Guidance on MoJ Qualifying Criteria
2019 Update

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Preamble

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

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

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

The Frequently Asked Questions to Guidance Document ('FAQ') that existed prior to the publication of this updated Guidance has been incorporated within this document. Should any future questions arise, a new FAQ document may be produced and published on MedCo's website. MROs should periodically check whether any FAQ updates have been published. The FAQ supplements this Guidance by providing answers to common queries raised since the Guidance was last updated. The Guidance and FAQ are produced only to indicate how MedCo may interpret the QC in given situations; neither are legal documents and may be revised from time to time.

The paragraph numbering in the sections below covering Tables 1 and 2 corresponds to the individual QC numbers in the QCD. As no guidance is deemed necessary for criteria 1.14, 2.7 and 2.8 there are no corresponding paragraphs in this Guidance document.

General Principles (to Assess Compliance)

a) The following general principles in previous versions of this Guidance can now be found in the MedCo Rules:
   i. The provisions on what constitutes evidence of compliance e.g. with the QC; and
   ii. The minimum requirements for a new registration MRO to be set to 'live' status on the MedCo Portal.

b) The following general principles in previous versions of this Guidance can now be found in the MedCo Policy Document:
   i. How MedCo considers the individual QC should be applied, both to existing MROs and new registration applicants;
   ii. The time periods MedCo considers relevant for assessing compliance with the QC; and
   iii. The tolerances to be applied when assessing compliance against qualitative and quantitative requirements.

c) The Guidance refers to **best practices** in certain sections. These practices do not form part of the minimum requirements to meet the QC. They are provided to facilitate differentiation amongst MROs and to encourage MROs to operate at above the minimum standards.

d) MROs that consciously operate all or multiple processes (especially core function processes) to the minimum standards should beware creating multiple single point failures in their QC compliance processes. Adopting widespread absolute minimum standards is considered a high risk compliance strategy with a high risk of breaching the QC. Such MROs should expect greater scrutiny by MedCo as a result.

e) New provisions in updated versions of this Guidance do not apply retrospectively, except where they arise from such scenarios (not an exhaustive list) as the following, where the changes involve:
   i. Additional detail that represents a logical extension to principles and practices already stated in previous versions of the Guidance at a more summary level;
   ii. Updates due to legal and regulatory changes, which may have been introduced in between updates to the Guidance;
   iii. Clarification of text in previous versions i.e. there is no change in the substance of how MedCo interprets the QC or the evidence it requires to demonstrate compliance with it;
   iv. Changes to SLA measures. SLAs should continue to be re-produced on a rolling 12 month basis using the new measures from the date the new Guidance comes into force, based on data for the previous 12 months to the extent that it is available; and
   v. Text from previous versions of this Guidance being moved to a different location within it or being transferred from/to other published documents that form part of the MedCo regulatory framework e.g. User Agreement, MedCo Rules, Policy document, Examination Guidelines and FAQs.

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

Table 1 – Minimum Qualifying Criteria

1.1 – Definition of a MRO

Certain key terms in the QC are additionally interpreted by MedCo as follows:

a) **Independent** (QC 1.1(i)):

i. A MRO is not independent if, as part of its MedCo and normal day-to-day trading activities, it expressly or on an implied basis uses or relies upon the name and/or branding in any way of a:
   a) MRO that is also its parent, subsidiary, fellow group company, associate or otherwise affiliated business (e.g. has individual shareholders in common for > 10% of shares); or
   b) Non-MRO organisation that services multiple MROs.

ii. Where a MRO uses parent, subsidiary, fellow group company, associate, or otherwise affiliated business resources, and vice versa, these transactions will be considered independent only if:
   a) They are for non-core activities paid for on normal commercial terms e.g. not free of charge or for a severely reduced consideration significantly below market rates;
   b) Each MRO has the ability to switch to a non-affiliated third party service provider and has entered into the current contract through an arms' length commercial tender process; and
   c) Such structures have not been set up specifically to exploit the random allocation model or in breach of criterion 1.8 (Ethics Policy). The onus will be on the MRO to demonstrate that this is not the case.

iii. A MRO should receive payments directly from instructing parties and pay medical experts directly i.e. to the expert's:
   a) Personal bank account (a bank account in the expert's name not controlled by a third party e.g. administrative agency's bank account is not a personal bank account); or
   b) Limited company bank account, provided that all three of the following are met: the company is owned by the expert and/or his immediate family (spouse and linear descendants), is not a MedCo-registered MRO and only handles work (MedCo or otherwise) for that one individual expert.

iv. To be considered independent, a MRO must have physically different premises with physically separate spaces from other MROs. Where one or more MROs operate from the same building, MedCo will presume that MROs are not independent of each other and the onus will be on the MROs to demonstrate that they are in fact independent, for example by demonstrating that:

a) They occupy separate floors/office spaces within a single office building that provides for multiple separate occupancies;
b) They are functionally operated as separate units in terms of business activities and infrastructure e.g. no shared wired IT networks, utility bills or rental agreements; and
c) There is no interchange of employees between the MROs i.e. indiscriminate use of employees in both units without regard to the segregated functions of such units.

v. A MRO is not independent in any of the following scenarios, where all MROs involved will prima facie be deemed connected and not independent of one another. The onus will be on each MRO to demonstrate to the contrary where it shares its:
   a) Confidential business information with competitors (organisations or individuals), whether MedCo-registered or not. This includes its MedCo audit reports – sharing learning points and concerns is acceptable, but not provision of the confidential information associated with them;
   b) Confidential business information with third party software providers and that information is:
      i. Made available directly or indirectly to the software provider's other MRO customers; or
      ii. Not required by the third party software provider to fulfil its obligations to the MRO;
   c) Business formula, such that MROs appear as if independent entities but operate in practice as clones of one another. Such entities are likely to act in a co-ordinated manner based around very similar characteristics; or
   d) Control over user access permissions to its case management system, database and access to case data with any third party. MROs should at all times be in full control of access to these applications and supporting data, granting access to third parties only as and when the MRO deems it necessary and only for as long as is needed. This control activity cannot be delegated outside the MRO and is also considered integral to meeting QC 1.6 (Information Security).

b) What constitutes "**properly staffed and resourced**" (QC 1.1(ii)) will vary according to each MRO's business model. However, the levels and factors involved should be consistent with the levels of instructions accepted and the objective of ensuring the provision of good quality and timely independent medical evidence. Indications of a MRO having appropriate staffing and resourcing:

   i. Include having the capability to:
      a) Undertake an effective clinical and non-clinical quality assurance role (see 1.13(g)-(i)) in the medical report production process in recognition that the onus on report quality does not rest solely with the medical expert.
      b) Establish and maintain formal relationships and interactions with medical experts and claimant solicitors to facilitate better quality medical reports, efficient use of appointment slots, resolve complaints / queries and provide prompt report turnaround for claimants.

c) Use technology (software and hardware), where the volume of reports is such that it enables a MRO to better directly manage the provision of good quality medical reports.
d) Use third party providers in non-core areas and/or areas that are not significant. MedCo considers activities set out in QC 1.1, 1.8, 1.10 (Responsible Officer role) 1.13, 1.16 and 2.2, as interpreted by MedCo in this Guidance to be core / significant areas of a MRO and so a MRO cannot outsource these and retain its MRO status.
e) Have a training and development programme in place, suited to the size and nature of the MRO, to ensure that all staff are suitably trained to conduct MedCo work to the minimum standards. Characteristics demonstrating that staff are suitably trained includes (not an exhaustive list) the trainer and at least 50% of Full Time Employees (FTE) staff (including directors, officers and management) each having:
    i. Either at least 6 months' prior experience working at an operational MedCo-registered MRO (per the Operational List of MROs updated weekly on MedCo's website) or one formerly MedCo-registered and operational that voluntarily gave up its MedCo registration (e.g. by withdrawing or not renewing it). Experience gained working at a MedCo-registered MRO terminated for non-compliance with the QC is not considered suitable;
    ii. Or if within the first year of trading, having relevant experience from working in non-MedCo medico-legal sectors or other industries (public or private sector) that are subject to regulation e.g. financial services, utilities and professional services and having undertaken relevant training to provide MRO services (see below);
f) Relevant training should be documented with evidence retained. It can include e.g.:
    i. Internal training that results in staff having a working knowledge of MoJ policies, the User Agreement, QC, Guidance and other relevant MedCo-related publications;
    ii. Attendance at industry conferences and MedCo events as occur from time-to-time;
    iii. Operational training e.g. how to validate experts' credentials and conduct non-clinical QA;
    iv. Functional training e.g. on information security, ethics, customer care/complaints handling, anti-bribery and changes in the law (including changes arising from case law); and
    v. Application training e.g. case management system, MedCo Portal and Excel (if use spreadsheets to calculate SLA performance).
g) Remain up-to-date with medico-legal reporting matters, practices and quality standards arising from relevant government, regulatory, industry or medical professional bodies.
h) To remain solvent and self-sufficient (which includes bank loans in the normal course of business) in terms of its funding to carry on in business.
i) Develop new service models through the competitive process, where the resultant new MRO form meets the QC as applied by MedCo, has support from the claimant community and is expected to improve the standard of independent medical report production.
j) Accept telephone calls from clients, experts and MedCo; respond to emails; and accept mail at its business premises during normal business hours. A MRO that is unable to do so on a day-to-day basis or regularly has such functions performed by non-MRO

personnel (other than e.g. short-term holiday or sickness cover) is prima facie a shell entity or in a non-trading state.

k) Be operational every business day of the year. Where a MRO cannot be operational (e.g. due to sickness) or it will not to be operational for any known period , it must:
   i. Put in place measures so that the production of medical reports it has in progress are not unduly prejudiced as a result; and
   ii. Not make itself available to accept new instructions from MedCo if it will not be trading for more than a few days and it has no effective contingency measures in place.

ii. Exclude organisations with one or more of the following characteristics:
   a) Clearing houses or entities that are not fully functioning in their own right e.g. MROs that have structured their resources to operate as a transaction processor rather than as a service provider, such that the MRO has no discernible functions relative to the volume of instructions received, to provide customer service for claimants and medical experts or for managing quality of the medical reports produced.
   b) Use of organisational short-cuts e.g. the use of such structures as virtual organisations, white labelling arrangements and reciprocal "swap" arrangements (where MRO1 has been selected but does not have the resources to produce the report, so engages (directly or otherwise) with MRO2 who completes it on MRO1's behalf, and that report is then submitted to MedCo as if MRO1 had done the work itself – with this service reciprocated if MRO2 encounters a similar issue).
   c) The use of rented, purchased or otherwise acquired third party content that is fundamental to a MRO's principle function e.g.:
      i. A pre-set medical expert panel established by another MRO or other third party without the MRO undertaking the direct management of expert checks set out in QC 1.13;
      ii. Use of pre-agreed access rights to medical experts' diaries (regardless of whether they have been added to that MRO's panel or not) established by an IT provider or other third party.
   d) Organisations which are not on a solid financial base, or which have "going concern" issues i.e. they may be dependent for day-to-day funding on periodic capital injections, loans or other financing from group companies/owners.
      i. A new entrant MRO yet to produce the report volumes needed to be self-sustaining, may be deemed to have a solid financial base where it can demonstrate that it has sufficient financial backing from an owner or third party (e.g. bank) in this period. MedCo deems this maximum time period and self-sustaining volume threshold as those set out at 1.4(f)(i).
   e) Staffing models based on a high proportion (i.e. 50% or more) of seconded staff from other MROs or non-MRO organisations that service multiple MROs.

