to the process; therefore, if the claimant accepts the risk they should be allowed to proceed before the liability decision is provided;
- There needs to be a method for unrepresented claimants to obtain a medical report even when liability is disputed;
- If everyone waited for the compensator to admit liability, they would just stall and delay the process; and
- It would be detrimental to claimants that require treatment, which would be delayed if they had to wait for a liability decision before obtaining medical evidence. This could also open up arguments that the claimant has not mitigated their losses.

**Government response:**

The responses to this question are mixed, with a little over half agreeing that the claimant should wait for the defendant to make their liability/causation decision before obtaining a medical report.

The MoJ notes that this proposal will result in a delay in some cases whilst the claimant waits for an initial liability decision from the defendant. However, under the current process such a decision must be made within 30 days (or 40 days where the MIB is the defendant) or liability will be automatically assumed to be admitted in full. Analysis of the data provided by OIC also shows that most liability decisions are made well before this maximum time limit.

Given that any delays arising from this change will be minimal and that it will enable better quality instructions to be provided to the expert, MoJ agrees that the claimant ought to wait for the liability decision before obtaining a medical report. This will improve the quality of medical reports by ensuring that the instructions to experts are comprehensive and include all relevant information to be considered during the medical examination process.

In turn, this should result in the need for fewer amendments to the medical report being required. This should help to reduce the time required to complete the medical evidence journey allowing for earlier settlements to be achieved.

Therefore, MoJ will work with the Civil Procedure Rule Committee to update the required secondary legislation to implement this change, which will ensure that where it is required, the court will be supported by good quality, accurate medical evidence.

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

**Analysis of responses:**

94. In total, **33** stakeholders answered this question, of which **26** agreed that changes to the RTA Small Claims protocol would need to be changed to underpin the proposals in either question 10 or 20. They are broken down as follows:

- 1 x claimant representative body;
- 1 x compensator;
- 1 x cross-sector representative body;
- 2 x defendant solicitors;
- 2 x defendant representative bodies;
- 8 x DMEs;
- 2 x medical representative body;
- 7 x Tier 1 MROs; and
- 2 x Tier 2 MROs.

**Summary of key points made in favour of the change proposed in this question:**

- A clause should be added which requires any instructions received which do not comply with 7.9 of the RTA Small Claims PAP to be returned to the representative for amendment;
- Amendments to the RTA Small Claims Protocol are required together with appropriate sanctions for failure to comply, otherwise there will be no meaningful behavioural change or compliance in this area; and
- Changes to the RTA Small Claims PAP would be helpful in that it would tackle ambiguity and bring clarity to all parties.

95. **7** respondents disagreed that changes would be needed to the protocol, including:

- 1 x claimant solicitor;
- 1 x compensator;
- 1 x defendant solicitor;
- 2 x DMEs;
- 1 x medical representative body; and

- 2 x Tier 2 MROs.

**Summary of key points in support of the view that no amendments would be needed to the RTA Small Claims Protocol:**

- The existing protocol is sufficiently clear and gaps in experts understanding can be covered by current MedCo guidance; and
- The requirements as to what medical report must contain are already clearly stated in the existing protocol, and better compliance with the existing protocol is what is needed.

96. Other comments were received which included suggestions for alternative changes to the protocol, including removing the need for medical reports to give the defendant's version of events, and for training to emphasise to medical experts that they should not get involved in interpreting legislation in the content of their reports. These points have been noted but are out of scope of the question and this consultation exercise.

**Government response:**

Almost four fifths of the respondents agreed that changes to RTA Small Claims Protocol would be required for either of the changes proposed in question 19 and 20. The MoJ agrees, and we will work with the Civil Procedure Rule Committee to update the pre-action protocol.