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

d) The **core functions** of a MRO are considered as a minimum to be those covered by QC 1.1, 1.8, 1.10 (Responsible Officer role) 1.13, 1.16 and 2.2, as interpreted by MedCo in this Guidance. **Non-core activities** include e.g. accounting, legal, compliance (i.e. QC 1.10 Compliance Officer role), HR and IT infrastructure.

e) MROs may be part of a "**common third party (individual and/or corporate) ownership model**" ("CTPOM") already existing or, by exception, newly formed (e.g. MRO acquired as a byproduct of a larger transaction) as long as they are also "**fully functioning**" i.e. the fact that the MRO is part of a CTPOM is incidental to its ability to operate as a fully functioning MRO and if it lost access to any non-core resources provided by that CTPOM, the impact on its ability to trade as a MRO would be negligible. Examples of this structure:

   i. Include:
      a) A fully decentralised group structure, where each decentralised business unit ('DBU') has different trading names, client markets, management and operational structures and each MRO operates under a different DBU so that it has to be fully functioning in its own right;
      b) Separate executive management teams are in place for each MRO at a comparable level of seniority (in titles and remuneration) to each other and neither one reports into the other, in a management or other group structure or ownership capacity;
         i. A specific exception to this is set out at 1.1(e)(ii)(d)(ii); and
      c) Acquisitions, where the organisations have taken account of the following three factors:
         i. Notice to MedCo: Adequate notice should be provided to MedCo where there is any change of control of a MRO, which will enable MedCo to consider whether the MRO will continue to meet the requirement to be independent in accordance with QC 1.1(i) post-completion of the acquisition;
         ii. Post-acquisition structure: The combined entity is expected to operate:
            a) Either as a single MRO on the MedCo Portal from the date at which it has legal control over the acquired entity;
            b) Or as a separately configured and branded unique, fully functioning business entity, with separation remaining uninterrupted pre-, during and post-acquisition; and

iii. MedCo's Ethics Policy: The acquisition must not undermine confidence in the MedCo service or the Government's stated policy objectives.

ii. Exclude:

a) White labelling arrangements i.e. an MRO / third party producing the medical report service (the producer) provides it to another MRO (the marketer) within the common ownership model that rebrands the service as if to appear as though the marketer had produced it;

b) A centralised group structure, where common operating processes (e.g. 1.13) are provided in some form of shared service or central processing unit to customer-facing entities;

c) A decentralised group structure where more than one MRO operates in the same DBU and all the MROs are subject to common management and operational processes and structures for that DBU i.e. no MRO is fully functioning in its own right, but are inter-dependent; and

d) Where one MRO executive management team either shares executive resources with another or, to all effect and purposes, is subordinate to another MRO's executive management in practice e.g. through level of seniority and/or remuneration:

i. 'Executive' includes (but is not limited to) those with the ultimate or material decision-making authority at the MRO i.e. depending upon the size and ownership of the MRO:

a) Directors of the MRO registered at Companies House, who have legal and fiduciary duties to fulfil, and their equivalents. The latter includes, where the MRO is a subsidiary of a larger organisation, those managers in the larger organisation whom the MRO's senior managers report into; or

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

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

f) The QC refers to "shells". A **shell** is interpreted by MedCo as a MRO that is unable to demonstrate that it meets the minimum standards i.e. Table 1 QC, in particular 1.1 (Definition of a MRO). Should an existing MRO be unable to meet these minimum standards, then the fact that it has been trading as an independent MRO previously does not exempt it from the

requirement to meet the minimum standards. MedCo presumes that the following MROs are shells, with the onus on the MROs affected to demonstrate to the contrary:

i. Where a MRO (whether with high volume, national status or not) has one or more parent, subsidiary, fellow group company, associate or otherwise affiliated businesses registered with MedCo as MROs, all of these additional MROs are presumed to be shells. In these instances, the onus is on each and every MRO to demonstrate the contrary to MedCo;

ii. Sharing good practices is encouraged e.g. where a MRO identifies such practices in another MRO and applies those principles to its own business and method of operating. Replication of another MRO's practices, especially if they are not good practices and extensive, however, is indicative of being a shell e.g. where the processes, documentation and procedures for QC 1.13 are substantially the same across multiple MROs that appear to be commercially and/or organisationally related, this will constitute evidence that those MROs are not independent of one another; and/or are not properly staffed or resourced to carry out these functions on their own (as they share resources); and/or are not fully functional and do not directly manage their panel of medical experts;

iii. MROs that include within their name as it appears on the MedCo Portal references or associations to other MROs or to non-MRO organisations that service MROs.

g) QC 1.1(iii)(e) makes it clear that MROs should not operate in a way contrary to the Government's stated policy objectives. As such, MROs should only accept instructions from Users that have selected them via the MedCo Portal. However, MedCo considers there to be two instances where a MRO can refuse an instruction from a User and this would not undermine the Government's policy objectives:
   i. These instances are where:
      a) To accept the instruction would result in the MRO breaching another QC e.g. 2.2.4; or
      b) There is a demonstrably untenable relationship between the MRO and Instructing Party e.g. significant commercial dispute or legal proceedings have commenced.
   ii. In such instances, the MRO should inform the User in writing that it is rejecting the instruction and the reason for this, so that the User is able to comply with its own obligations to MedCo i.e. provide the reason (with supporting evidence) for making a second selection for the same instruction. Failure by the MRO to complete these formalities would be considered a breach of MedCo's Ethics Policy – the same would apply to the User in respect of its compliance with MedCo's Ethics Policy.

1.2 – Direct Financial Links

a) MROs should declare all potential direct financial links per the MoJ's revised statement (http://www.medco.org.uk/media/1210/moj-revised-statement-on-direct-financial-links-

december-2016.pdf) and changes thereto to MedCo at the earliest opportunity i.e. as and when they happen and not just at the time of making the annual declaration.

b) If in doubt as to whether a link constitutes a direct financial link, MROs should inform MedCo to avoid potential non-compliance if it subsequently turns out that the link in question does constitute a direct financial link and it was not previously declared. For example, MedCo considers the role of company secretary could fall within the definition of a direct financial link as set out in the MRO User Agreement.

c) Should a MRO fail to declare a direct financial link, whether deliberate or inadvertent, and MedCo identifies this through its own activities the MRO will be considered to have:
   i. Failed to meet this criterion and 1.8 (MedCo's Ethics Policy, standards 3, 4, 6 and 7);
   ii. Breached the User Agreement (see warranties section) and
   iii. Undermined MedCo's confidence in the MRO's ability to self-declare all its direct financial links.

1.3 – Payment of Experts on Set Credit Terms

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

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

c) Where payment terms deviate significantly from the Prompt Payment Code or experts are paid only after the MRO has itself been paid by the Instructing Party, a rebuttable presumption will exist that such payments may be contingent (1.3), medical experts may not be directly managed appropriately (1.13) or be sufficiently independent (1.13(b)(iii) & 2.2.1) and that such terms may compromise the quality of their medical reports. In such situations, the onus will be on the MRO to demonstrate that this is not the case.

1.4 – Financial Instrument

a) The MRO can purchase any financial instrument provided that it meets all of the following criteria i.e. it must:
   i. Operate in the event of the failure of the MRO and solely in favour of its contracted medical experts;
   ii. If activated, be operated by a named independent third party administrator that has agreed to provide this service. That named party cannot be the MRO, MedCo or "medical experts";

iii. State that the beneficiaries are any MedCo-registered expert that has been instructed by the MRO to produce a MedCo report for it; and
iv. Not be capable of being cancelled, lapsed or otherwise rendered ineffective through the sole actions, inactions or failure (including administration, solvent/insolvent liquidation, creditors' arrangement, dissolution or other corporate event that results in an inability to pay its debts as they fall due in full) of the MRO.

b) MedCo considers that insurance policies (and equivalent financial instruments) can meet (i) - (iii) above, but not (iv) as they are at risk of being cancelled or lapsed, risks that are likely to increase should a MRO get into financial difficulties.

c) MedCo is only aware of one type of financial instrument that with the appropriate wording meets all four of the above criteria – a standard escrow agreement, whether for cash or assets of at least equivalent value.

d) Any financial instrument obtained must be issued by an authorised firm in order for MedCo to accept that QC 1.4 has been met. Authorised firms include:
   i. All authorised insurers (including insurers at Lloyd's) authorised to write business in Class 15: suretyship;
   ii. Banks authorised to accept deposits in the UK, including those authorised in the EU or with appropriate "passports" to conduct business within the UK; and
   iii. Payment institutions (e.g. escrow agents) either registered with, or authorised by, the Financial Conduct Authority.