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| **Question 22:** | **Do you agree that the process for sourcing medical reports for represented and unrepresented claimants should be the same?**<br><br>**Please explain your reasoning for or against this proposal along with any evidence in support of your position.** |

**Analysis of responses:**

97. Overall, **41** responses were received on this question, of which **24** agree that the process of sourcing medical reports should be the same for represented and unrepresented claimants. These are from the following sectors:

- 1 x AA;
- 3 x compensators;
- 3 x defendant solicitors;
- 2 x defendant representative bodies;
- 8 x DMEs;
- 1 x medical representative body;
- 1 x Tier 1 MRO;

- 3 x Tier 2 MROs;
- 1 x judicial representative body; and
- 1 x other.

**Summary of key points made in support of having the same process for obtaining medical reports for represented and unrepresented claimants:**

- Having a consistent approach would be sensible for both claimant types and would drive compliance with the protocol on the contents of medical reports;
- While this is a good idea, it is vital that an API which allows for effective application-to-application functionality is put in place; and
- If the process for represented claimants is changed to the process in place for unrepresented claimants, this would assist with gathering useful data.

98. **16** respondents did not agree that represented and unrepresented claimants should follow the same process for obtaining medical reports, and these are broken down as:

- 2 x claimant solicitors;
- 1 x claimant representative body;
- 1 x cross-sector representative body;
- 2 x DMEs;
- 1 x medical representative body;
- 7 x Tier 1 MROs; and
- 2 x Tier 2 MROs.

**Summary of key points made by stakeholders against represented and unrepresented claimants following the same process for obtaining reports:**

- There is no reason to interfere with the process of a legal representative instructing the medical expert early and advising their claimant of the possible consequences and then seeking instructions before uploading the report;
- It would not be fair to force the medical report to be uploaded to OIC before it has been reviewed by the claimant and their legal representative;
- Many unrepresented claimants are assisted by Third-Party Capture schemes, so comparison between represented and unrepresented claimants is not valid;
- There is insufficient data or informed rationale to justify the change; and
- MROs have invested significantly in technology for the current system and the costs of changing the process could drive MROs from the market.

**Government response:**

Around 60% of respondents agreed with the proposal to align the process so that represented claimants follow the process for unrepresented claimants when obtaining medical evidence.

Those in favour generally felt that alignment would be sensible and would both drive compliance with the rules and provide a consistent approach to how claims for represented and unrepresented claimants were dealt with.

Some claimant representative respondents opposed to the change raised concerns that such an alignment of processes would mean they would be forced to disclose their medical report before they had fact checked the report or were ready to disclose. This is not a correct assumption however, and claimants would retain the ability to check and disclose their report at a time of their choosing. The system would, however, notify the defendant insurer that a report had been completed and uploaded onto OIC.

Some claimant solicitors and MROs were also concerned about the cost of the changes that would be needed to implement this change, which could cause some to exit the market. MoJ acknowledges that some software changes would be needed but we do not consider there to be a significant risk of providers exiting the market.

Overall, we see benefits in there being a single medical reporting process. This would remove the current two-tier system, provide certainty as to the process to be followed and encourage compliance with the rules. Such a change would also allow for better data collection and improved monitoring of the process to inform future improvements to both the Small Claims Protocol and the OIC system.

However, we note the concerns raised by respondents in relation to this proposal. Therefore, although having a fully aligned process would be beneficial, we have decided that the decision taken to ensure that medical reports cannot be obtained until a liability decision has been made, will be implemented first.

In addition, further work will be undertaken with all stakeholders to explore the development of an aligned process that is suitable for both unrepresented and represented claimants. Once this is complete MoJ will consider the next steps regarding implementing the agreed changes.

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| **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?** |

**Analysis of responses:**

99. A total of **21** responses were received in answer to this question, and they are broken down as follows:

- 2 x claimant solicitors;
- 1 x claimant representative body;
- 2 x compensators;
- 1 x cross-sector representative body;
- 3 x defendant solicitors;
- 2 x defendant representative bodies;
- 2 x DMEs;
- 1 x medical representative body;
- 3 x Tier 1 MROs;
- 2 x Tier 2 MROs; and
- 2 x other.

**Summary of key points made by stakeholders in response to this question:**

- Detailed data about the medical reporting process is not required for represented claimants because any delay could be dealt with by the claimant complaining to their solicitor;
- If represented claimants were to follow the process already followed by unrepresented claimants, this would greatly assist in obtaining data on the medical reporting opportunity;
- We expect data gaps in the OIC system to be filled by instructing OIC and MedCo to map the same data points on the medical reporting process;
- There is a lack of transparency about what data is collected and published and an independent body should be created to oversee this;
- MedCo's remit should be expanded to cover additional reports; and
- If the progress of all OIC claims is to be tracked at system level, then the same process should be applied to CPL so that all relevant data is available.

**Government response:**

The MoJ recognises that data is one of the key tools we need to improve the justice system. Without reliable and relevant data, it is impossible to assess how well a service is functioning, and the medical reporting journey in relation to RTA related small claims cases is no exception. Although not all the comments made in response to this question are strictly about data collection on the medical reporting journey, some useful ideas were shared.

As already outlined above, if represented claimants were to follow the process that unrepresented claimants currently follow, this would allow OIC to collect additional directly comparable data for the different stages of obtaining a medical report.

Other suggestions include asking MedCo and OIC to map the same data points, so fully comparable data is collected on the medical reporting journey for both represented and unrepresented claimants. An exercise of this nature has already been completed with OIC, MedCo and Claims Portal Limited and will be repeated in future.

While not strictly a point on data collection, one stakeholder made a useful suggestion that MedCo could expand its remit include obtaining additional medical reports.

# Part 7: Equalities

100. The Public sector Equality Duty came in to force in April 2011 and public authorities including the Ministry of Justice are now required to have due regard to the need to achieve the objectives set out under s149 of the Equality Act 2010 to:

    (a) eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under the Equality Act 2010;

    (b) advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it; and

    (c) foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

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

102. As part of this consultation, the government sought input from stakeholders for mostly minor changes which aim to improve the quality of medical reports and the efficiency of the medical reporting process. The consultation included (see question 24 below) a question in which stakeholders were asked about the impact of the proposals in this consultation on those with protected characteristics.

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| **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?**<br><br>**Please explain your reasoning.** |

**Analysis of responses:**

103. A total **26** responses were received in answer to this question from the following sectors:

- 3 x claimant solicitors;
- 2 x compensators;
- 1 x cross-sector representative body;
- 3 x defendant solicitors;
- 1 x defendant representative body;
- 5 x DMEs;
- 1 x medical representative body;
- 6 x Tier 1 MROs;

- 3 x Tier 2 MROs; and
- 1 x judicial representative body.

**Summary of key point made in answer to this question:**

- **19** respondents stated that they are not aware of any prejudicial impact on protected characteristic groups in relation to the proposed changes in the consultation document;
- The proposed increases to the FCMR may encourage more experts into the market. This could assist claimants with specific characteristics by creating a better opportunity to find someone suitable;
- One stakeholder suggested the proposal to delay instruction of the medical report until the liability decision or provision of the defendant's version of events could impact those with pre-existing conditions (including those with a disability), as it could delay treatment. These people could be disproportionately affected by the delay; and
- Any process changes should be communicated using visible and comprehensive guidance for users with a broad range of access needs.

**Government response:**

Almost three quarters of the responses received to question 24 indicated they were not aware of any prejudicial impact on those with protected characteristics in relation to the proposals set out in the document.

One stakeholder said that making a represented claimant wait for a liability decision before instructing an expert could impact on those with pre-existing conditions more than those without, as it could delay any treatment they need. They did not, however, explain how the impact would be prejudicial in comparison with someone who is not disabled but has a pre-existing condition. Given that many people have pre-existing conditions but not a disability, it does not follow that the proposed changes would unlawfully discriminate against those with a disability.