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

f) MedCo considers that MROs providing greater volumes of instructions to medical experts need to provide greater certainty of being able to pay them in the event of the MRO's failure. Consequently:
   i. A MRO only within its first 24 months of operation as a MRO, and only if within that timeframe it provides less than 1,000 instructions to medical experts pa (pro-rated where appropriate), may satisfy this criterion by meeting 1.4(a)(i) - 1.4(a)(iii) only i.e. not 1.4(a)(iv):
      a) This exception does not apply where a new MRO acquires the business of an existing MRO in part or in whole, as the MRO's period of operation is then deemed to be continuous;
   ii. All other MROs can only satisfy this criterion through meeting 1.4(a)(i)-(iv); and
   iii. Where MROs exist (including new MROs i.e. (i) above) that are connected by any form of group ownership (including that of a common third party (individual and/or corporate) ownership model where the individual MROs are fully-functioning and independent entities) this criterion can only be satisfied through meeting 1.4(a)(i)-(iv). This is because the effect of cross-guarantees and other financial links within group structures can reduce

the certainty of medical experts not being paid by the MROs and it is not within MedCo's remit or abilities to assess or monitor group risks.

g) The bond must include a clause that ensures that a minimum 18 month run-off period is in place, such that no expert is disadvantaged by a MRO's decision to cease to trade, exit MedCo business or switch from one approved bond provider to another.

1.5 – Insurance

a) All liability insurance must specifically state / cover the business as a MRO. A description of the business for insurance purposes that is either partially or materially different to this (e.g. administration or call centre) will be indicative that the business does not meet criterion 1.1.

1.6 – Information Security Policy

a) MROs should be able to demonstrate that they have assessed and acted upon their information security risks through, as a minimum:
   i. Familiarising themselves with the ICO's Guide to Data Protection – https://ico.org.uk/for-organisations/guide-to-data-protection/ including all the related links on the left hand side of the web page e.g. "What's new", Key definitions, Principles, Lawful basis of processing, Individual rights, Accountability & governance, Security, Personal data breaches, International transfers and Exemptions;
   ii. Developing, documenting and tailoring their privacy policy and information security policies to fit the nature, size, organisational set-up and data management practices of their business, thereby demonstrating their ability to apply the Data Protection Legislation requirements to their business. Where MROs use IT controls, it is their responsibility to ensure that they are fit for purpose and operate as intended.
   iii. Completing the relevant applicable ICO data assessment checklists (7 are available covering different characteristics) – https://ico.org.uk/for-organisations/data-protection-self-assessment/;
   iv. Documenting their own information security risk assessment over all data under the MRO's control including that which passes to/from third parties (e.g. administrative companies) and using equipment or services of the MRO's third party providers e.g. IT software and infrastructure firms;
   v. Implementing controls, based on the above, that are appropriate to the MRO's nature, size, organisational set-up and data management practices and which cover the MRO's role as data controller; and

vi. Training all staff sufficiently on the MRO's information security obligations, its processes for fulfilling these, controls to ensure that data is secure and staff responsibilities in these respects.

b) Additional guidance for healthcare related data is available via NHS Digital's Data Security Standards (https://digital.nhs.uk/about-nhs-digital/our-work/nhs-digital-data-and-technology-standards/framework/beta---data-security-standards#the-data-security-standards). This includes a review of how different security frameworks (e.g. ISO 9001, ISO 27001, CyberEssentials) measure up against these data security standards.

c) Additional guidance for MROs that use various forms of external hosting, in particular cloud computing, can be found via the Australian Government's Cloud Computing Security Considerations publication https://www.cyber.gov.au/sites/default/files/2019-03/Cloud_Computing_Security_Considerations.pdf. MROs should note that:
   i. Using a third party does not absolve the MRO of responsibility for security of its data. The MRO remains responsible under all circumstances and must ensure that it has a written agreement in place;
   ii. MROs should be able to demonstrate that whatever elements of its IT software and hardware that are managed by third parties have been structured to be sufficiently secure to manage sensitive personal data such as medical reports;
   iii. It is insufficient for the MRO to rely upon its contract with a third party or assertions from the third party that it has appropriate security controls in place. The MRO should obtain written evidence to satisfy itself that this is the case and that it is aware of any breaches that have occurred; and
   iv. The merits of different security frameworks used by third party providers should be assessed e.g. using the NHS Digital Security Standards comparisons above to ensure that no residual risks remain without adequate controls.

d) Where a MRO has been trading for a number of years and/or is processing higher volumes of reports, MedCo considers it unlikely that no breaches of a MRO's security policy will have occurred in the previous 12 months e.g. use of shared passwords. MedCo will expect to see evidence of self-reporting and may inspect the MRO's breach records. In such situations the onus is on the MRO to demonstrate that its information security controls are appropriate and effective:
   i. Evidence of effective controls can relate to the MRO's non-MedCo business, if both the MedCo and non-MedCo businesses are subject to the same information security controls;
   ii. Security breach means any adverse action that could affect the confidentiality, integrity or availability of information (in all formats) processed by the MRO e.g. use of shared passwords and unrestricted access to premises; and
   iii. Security incident means a security breach where sensitive or confidential information has potentially been stolen, viewed or accessed by an unauthorised person. Data security incident trends are published by the ICO – https://ico.org.uk/action-weve-taken/data-security-incident-trends/ – on the types of security incidents generally and by sector.

e) Given the importance of information security for claimants' sensitive personal data (medical and that used for official identification), minimum service levels are applicable for this criterion that attest to the effective operation of the above controls in their entirety – see 1.16.

1.7 – Anti-Bribery Policy

a) MROs should be able to demonstrate that they have assessed and acted upon their bribery risks through, as a minimum:
   i. Reading the MoJ's Bribery Act 2010 Quick Start Guide and, if required, related links – https://www.justice.gov.uk/downloads/legislation/bribery-act-2010-quick-start-guide.pdf;
   ii. Documenting its own bribery risk assessment. Further guidance with examples is available from The Institute of Risk Management's and Transparency International UK's Bribery Risk Guide at https://www.theirm.org/media/2218767/IRM-TI-UK-Bribery-Guide-A5-V6-Low-Res-proof.pdf; and
   iii. Implementing preventative and detective controls, based on the above, that are appropriate to its size, staff structure (number, seniority and familiarity with UK business norms), technological sophistication and type of business. These controls may include e.g. anti-bribery training, related party link checks, due diligence on third parties prior to services commencing, common sense checks on the size of payments received/paid relative to the services provided/received, complaints monitoring and "mystery shopper" exercises of its staff.

b) Where a MRO actively solicits business from MedCo accredited users, it should document clearly its methods of sourcing business (including any arrangements that it is a part of through any parent, group, associated, common control or related undertakings) and that these arrangements comply with the Bribery Act, taking into account the MoJ's Guidance at https://www.justice.gov.uk/downloads/legislation/bribery-act-2010-guidance.pdf.

c) Where a MRO or a shareholder, director (including shadow and non-executive directors) or employee of the MRO has financial dealings with organisations or individuals from a country designated as "high risk" or "very high risk", as measured by Trace International's Trace Bribery Risk Matrix (https://www.traceinternational.org/trace-matrix), then there is an increased bribery risk. The MRO needs to demonstrate that it has assessed this risk comprehensively and documented the steps it has taken to mitigate the risk.

1.8 – Ethics Policy

a) MROs must adhere to the MedCo Ethics Policy ('Ethics Policy') that forms part of their User Agreement with MedCo. MROs may adhere to their own internal company ethics policy ('Internal Ethics Policy'), only when the latter is judged by MedCo to be of an equal or higher

standard than the MedCo Ethics Policy http://www.medco.org.uk/core-documents-help/ i.e. it incorporates as a minimum all the elements of the Ethics Policy.

b) **Commitment** to the Ethics Policy means that an MRO:
   i. Operates to both the **spirit** and the letter of the QC, with spirit referring to the MoJ's published policy objectives, intentions and any future updates thereto;
   ii. Where necessary, seeks training, resources and guidance on ethical matters to ensure it can meet its obligations e.g. from the UK's Institute of Business Ethics at https://www.ibe.org.uk/home/1;
   iii. Co-operates with MedCo's processes published on MedCo's website at http://www.medco.org.uk/core-documents-help/;
   iv. Matches its actions to its risks such that where it has heightened ethical risks the onus is on the MRO to demonstrate that it has taken more than the minimum ethical actions required in order to mitigate these heightened risks. Such risks include (not an exhaustive list):
      a) A heightened anti-bribery risk (see 1.7(c));
      b) Previous failings of MedCo's ethics policy; and
      c) Previous suspensions and/or rejections (if new registration) from the MedCo Portal.
   v. Embraces standard 3 of the Ethics Policy in particular, specifically that its "actions should not undermine **confidence** in the MedCo service", which MedCo interprets as meaning both an MRO's actual and perceived actions or inactions, with equal emphasis on actual and perceived; and
   vi. Takes **pro-active** action to identify and address any issues under standard 4 of MedCo's Ethics Policy, particularly where they relate to controlling shareholders, directors or senior management.

c) **Compliance** with the Ethics Policy includes all of the following:
   i. Implementing it in a manner that is appropriate to the:
      a) MRO's size, business and clientele. For instance, with smaller MROs the actions of the MRO's owners/directors are more significant than documentation, whereas with larger organisations the corporate culture is more prevalent and is explicitly formalised;
      b) MRO's compliance history i.e. a previously rejected new MRO applicant or suspended MRO (including its individual owners and directors) that failed on QC 1.8 would be expected to provide demonstrable evidence of fundamental change in behaviours upon re-application;

   ii. Behaving ethically e.g. in this behavioural change model (https://www.verywellmind.com/the-stages-of-change-2794868), MROs are expected to be operating at stages 4 ("action") and 5 ("maintenance"), with strategies in place to prevent stage 6 ("relapse");

   iii. Conducting business in accordance with each standard in the Ethics Policy and not conducting activities that contravene commitment to, or compliance with, it;

iv. Demonstrating that the Ethics Policy has been incorporated into its day-to-day operations e.g. 1.8(b) above and by conducting a risk assessment of its day-to-day activities against each ethical standard and setting out how it mitigates those risks or a gap analysis of its activities against each standard. By way of an example approach to a gap analysis, key characteristics include e.g.:
   a) A description in relation to each ethical standard of:
      i. The current state i.e. what is happening;
      ii. The desired state i.e. what should be happening; and
      iii. Gap i.e. difference, with the reason why it exists and the underlying root cause;
   b) The gap is classified as due to a lack of one or more of e.g.:
      i. Knowledge i.e. doesn't know;
      ii. Skill i.e. doesn't know how; and
      iii. Practice i.e. does not do.
   c) The gap is closed by the learner gaining the missing knowledge, being able to apply that knowledge and then translating that knowledge and skill into demonstrable practice, which the MRO should provide evidence of;

v. Being able to recognise and identify ethical issues. Examples of scenarios where a MRO should be alert to potential ethical issues are (not an exhaustive list) where it:
   a) Does not agree with an audit assessment that it has encountered any ethical issues or that any of its conduct is unethical. In such instances the MRO should consider sending employees and directors on a formal ethics training course;
   b) Circumvents the MedCo Portal e.g. acts upon MedCo instructions received outside the MedCo Portal or fulfils an instruction where another MRO had been selected through the MedCo Portal;
   c) Uses the knowledge and recommendations gained via MedCo's audit process as the MRO's primary means of understanding what its obligations are under the User Agreement and how to implement them in lieu of it doing this for itself and/or in lieu of paying advisors/consultants;
   d) Accepts or potentially accepts referral fees in breach of LASPO as it is not sufficiently familiar with LASPO requirements. For this purpose, MedCo takes account of the SRA's Guidance (https://www.sra.org.uk/solicitors/code-of-conduct/guidance/guidance/prohibition-of-referral-fees-in-LASPO-56-60.page) on the application of LASPO;
   e) Receives report amendment requests that affect the prognosis or prognosis period in sufficient numbers or patterns that indicate concerns about the potential for reports being amended without good cause;
   f) Stands to benefit from referral work and there is a noticeable incidence of its reports containing referral recommendations with no clear or obvious need for referral;
   g) Fails to conduct trend analysis and identify suspicious patterns of behaviour amongst its experts and/or clients' instructions;
   h) Receives reports ostensibly produced by experts but actually written by third parties (e.g. administrative agencies) as it does not have a system to ensure that experts have seen the final report; and

i) Does not report unethical behaviour by its clients to MedCo; i.e. where a solicitor has instructed the expert before sending the instruction to the MRO and the MRO allows this to occur and processes the resultant report as normal.

vi. Developing and implementing a suitable framework to evaluate its ethical decisions e.g. see sections 3 and 4 of the Brown University paper "Making Choices: A Framework for Making Ethical Decisions" – https://www.brown.edu/academics/science-and-technology-studies/sites/brown.edu.academics.science-and-technology-studies/files/uploads/Framework.pdf and then evaluating all decisions identified;

vii. Where potential actions might contravene the Ethics Policy, that these have been fully evaluated as to whether or not they breach it (see 1.8(e) below) and compliant actions taken as a result;

viii. Not breaching the minimum standards i.e. MedCo's 9 ethical standards and equivalents;

d) Material **non-compliance** with the Ethics Policy includes one or more of the following, where:
   i. The MRO's evidence of compliance is based substantially on form (e.g. policy documentation) or verbally articulated concepts rather than substance i.e. real-world application of its stated policies;
   ii. The MRO denies it has any ethical issues in the face of evidence to the contrary i.e. it is in the 1st "precontemplation" (or denial) stage of the aforementioned behavioural change model and unable to recognise ethical issues - see 1.8(c)(v) above;
   iii. The MRO admits ethical breaches, but the circumstances of its admission (e.g. only admitted once evidence of non-compliance is undeniable) is in the 2nd "contemplation" or 3rd "preparation" stages of the aforementioned behavioural change model;
   iv. The MRO demonstrates a pattern of not cooperating with the audit process.

e) Where a MRO's actions might contravene the Ethics Policy, MedCo will consider a MRO to have fully evaluated these and reached a compliant outcome if it has performed ALL of the following:

   i. Recognised ethical matters that it should have considered. Examples include:
      a) "Multiple registrations" for each and every MRO connected to one another. Failing to disclose any such connections will be considered a breach of the Ethics Policy by each MRO so connected;
      b) Business models and organisational and ownership structures that may, or be perceived to have been, designed to circumvent MoJ or MedCo objectives and QC 1.1, including:
         i. MROs under common control that do not operate independently from one another;
         ii. MROs with a common shareholder and/or director (directly or indirectly) where the nature of the relationship between the MROs is not on an arms' length competitive basis;

iii. Where a pattern of ownership, control or management structures is established in the setting up and operation of two or more MROs;
iv. "Standalone" MROs each operated/controlled by different members of the same family;
v. MROs with a similar profile in close proximity to one another; and
vi. MROs whose business has grown disproportionately rapidly since registering as High Volume National status rather than due to e.g. business competency;

c) Acquiring another MRO primarily to boost its share of instructions received; and
d) Aiding, by any means, organisations not registered with MedCo as MROs to act as, or be perceived as, MROs. MedCo will consider MROs aiding such organisations to be breaching standard 3 i.e. "should not undermine confidence in the MedCo service".

ii. Considered these matters before and not after the event, or if in place before MedCo was established then considered them before registering with MedCo.

iii. Considered these matters predominantly in ethical terms rather than in:
a) Legal terms, as it is entirely possible for an outcome to be legal, but unethical; and
b) Commercial terms, as commercial considerations do not make an unethical activity ethical.

iv. Documented:
a) The nature of the potential conflict with the Ethics Policy;
b) The actions it proposes to take to address any conflicts;
c) Plausible, rational explanations that explicitly set out how any actions it proposes to take are consistent with (i) all the MoJ's stated policy objectives; (ii) maintaining confidence in the MedCo service; and (iii) the MRO's commitment to the Ethics Policy; and
d) The names and job titles of all those involved in the final decision and dates of discussion.

1.9 - Complaints Handling Process

a) An MRO's end-to-end complaints process should:
i. Differentiate between a complaint and an enquiry. Where there is any doubt, the MRO should treat it as a complaint, whether expressed verbally or in writing;
ii. Apply to claimants, defendants/compensators (and their representatives) and to medical experts;
iii. Be appropriate to the size and nature of the MRO in terms of the volume of reports produced and resources required to support timely, effective and efficient handling of complaints;
iv. Be consistent with the principles specified in the:

a) Parliamentary and Health Service Ombudsman Principles of Good Complaints Handling (https://www.ombudsman.org.uk/about-us/our-principles/principles-good-complaint-handling); and
b) British and Irish Ombudsman Association's "Guide to Principles of Good Complaint Handling" (http://www.ombudsmanassociation.org/docs/BIOAGoodComplaintHandling.pdf);

v. Be clearly accessible to all (e.g. published on the internet);
vi. Include the compilation of statistics on the MRO's performance and root cause analysis to identify and rectify any systemic issues in the service it provides; and
vii. Be documented.

b) Evidence of complaints received, how they have been dealt with and the final outcome should be accurately documented and retained.

c) Given the importance of customer service, minimum service levels are applicable for this criterion that attest to the effective operation of the above controls in their entirety – see 1.16.

d) Where a MRO claims that it has not received any complaints, the onus will be on the MRO to demonstrate the credibility of its assertion relative to e.g. its own complaints process, business volumes (MedCo and non-MedCo), compliance with those QC instrumental in delivering a quality service and MedCo MI (e.g. complaints received about the MRO and complaints levels of its peers).

1.10 – Responsible Officer / Compliance Officer

a) MedCo considers there to be two separate roles, which in smaller MROs (e.g. 5 or less MedCo and non-MedCo FTE staff) may be less formalised (e.g. not in job description) and be combined into a single role:
i. Responsible Officer – this is an executive (core) role, accountable for the MRO's overall compliance with the QC and MRO User Agreement. This role would be expected to deal primarily with key issues (e.g. areas of potential non-compliance) that relate to MedCo.
ii. Compliance Officer – this is a management (non-core) or senior clerical role. This role is expected to be fully informed about the MoJ's publications and stated objectives for the MedCo service, the QC, MedCo's Guidance document, the MRO User Agreement and MedCo's operation. This role is responsible for:
a) Assessing whether the MRO complies with all the above requirements day-to-day;
b) Providing at least quarterly reports to the MRO's senior management and Responsible Officer on the state of compliance, for any corrective actions to be agreed; and
c) Retaining evidence of how the MRO complies with MedCo's requirements.

b) Where a MRO forms part of a larger group, the above non-core Compliance Officer role (but not the core Responsible Officer role) could be performed at a group level. In such instances,

responsibilities for MedCo compliance must be assigned to specific individuals within the group function and any group systems utilised must service the specific compliance requirements of MedCo. For example, where a MRO asserts that its MedCo risk assessments have been conducted as part of the overall group's risk assessment, this will not be considered compliant e.g. in a group context, the MRO and its associated MedCo compliance risks may not be material.

1.11 – Restriction on Providing Medical Evidence

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

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

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

1.12 – Directors and Officers

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

b) QC 1.12 strictly applies only to Directors and Officers. However the rationale for QC 1.12 makes clear the MoJ believe that those exercising control via ownership should also be of appropriate character. MROs are invited to consider similar checks as above to owners or shareholders, at the time that they invest and annually thereafter in order to ensure that they can meet the requirements of the Ethics Policy, where:
   i. The business is privately owned (whether directly, through trusts or investment funds) i.e. it is not listed, or part of a group that is listed, on the UK or overseas stock markets; and
   ii. Each individual shareholder or beneficial shareholder owns or controls in aggregate, including through related parties, at least 10% of the equity or voting rights in the MRO or entity that owns or controls the MRO.