After considering the evidence and the responses from stakeholders, the MoJ is satisfied that none of the decisions made in this consultation will result in anyone with a protected characteristic being put at a particular disadvantage compared to someone who does not share the protected characteristic.

# Conclusion and next steps

The government will move forward with following changes:

**Part 1: Changes to MedCo Qualifying Criteria**

MoJ will work with MedCo to update the qualifying criteria for MROs, including reducing the required report capacity for tier 1 MROs from 40,000 to 28,000 per year, and reducing the number of active experts from 225 to 175. MoJ will retain the requirement for tier 1 MROs to have active experts in 80% of regions in England & Wales.

**Part 2: Amended DME Rules**

MoJ will work with MedCo to implement the proposed changes to the DME rules and, following a suggestion made by a stakeholder, we will slightly modify the wording around the role of the audit committee.

**Part 3: Review of MedCo 'Offer'**

MoJ will work with MedCo to change the 'offer' for represented claimants. They will be offered two tier 1 MROs, six tier 2 MROs and seven DMEs. Unrepresented claimants will continue to be offered two tier 1 MROs, two tier 2 MROs and five DMEs.

**Part 4: Use of Administration Agencies by Direct Medical Experts**

MoJ will work with MedCo to develop a range of QCs which fairly encompass the support activities of different types of AA before changes are made to the necessary secondary legislation.

**Part 5: Review of Fixed Cost Medical Report**

MoJ will increase the fixed cost medical report levels as outlined in this document and will consult on the required rule changes and new figures before implementation.

**Part 6: Official Injury Claim: Medical report process**

MoJ will work with MedCo to review and refine the MedCo Accreditation process and training, in line with stakeholder feedback. This is aimed at improving compliance with Parts 7.8 of the RTA PAP and 7.9 of the Small Claims PAP and improving the quality of MedCo medical reports generally.

MoJ will amend the RTA Small Claims PAP and accompanying Practice Direction 27B to ensure represented claimants using the OIC system must receive the defendant's response on liability before instructing a medical expert. This is to ensure the instructions to the medical expert are complete and improve the quality of medical reports.

MoJ will also work with stakeholders to explore the development of options for aligning the processes for obtaining medical reports, so that represented and unrepresented claimants follow the same medical reporting journey.

# Impact Assessment, Equalities and Welsh Language

## Impact Assessment

104. 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 Impact Test

In accordance with the Welsh Language Act 1993, the MoJ's Welsh Language Scheme, a summary of this document will be made available in Welsh.

# Consultation principles

This consultation was conducted in accordance with the principal 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:

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/691383/Consultation_Principles__1_.pdf

# Annex A – List of respondents*

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|---|---|
| Association of British Insurers | KSI Medics |
| Association of Consumer Support Organisations | MAPS Medical |
| Association of District Judges | MedCo |
| Association of Medical Reporting Organisations | Medicolegal Direct Ltd |
| Association of Personal Injury Lawyers | Medicus Luminare |
| Ather Medicals Ltd | MLA |
| Back Medicolegal Services Ltd | Mobile Doctors Ltd |
| Blackrock Medical Reporting Ltd | Motor Accident Solicitors Society |
| Bodycare Clinics | NFU Mutual |
| Carpenters Group | OTSE |
| Chartered Society of Physiotherapy | Premex Services Ltd |
| Chartwell Medical | Premier Medical Group Ltd |
| Claims Portal | RSW Medico Legal Ltd |
| DAC Beachcroft Claims Ltd | SK Medical Practice |
| Denton Ross Medical Ltd | Speed Medical Examination Services |
| Direct Line Group | Thompsons Solicitors |
| Doctors Chambers (UK) Ltd | Winn Solicitors Ltd |
| Doctors Plus Ltd | Tri Star Medicals |
| DWF | UK Independent Medical Ltd |
| The Expert Witness Institute | Vantage Medicals UK Ltd |
| Forum of Insurance Lawyers | Zurich Insurance |
| Keoghs | |

*List includes responding organisations only - no individual stakeholder respondents are named here.