1.13 - Direct Management of an MRO's Panel of Medical Experts

a) **Direct management** means substantive and good quality decision-making being taken by a MRO based upon information at its disposal. It does not include a MRO rubber-stamping decisions effectively made by other MROs or other third parties based on information at their disposal.

b) **Direct management** means that staff of that MRO must deal directly with a medical expert:
   i. The MRO **cannot delegate** part or all of the expert management process to:
      a) Other MROs, whether MedCo-registered or otherwise;
      b) Intermediaries, whether medical agencies, administrative agencies or other third party service providers, and whether external or fellow group companies;
      c) Administrative agencies, where the economic, legal and decision-making arrangements between the administrative company ('AC') and expert are such that in practice the administrative company is effectively in control of the relationship, with the expert acting at its direction. The onus is always on the MRO to ensure that it is not dealing with an intermediary. Examples of dealing with an intermediary include where the MRO:
         i. Outsources core MRO functions to the AC;
         ii. Sends instructions to the AC without explicitly naming the medical expert to produce the report on each occasion;
         iii. Receives and acts on requests from the AC to change which medical expert produces the report;
         iv. Enters into any agreements, contractual, performance or otherwise, with the AC on behalf of the medical expert rather than with the medical expert; and
         v. Makes payments to the AC on behalf of the medical expert.

      d) Automated software. except as set out at 1.13(b)(iii) below; and
      e) Any other arrangement that creates a disconnect between the MRO and the medical expert.

ii. The MRO **can**:
   i. If it is a RB MRO, contract a medical professional to review medico-legal reports for clinical quality.
   ii. Liaise with experts' medical secretaries and any other staff employed directly by a medical expert to:
      i. Schedule appointment slots within parameters agreed by the MRO and medical expert;
      ii. Submit reports produced by the medical expert to the MRO; and
      iii. Submit bills for work performed by the medical expert to the MRO.
   iii. Use industry-wide diary management systems so that multiple MROs can book appointments with multiple experts and experts can offer their available appointment slots to multiple MROs.

iii. **Automated functionality** may be used by a MRO to help it meet its responsibilities under the QC, provided that:
   a) The software is directly managed by the MRO i.e. it:
      i. Has been developed in-house; or
      ii. If owned or rented from a third party, the software enables the MRO to establish and maintain its own medical expert panel and set up its own access rights with medical experts to allow electronic diary access, but only once an agreed contract is confirmed as being in place directly between the MRO and individual expert – see 1.1(a)(v)(d).
   b) It enables the MRO to meet its responsibilities, but is not so extensive as to render redundant or substantially redundant the:
      i. MRO's knowledge of the QC and this Guidance;
      ii. MRO's ability to differentiate its business from other MROs using the same software; and
      iii. Exercise of the MRO's judgement and decision-making in relation to any of the MRO core functions (see 1.1(d)).
   c) The MRO alone is responsible for meeting the QC and this Guidance and not the software supplier to provide a system that does. Responsibility for any failures to meet the QC and this Guidance that result from any automated functionality used by the MRO reside wholly and exclusively with the MRO. As such, the MRO should pro-actively:
      i. Understand fully how the software works, especially any functionality to satisfy the QC. MROs are expected to be able to explain this to MedCo and its auditors upon demand without reference to the software supplier or the auditors' knowledge of IT systems;
      ii. Decide whether, in the MRO's opinion, the software satisfies the QC;
      iii. Test that the software works as stated both when implemented and whenever it is updated. Should any non-compliance occur due to software updates, the MRO is responsible;
      iv. Check that all system-generated checks run when they are supposed to;
      v. Follow up on any exceptions generated by the system; and
      vi. Retain evidence of performing the above software tests and checks.

d) Its methods for recording and retaining evidence of compliance satisfy the evidence provisions set out in the MedCo Rules:
   i. Examples of recording methods that do this include date/time stamps that record specifically who did what and when; system notes (qualitative and quantitative) added by users; documents, emails and other files added by users; and the availability of full audit trails from inputs to outputs.
   ii. Examples of recording methods that do not do this include "tick-box" checks (for one or multiple boxes), as such boxes could simply be ticked without any check actually being performed; and all recording methods where the system functionality enables the data to subsequently be amended, deleted or otherwise changed without any record as to what was changed, why and by whom.

iv. **Contractual arrangements** between an MRO and a medical expert are interpreted to be all of the following respectively:

a) They must be direct arrangements between a MRO (organisation) and a named medical expert (individual). Any other arrangement is considered to be indirect and not a relevant contractual arrangement. This includes separate back-to-back contracts between experts and platform providers and then between platform providers and MROs, where such **platform providers** may be administrative agencies and/or software providers (e.g. appointment booking or medical reporting software);

b) A terms of business ('ToB') document is considered a valid contract, with or without a SLA, where it is unambiguously signed (electronically or otherwise) and dated by both named parties and, as a minimum, the terms include (not an exhaustive list):
   i. The timescale to deliver a medical report and answers to additional questions;
   ii. Availability for appointments and types of appointments covered e.g. home visits;
   iii. Fees payable for being an expert witness and timescales for payment. No terms may be contingent on the outcome of the case in any form nor can an expect offer or provide a write-off facility (or equivalent) to a MRO;
   iv. Any mutual obligations respectively upon both the MRO and expert;
   v. The role of any third party (e.g. employed medical secretary or outsourced administrative agency) in assisting the expert to provide the medical report to the MRO;
   vi. Arrangements for data protection and confidentiality; and
   vii. Any other provisions applicable as set out in the QC and this Guidance;

c) Contractual arrangements must be open-ended i.e. a medical expert can produce reports without entering into a new ToB each time as opposed to ad hoc arrangements where a new ToB is required for each report; and

d) Whilst commercial terms are matters for MROs and medical experts to agree, the onus will be on the MRO to demonstrate that they do not work to impair the independence

of the medical expert's opinion in breach of QC 1.8 and 1.13 and that the MoJ's policies as set out in the preamble to the QC are not being undermined by its actions.

v. **Independent** means that the medical expert:
   a) Has not treated the claimant, save for as provided in the RTA Pre-Action Protocol – https://www.justice.gov.uk/courts/procedure-rules/civil/protocol/pre-action-protocol-for-low-value-personal-injury-claims-in-road-traffic-accidents-31-july-2013;
   b) Has no ownership or controlling or financial interest in whole or in part, directly or indirectly, over the MRO commissioning it or any of the commissioning MRO's directors or key management;
   c) Is not contracted by any one MRO or MRO group to either work exclusively for it or to not work as a medical expert for any other MROs / MRO groups, whether named or not; and
   d) Is not beholden to, or perceived to be beholden to, any MRO or MRO group (including parent, subsidiary, fellow group company, associate or other affiliated business) by contractual terms, contingent payments (see 1.3 – Payment of Experts) or volume of reports produced for that MRO:
      i. For instance, the rebuttable presumption will be that the expert is no longer independent of that MRO where the expert derives e.g.:
         a) All his/her annual income from medico-legal work and his/her reports for any one MRO exceed 33% of all the expert's reports pa year-on-year; or
         b) One third of his/her total annual income comes from medico-legal work for one MRO,
      ii. The onus is on the MRO to ensure report quality is maintained and that it's use of medical experts does not compromise their independence, which it can do by monitoring the volume and proportion of instructions it provides to its experts.

c) A MRO demonstrates its responsibility for **recruitment** of medical experts by:
   i. Developing and documenting a recruitment process that is robust and consistent with the objective of ensuring the provision of good quality and timely independent medical evidence, setting out e.g.:
      a) Its views as to what expert type, size, experience level (in medico-legal work) and geographical coverage of its medical expert panel it believes is appropriate for its business and why; and
      b) How, and from where, it sources medical experts. Where a MRO sources experts via platform providers, the presumption will be that the MRO is not directly managing those experts but is using third parties to perform core MRO tasks i.e. by relying upon the platform provider to liaise with experts to have the appropriate minimum documentation available on its platform for MROs to then access. The onus will be on the MRO to demonstrate to the contrary e.g. whether it conducts more than the minimum recruitment checks (see 1.13(c)(ii) below) and has an audit trail that shows it acted independently from the platform provider.
   ii. Not instructing experts until the following minimum recruitment checks have been satisfactorily completed to source data/websites i.e.:

a) GMC/HCPC registration;
b) MedCo accreditation and operational status;
c) ICO registration;
d) Insurance or indemnity cover via insurance companies or medical defence organisations that covers the expert for medico-legal work as set out by:
   i. Either the expert's professional body e.g. GMC (https://www.gmc-uk.org/registration-and-licensing/managing-your-registration/information-for-doctors-on-the-register/insurance-indemnity-and-medico-legal-support);
   ii. Or medical defence organisation membership e.g. (https://www.themdu.com/my-membership/frequently-asked-questions/legal-requirement-for-doctors-to-have-insurance-or-indemnity;
e) DBS, where minors, vulnerable patients and home visits etc. may be involved; and
f) Signed contract is in place between the MRO and the expert;

iii. In terms of best practices (not exhaustive list), uses one or more additional criteria to determine whether medical experts are suitable for its panel e.g. whether the MRO:
   a) Determines the level of good quality independent medical evidence it aims to recruit for e.g. minimum levels of post-qualification experience its experts should have obtained and particular programmes or courses they should have undertaken (if any) over and above the minimum requirement;
   b) Reviews (not just receives copies of) sample medical reports and CVs setting out medico-legal experience to compare against the above;
   c) Obtains and verifies references and, if so, they are recent and direct from referees;
   d) Checks the expert's identity;
   e) Conducts a face-to-face interview with the expert (either physical or via a video-conferencing application). This supports a direct relationship between the MRO and expert and helps prevent intermediaries insert themselves into the relationship;
   f) Where applicable, assesses the expert's experience of conducting home visits, pre-visit practices and appreciation of the additional complexities involved in assessing patients in an unfamiliar, non-clinical environment where family members may be present;
   g) Documents its rationale for accepting experts to its panel and any particular notes that may be relevant to monitoring that expert's performance going forward e.g. expert is new to the medico-legal reporting industry or has some fitness to practice concerns; and
   h) Assesses the expert's proposed venues for consultations for appropriateness and clinic availability – see 1.13(h)(ii) below.

iv. Executing the above processes and retaining evidence thereof at the point of recruitment;
v. Periodically reviewing the effectiveness of its recruitment process in the light of claimant / solicitor complaints, medical experts' performance and the MRO's internal report quality assurance activities; and
vi. Avoiding such poor practices as recruiting experts only after instructions are received or on an ad hoc basis, such that it effectively has no fixed regular panel of experts.

d) A MRO demonstrates its responsibility for **validation** by developing, documenting, executing and retaining evidence of:

i. Checks back to source documentation/websites (see 1.13(c)(ii) above) at the time of validation of:
   a) The on-going validity of the GMC / HCPC registration, MedCo operational status and ICO registration (medico-legal reporting issues to be covered in the expert's data privacy notice) of the medical experts on its panel at least monthly to identify e.g. any disciplinary matters that may affect medical experts' ability to produce credible medical reports and act accordingly.
   b) Medical experts' processes in place to ensure that they remain up-to-date on relevant medical matters e.g. attendance at MedCo events and CPD requirements introduced by MedCo.
   c) The on-going validity of the appropriate insurance policies (which must cover medico-legal reporting) and DBS certificates (where applicable) of the medical experts on its panel.

ii. Investigating promptly the reasons for a failure in the validation of any of an expert's credentials, deciding what action to take as a result and then implementing that.

e) A MRO demonstrates its responsibility for **managing** by developing, documenting and executing processes (with evidence retained) for all the functions and activities set out in paragraphs (f) – (k) below, in addition to maintaining a clearly identifiable panel of experts with dates of when experts joined and left (both temporarily and permanently).

f) A MRO has developed, documented, executed and retained evidence of its processes for**:**
   i. **Suspending** individual medical experts from its panel promptly as required e.g. for poor performance, failing any of the validation checks above and unacceptable levels of complaints;
   ii. **Removing** individual medical experts from its panel promptly as required e.g. retirement, death, emigration, cease to practice, medical registration withdrawn, MedCo accreditation expired and poor performance; and
   iii. **Reinstating** experts should it be satisfied that the issues have been addressed. Reinstating a suspended/removed expert on an instructing Party's request is not acceptable if the reason(s) for suspending/removing the expert have not been remedied.

g) A MRO has processes for conducting **Quality Assurance** on the reports it produces, (see also QC 1.1(iii)(d)). The QC refers to MROs producing medical reports of a certain **quality**. MedCo interprets this standard of quality as being that fit to be presented to a court of law and comprising both clinical and non-clinical quality aspects.

h) **Clinical quality** involves the MRO defining, documenting and implementing suitable processes that cover:
   i. Setting, implementing (e.g. via contractual requirements) and monitoring (e.g. via client satisfaction surveys) its experts' adherence to the minimum appointment time and maximum number of appointments per day standards set out by MedCo in the applicable MedCo Examination Guidelines (Published 1 October 2019), to the extent that it is practical to do so:

a) These Guidelines are aimed primarily at experts, but are also applicable to MROs to the extent that they affect how MROs and experts interact when arranging and booking appointments;
b) Where a MRO e.g. contracts with an expert to exceed these guidelines or knowingly books numbers of appointments per day that will exceed these guidelines, then the MRO should provide a rationale as to why it is appropriate and why it believes the quality of the resulting examination will not suffer as a result;

ii. The provision of suitable locations for consultations.
a) A physical (not virtual) face-to-face appointment must take place with the injured party;
b) MedCo considers that at all times the best interests of the claimant must be considered and locations must be confidential, private, safe, secure and be regarded as a professional environment.
c) Currently, MedCo considers the following venue types as examples but not an exhaustive list:
i. Best practice: Medical facilities e.g. clinics, GP practices and other medically equipped centres.
ii. Acceptable: Hotel conference / meeting rooms, offices, experts' private consulting rooms at/adjacent to their residence (equipped to an equivalent standard to medical facilities that are confidential, private, safe and secure) and home visits (eg elderly/vulnerable patients).
iii. Inappropriate: Hotel bedrooms, other offices / commercial premises, private residences and via webcams or other means whereby the medical expert is remote from the patient.
d) If in any doubt, MROs should refer medical experts back to their own regulator and published medical good practice to seek guidance;

iii. Reviewing the quality of medical reports produced by its medical experts. This should be performed by a medically qualified individual (e.g. doctor, therapist or nurse) or person specifically trained to do this through practical experience (in lieu of a medical qualification) in a medical setting by someone medically qualified. This person may be an employee (e.g. HVN MRO) or a contractor (e.g. RB MRO) and in the latter instance is the only instance of a core MRO function that may be outsourced to a third party and then only by a RB MRO.

iv. The review of medical reports should cover (not an exhaustive list) e.g.:
a) Reviews of all initial reports by newly appointed medical experts and following up any issues;
b) Periodic reviews of reports produced by its existing experts, such that all experts are covered annually and those more frequently whose reports indicate signs of concern (e.g. number of reports returned by solicitors for clinical issues, number of prognosis amendments, complaints, unusual prognosis periods, performance, volume of reports written and any ethical concerns);

c) Trend analysis for signs of potential concerns about clinical matters in panel members' reports e.g.:
   i. All injuries identified;
   ii. Length of recovery times;
   iii. Whether the injuries fall outside of the scope of the fixed cost medical report for soft tissue injury claims brought under the Pre-Action Protocol; and
   iv. The extent to which an expert has advised a claimant that he/she has no injury, taking into account e.g. the volume of reports produced for the MRO and any close relationships with Instructing Parties (e.g. where the Instructing Party instructs the MRO to use the expert);
d) Whether the expert spent sufficient time examining the patient. This should take account of patient specific circumstances such as injuries, language barriers and vulnerability;
e) Whether medical records (including GP, ambulance and hospital) should have been obtained and reviewed by the expert;
f) Whether the expert's reports present as being "factory produced" rather than specific to the claimant e.g. key details around clinical matters exhibit:
   i. Significant "copying and pasting";
   ii. Standard prognoses;
   iii. Broad, vague and non-specific timescales and explanations;
g) Examples of potential clinical concerns in addition to the above include (not an exhaustive list):
   i. Opinion and prognosis is based predominantly upon the claimant's account of events rather than a physical examination and factual records;
   ii. Physical appointment occurs, but involves only an insufficient, cursory or no physical examination;
   iii. Onset of symptoms for the injury is vague or unclear;
   iv. Absence of a mechanism of injury being described;
   v. Inconsistent findings e.g. examination is normal but psychological issues are described;
   vi. Relevance of health factors to the accident is unclear;
   vii. Report contains inconsistent treatment behaviour by claimant and/or recommendation by expert;
   viii. Whether any recommended treatments are unnecessary;
   ix. Justification for referral to one or more specialists is unclear;
   x. Explanations are not provided, insufficient or not plausible. This is especially so where prognosis periods are extended;
   xi. Opinion and prognosis are not provided for all injuries relevant to the accident;
   xii. Report omits facts that do not support the expert's opinion; and
   xiii. Commenting on matters beyond the scope of the medical expert's expertise.
h) State who conducted the review, what was reviewed and the results of the review:
   i. The use of "tick-boxes", "yes/no" responses and standardised review comments are indicative of a lack of scrutiny of the reports.

ii. Better quality reviews would results in qualitative comments on positive and negative aspects of the report with reasons for such views tailored to the expert and claimant's situation. These could also be learning points for the expert's benefit.

i) Feedback to the expert where concerns have been identified, with retained evidence of this dialogue including the expert response(s), outcomes, any agreed follow up action undertaken as a result and ongoing monitoring. Where a MRO claims that it has not identified any concerns that warrant this feedback, the onus will be on the MRO to demonstrate the credibility of its assertion relative to e.g. its own QA processes, business volumes, compliance with those QC instrumental in delivering a quality service, complaints and MedCo MI.

v. Where a MRO operates both its recruitment and Clinical QA processes to the absolute minimum standards, both processes have to be fully operational in all respects and all elements performed consistently to a high standard in order to meet the minimum standards for quality per the QC.

vi. In terms of best practices (not exhaustive list):

a) Understanding and approving each individual expert's process for conducting the physical examination and producing the medical report, including the use of any tools e.g. questionnaires and report writing software, to identify potential systemic issues affecting report quality upfront. For instance, whether an expert's medical notes are likely to be sufficient to support the medical report and, in particular, any subsequent amendments to it especially those relating to the prognosis and prognosis periods;

b) Providing support to medical experts e.g. where the expert:

i. Has a less common event e.g. a home visit, vulnerable adult, minor or translator is involved;

ii. Believes the claimant has been coached or his/her statements lack integrity;

iii. Feels pressured to provide a particular prognosis; and

iv. The claimant (and/or expert) wishes to record (audially and/or visually) the consultation.

c) Periodically interacting with experts directly i.e. face-to-face and/or via telephone. Where communication between the MRO and an expert is entirely indirect e.g. via post, email, online messaging apps or third parties (medical secretaries, administrative agencies or platforms), the MRO cannot be certain whether it is managing the expert directly or via intermediaries. The onus is on the MRO to ensure that it is managing its experts directly at all times.

vii. Its CMO. A MRO may appoint an employee or an external third party as its Chief Medical Officer and it may select its CMO and suitably qualified internal staff as medical experts to produce medical reports for it where:

a) The individual concerned:

i. Satisfies all the requirements, just as any other medical expert on the MRO's panel;

ii. Has a clearly defined time allocation to spend performing his/her role for the MRO as well as that of a medical expert e.g. 60% as Chief Medical Officer and 40% as a

medical expert. It will not usually be acceptable for the individual to be producing reports for the same MRO as they are the CMO for, save in circumstances where there are adequate substantive provisions in place to check the quality of the reports prepared by the CMO;

iii. Has no ownership or controlling or other financial interest in whole or in part, directly or indirectly, over the MRO or any of the MRO's directors or key management; and

iv. Has clearly defined roles and responsibilities in respect of his/her role for the MRO as a CMO and that of a medical expert; and

b) The MRO:

i. Has appropriate processes in place to manage any conflicts of interest e.g. the CMO or suitably qualified internal staff cannot be involved with (or perceived to be able to influence) in any way a complaint or internal quality review matter related to any medical report that he/she has produced;

a) Further, whoever is performing such roles in lieu of the "normal" MRO employee has to have sufficient status within the MRO to perform these roles effectively; and

ii. Is not owned or controlled in whole or in part, directly or indirectly, by any medical expert producing reports for it. In such circumstances, the MRO is judged incapable of putting in place sufficient safeguards to mitigate any conflicts of interest due to the medical expert's actual or perceived degree of control or influence over the MRO's actions or inactions.

i) **Non-clinical quality** involves the MRO defining, documenting, implementing and retaining evidence of suitable processes that cover:

i. At least the minimum standard of quality assurance e.g.:

a) Its staff should be sufficiently trained to conduct the minimum non-clinical checks effectively – see 1.1(b)(i)(f);

b) Checking that each report meets the following minimum standards/requirements:

i. Completeness and accuracy of basic information e.g. names, addresses, dates of birth, accident date, MedCo reference, solicitor's reference and precise examination location;

ii. Expert has checked the claimant's identification, noting the official document type and (ideally) its number;

iii. Expert's description of the claimant's occupation is not vague e.g. "worker";

iv. Part 35 (Experts and Assessors) of the Civil Procedure Rules (https://www.justice.gov.uk/courts/procedure-rules/civil/rules/part35) and its associated Practice Direction (https://www.justice.gov.uk/courts/procedure-rules/civil/rules/part35/pd_part35) in particular all the items listed out in Para 3 "Form and Content of an Expert's Report" of the latter;

v. States the source of statements of fact that are relied upon;

vi. States whether the report is provisional;
vii. Where a third party is in attendance (e.g. a translator or McKenzie friend), states the name of the individual attending and employer – the latter only if the firm features on the claim;
viii. Sets out any assumptions made;
ix. Sets out any calculations made ;
x. Whether all key documents were provided to the expert;
xi. Language does not advocate for the instructing party; and
xii. **Overall style, size and tone of report is "more focused on analysis and opinion than history and narrative. In short, expert reports must be succinct, focused and analytical. But they must also be evidence-based."**;

c) The MRO should retain suitable evidence that for each report the minimum checks/requirements (above) have been performed and the outcomes noted, with the results feeding into any monitoring checks it performs (below).

d) Trend analysis for signs of potential concerns about non-clinical matters regarding existing panel members' reports e.g. number of reports returned per expert or per type of issue/error. Anomalies or concerns should be investigated;

ii. Monitoring the levels of reports the MRO returns to experts for correction due to inaccuracies, omissions or other queries identified during its review process. Where a MRO claims that it has not returned any reports to medical experts for amendment, the onus will be on the MRO to demonstrate the credibility of its assertion relative to e.g. its own QA processes, business volumes, compliance with those QC instrumental in delivering a quality service, complaints and MedCo MI;

iii. Monitoring the levels of reports solicitors return to the MRO for correction of non-clinical matters, which solicitors identified during their checking processes; and

iv. Those elements consistent with a higher level of quality assurance that the MRO may provide e.g.:
a) Independently checking (e.g. by management or more senior/experienced MRO staff) that the MRO's day-to-day non-clinical QA work is effective;
b) Checking the MRO's own performance and expert SLA requirements e.g. turnaround times;
c) Mechanism to identify and refer any reports of concern to the CMO (or whoever performs the Clinical QA function) for review;
d) Extending QA to cover supplemental and addendum reports; and
e) Continuous improvement such as root cause analysis to identify why the MRO didn't identify report errors that solicitors subsequently identified.

j) Effective **appointment capacity** monitoring and planning, (see also QC 1.1(iii)(c)), so that it has sufficient availability of appointment slots with medical experts to deal with all instructions received:
   i. Planning strategies can range from being fully planned e.g. block-booking of appointment slots in advance to fully ad hoc i.e. contact medical experts for availability as and when needed;
   ii. Capacity planning conducted on an ad hoc basis is more suited to smaller RB MROs, whilst block booking in advance is more suited to HVN MROs (see 2.2.2(a)); and
   iii. Capacity planning should allow for lost appointments e.g. "no shows" and cancellations.

k) **Geographical** planning, so that:
   i. Instructing parties have a credible selection choice from the MROs presented by the MedCo Portal to service an instruction i.e.:
      a) Demonstrable engagement in each postcode area claimed e.g. the MRO has a track record of activity in the postcode area and does not service it solely on an adhoc and reactive basis.
      b) Having a website and a presence on the MedCo Portal constitute passive marketing and neither is considered to be demonstrable engagement.

   ii. It has sufficient numbers of medical experts operating consulting rooms in the geographical regions that it purports to serve (and does not claim coverage otherwise), to:
      a) Provide sufficient choice and convenience of appointment slots for the claimant;
      b) Offer a quality service in terms of venue, length of appointment and dependability; and
      c) Avoid any need to stockpile instructions (stockpiling occurs where a clinic is only scheduled when a MRO has enough instructions to make it financially viable); and

   iii. Population density differences are accounted for between urban and rural areas i.e. one medical expert may constitute sufficient coverage for a low density rural location but not for a high density major metropolitan area. MedCo assesses population density by postcode area using the Office for National Statistics' ('ONS') usual resident population density measure (persons per hectare) and considers densities of 4.0 and below as rural postcode areas. Population densities by postcode area are set out in Appendix 2.

   iv. A MRO can claim geographical coverage in a postcode area (see 2.2.3 (a)) where:
      a) The MRO has sufficient medical experts under contract to service the demand in that area i.e. 3 per urban postcode area and 1 per rural postcode area;
      b) Each expert above produces at least one report from one or more venues within that postcode area year-on-year:
         i. A venue is a **practicing address** as defined in the MedCo Rules;
         ii. Where a MRO expands into a new postcode area, this provision does not apply during the first 12 months from when it first claimed coverage on the MedCo Portal;
      c) By definition, a RB MRO should rarely be in a position to provide national coverage

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

1.15 – Upload Anonymised Case Data

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

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

c) Where a MRO has already uploaded case data to the MedCo Portal on the basis that it believed it to be final, but an amended or addendum report has been produced subsequently, then:
   i. If the nature of the change has absolutely no substantive effect (e.g. corrects errors of spelling, grammar, administrative data (e.g. address or reference numbers) or semantics (e.g. substitutes "personal assistant" for "secretary")), then the case data previously submitted to the MedCo Portal is considered the **final** report for calculating SLA7 and not the amended or addendum report data.
   ii. If the nature of the change relates to the prognosis, prognosis period or other information that might reasonably affect an assessment of the damages a claimant is entitled to (e.g. significant change in job description, accident circumstances, identity check not performed), then the amended or addendum report is considered the **final** report for calculating SLA7.
   iii. If in doubt, the amended or addendum report is considered the **final** report for calculating SLA7.

1.16 – Minimum Standards and Service Levels as Set by MedCo

a) The minimum standards and service levels for a Regional-Based MRO are set out at Appendix 1, all of which have to be met to satisfy this criterion, and are grouped into the following five areas:
   i. Efficiency, so that claimants receive their reports on a timely basis;

ii. Customer service so that claimants are treated fairly and appropriately;
iii. Quality, so that MROs perform their quality assurance role effectively over medical experts and claimants receive a fair and accurate report;
iv. Data security, so that claimants' sensitive personal data is adequately protected at all times; and
v. MedCo compliance, to ensure that areas of deficiency are addressed promptly.

b) For clarity, these standards and service levels do not represent good or best practice, but acceptable practice for an organisation to operate as a RB MRO and still be registered with MedCo:
   i. Any RB MRO looking to deliver good or best practice should aim to exceed these standards and service levels e.g. by aspiring to those for HVN MROs; and
   ii. Monitoring performance against the SLAs on a monthly basis would be considered acceptable practice.

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

d) The provisions at 1.13(b)(iii) on the use of automated functionality and the MRO's responsibilities are applicable.

e) The appropriate bases to calculate SLAs 1 and 2 are illustrated by the worked example below, based on 10 cases with the following characteristics:
   i. 7 cases with no valid delay requested by solicitors: 4 within SLA and 3 outside SLA;
   ii. 3 cases with a valid delay requested by solicitors: 1 within SLA and 2 outside SLA; and
   iii. SLA days is a variable, depending upon SLA number and whether part (a) or (b) of the SLA.

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

Table 2 – Additional Qualifying Criteria

a) MedCo considers that the overriding requirement for a MRO applying for High Volume National ('HVN') status is that it is genuinely capable of acting at that level to the expected quality standards both in the spirit and letter of the QC. The sections that follow set out further guidance, definitions and clarifications as to the letter and spirit of the Table 2 QC, as interpreted by MedCo.

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

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

2.1 – Trading History

a) **Trading history, confidence in the MRO's sustainability** and **demonstrable record of delivery** are interpreted as follows, the MRO has:
   i. Audited financial statements where the signed Auditor's opinion on these is "unqualified". In the absence of this, the MRO is not considered sufficiently large or credible to operate at HVN level. Any RB MRO aspiring to HVN status that meets the exemption requirements for statutory audits should arrange with its external auditor for a statutory audit to be undertaken and the issued audited accounts to be available as part of its MedCo re-categorisation audit;
   ii. Turnover based on delivery of either 40,000 medical reports of any type or, if less than that, the number the MRO uses to satisfy the capacity element of criterion 2.2 (Operational Capability);
   iii. A track record of profitability i.e. profit before tax and margins;
   iv. Material net assets (i.e. all assets less current liabilities) to demonstrate solvency; and
   v. Positive cash flow (i.e. cash less overdrafts / bank loans) to demonstrate solvency and longevity.

2.2 – Operational Capability

2.2.1 – Capacity

a) **Unlinked source** means an entity with no direct financial links to the MRO.

b) A MRO automatically meets the capacity requirement if it has physically produced at least 40,000 medical reports pa in any one continuous 12 month period in the previous 4 continuous calendar years.

c) For a MRO that has not previously produced 40,000 MedCo and non-MedCo independent medico-legal reports, letters of support from Instructing Parties can provide relevant and substantive evidence of the MRO' s ability to meet this capacity as long as they:
   i. Are authentic i.e. from a named individual at a sufficient level of seniority, who can clearly be attributed to the Instructing Party e.g. letter is on the firm's original headed notepaper;
   ii. Quantify the additional volume of instructions they would look to provide the MRO should it attain HVN status. This additional volume can cover MedCo and non-MedCo instructions; and
   iii. Explain the rationale for their support, which is consistent with the other evidence provided by the MRO and MedCo's understanding of the Instructing Party's MedCo business based on the MI it has submitted to MedCo.

d) For a MRO that has not previously produced 40,000 MedCo and non-MedCo independent medico-legal reports and does not have sufficient evidence of supporting letters, its **business strategy** means a written, comprehensive and credible business plan of a standard suitable for a MRO to use to apply for a bank loan from any high street bank or equivalent. This business plan must address specifically:

i. The MRO's plan to achieve HVN status, demonstrating how its past actions and achievements are consistent with this aim and what its future plans are to realise this. MedCo is likely to consider plans as being more credible where they are:
   a) Specific rather than generic e.g. tangible actions with owners and deadline dates;
   b) Indicative of a medium-long term business view rather than being short-term or opportunist i.e. where the plan for the next 12 month horizon is an integral part of a longer term strategy that has already realised the development of the MRO from e.g. inception / a small MRO to e.g. a medium / large RB MRO; and
   c) Forward-looking rather than backward-looking i.e. past performance is relevant only in the context of how that enables future performance;

ii. Any inorganic growth strategies e.g. acquisitions of MedCo and/or non-MedCo medico legal businesses (see 1.1(e)(i)(c));

iii. Growth in its MedCo and non-MedCo businesses;

iv. The growth required to consistently produce 40,000 medical reports pa from its current position. The focus is not growth in numbers of reports per se, but the rate of growth as that is integral to managing capacity, which tends to be implemented successfully through a series of step changes rather than linearly. The plan should cover recognition of these step changes and how each would be managed. The greater the capacity gap between 40,000 reports and the current state, the more challenging capacity management becomes, which should be reflected in the plan;

v. How that growth will arise i.e. why claimant representatives would select it over other MROs in the required additional volumes (reductions in the number of HVN MROs is not a valid explanation, as the MRO has no knowledge of potential additions to HVN status). This supports credibility of the above capacity management plan and requires:
   a) Analysis of its current and proposed customer base;
   b) Including in its capacity calculations the investments it will need to make to encourage Users to select it more often, based on recognition that simply by being registered as a HVN MRO does not guarantee it will receive new instructions – only that it will be presented more frequently. Examples of factors to consider include:
      i. Analysis of its competitive position relative to peers, both HVNs and RBs; and
      ii. Having a clear, unique selling proposition.

vi. Its historic growth rate; and

vii. That its **operational functions** (see para below) are sufficiently robust and scalable per QC 2.2 (bullet 1, subsection ii), which MedCo assesses in terms of performance against the MedCo SLAs (see 2.2.5) and MoJ SLAs (see 2.2.3).

e) Demonstrating that **operational functions** are sufficiently robust and scalable involves the MRO:
   i. Already performing or having performed within the past 4 calendar years at levels:
      a) Either substantially above a combined volume of MedCo and non-MedCo reports at 4,000 per annum (10% of the HVN requirement), below which MedCo deems it unrealistic for a MRO to be able to meet the Additional QC or for it to be viable to conduct an audit;
      b) Or at the upper end of the MedCo RB spectrum typically in the top 20% of all HVN and RB MROs in terms of the number of MedCo medical reports it produces per annum (published on the MedCo website);
         i. Should a MRO with HVN status subsequently perform at a level outside the top 20% of all HVN and RB MROs in at least 2 of the previous 3 years, it would suggest that it no longer has the means to operate at HVN level and RB status may be more appropriate;
   ii. Performing a gap analysis on the structures / resources used by MROs producing significantly more reports per annum than it does, to identify any significant improvements it needs to make. MedCo considers that step changes in resources are required at certain report volume levels, so straight line scaling up of existing resources is not considered to be sufficiently robust;
   iii. Producing resourcing and appointment capacity plans that set out, with rationale and supporting calculations, the additional resources it requires (consistent with 1.1, definition of a MRO) and when to produce at least 40,000 medical reports pa of sufficient quality within the next 12 months;
   iv. Demonstrating that it can achieve the HVN SLAs within 12 months, through e.g.:
      a) Meeting the MedCo SLAs comfortably and consistently at its current level of volumes, to give confidence that it can maintain these levels if volumes were to sharply increase; and
      b) New or spare capacity within the existing teams / systems to maintain these standards at higher volumes, including any stress testing that the MRO has conducted.

f) Where a HVN MRO shares any of its resources with any other MRO, the presumption will be that its capacity to operate to HVN levels/standards has been compromised. The onus will be on the HVN MRO to demonstrate the presumption to be incorrect for each resource shared and that its behaviour and relations with the other MROs is compliant with the other QC e.g. 1.1 (Definition of MRO) and 1.8 (Ethics Policy).

2.2.2 – Medical Experts

a) **Contractual arrangements** between an MRO and a medical expert for the purposes of assessing HVN status are interpreted to be those which meet 1.13(b)(iv) and the **appointment capacity** provisions at 1.13(j) including the following additional provisions:
   i. Arrangements must be such that MROs should be able to secure a medical expert's capacity in terms of available appointment slots on a forward basis, en bloc, and not be in a position of having to contact medical experts to find available appointments only once an instruction is received; and
   ii. For RB MROs aspiring to HVN status, where instruction volumes are insufficient for them to secure large scale block booking arrangements with experts, they should be able to demonstrate an ability to forward plan and manage adequate appointment capacity on a c.3 month horizon such that they meet all the MedCo efficiency SLAs (see Appendix 1).

b) A MedCo-accredited medical expert is considered to be **active** for the purposes of assessing HVN status where all of the following are met:
   i. There is an on-going relationship between the MRO and medical expert demonstrable through the nature of their interaction, the MRO's regular use of that expert and his/her contribution to the MRO's SLAs in respect of efficiency, customer service and quality;

   ii. **Regular use** is where each MedCo-accredited expert produces for the MRO on average:
      a) At least 16 MedCo and non-MedCo medical reports pa, where the expert is either a generalist (e.g. GP) or services an urban area;
      b) At least 4 MedCo and non-MedCo medical reports pa, where the expert is either a specialist (e.g. Orthopaedic consultant) or services a rural area;
      c) The above minimum report numbers:
         i. Are pro-rated only to reflect the time that medical experts are on a MRO's expert panel during the year, to take account of on-going changes made by the MRO to its panel;
         ii. Are considered on up to a three year horizon to allow for fluctuations in instructions year-to-year provided an expert produces at least one report in each year (e.g. an urban GP producing 20, 10 and 18 reports for the same MRO over 3 consecutive years constitutes regular use by that MRO); and
      d) The average number of medical reports possible per medical expert pa is 160, based on 250 medical experts producing 40,000 medical reports. This enables MROs to direct more work to, in their view, better performing experts.

   iii. Where medical experts produce fewer medical reports pa than is considered to be regular use (above), these medical experts do not count towards the 250 metric. This is to prevent MROs establishing contracts with medical experts in a largely nominal capacity i.e. they are on its panel primarily to boost the MRO's numbers of medical experts but, in practice, do not form part of its day-to-day business.

c) All the above requirements apply in full to a RB MRO applying for HVN status on the basis that it has not produced 40,000 medical reports historically, but has capacity to operate at HVN levels.

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

2.2.3 – MoJ SLAs on National Coverage

a) MedCo interprets **postcodes** using the Royal Mail postcode format and defines "**postcode**" as the postcode area (first two letters of the postcode), of which there are c.105 in England and Wales, and not the postcode district or any other smaller zone.

b) An MRO meets the first MoJ National Coverage requirement (80% of the postcodes), where in 80% of the 105 postcode areas it has 1 contracted **active** MedCo operational medical expert with a fixed consulting room/practicing address in that postcode area. Factors indicative of a fixed consulting room/practicing address for HVNs (as opposed to regional-based MROs / Tier 2s) include, but are not limited to, it being used as a clinic (i.e. the expert holding consecutive appointments in the same consulting room) and the clinic being:
   i. Consistently held at the same time and place;
   ii. Frequently held e.g. daily, weekly or fortnightly for an urban postcode area and fortnightly or monthly for a rural postcode area;
   iii. Available for MedCo and non-MedCo medico-legal appointments for one or more MROs / instructing parties); and
   iv. Of such duration that an expert could not hold more than 2 clinics (i.e. at different locations) per day.

c) When calculating the distance the injured party has to travel to attend an appointment with a medical expert, this should be measured from the full post code of the injured party's residential address (which could be a prison or hospital) to the full postcode of the medical expert's consulting rooms, using actual travel distances injured parties may use e.g. public highways measured via e.g. Google maps and not on a theoretical basis e.g. "as the crow flies".
   i. If the injured party prefers to see the medical expert closes to his/her work address, the work postcode may be used instead of the residential address.

d) Both metrics apply in full to a RB MRO applying for HVN status on the basis that it has not produced 40,000 medical reports historically, but has capacity to operate at HVN levels.

2.2.4 – Clients

a) **Clients** are interpreted to be regular customers of the MRO i.e. a claimant representative or defendants/compensators or their representatives that have a contract with the MRO and submit at least 100 instructions pa to the MRO covering any type of medico-legal report:
   i. Occasional or transactional (i.e. no on-going relationship) buyers of the MRO's services are not considered to be clients.
   ii. A claimant representative firm for an in-house MRO is considered to be a client.

b) **Total instruction volume** includes all types of medico-legal reports produced by the MRO, whether soft tissue injury only or not, initial or follow-up reports, produced for clients or occasional / transactional buyers and whether for in-house MROs or not.

c) The 40% threshold applies to 12 months' data measured on a rolling monthly basis, so a MRO may be below the 40% threshold at a given point in time, but if it has exceeded it repeatedly during the year (i.e. on more than 3 occasions within a 6 month period), it has breached this criterion on numerous occasions also. Where there is more than one entity that instructs an MRO within a group of companies, the 40% threshold applies to the aggregate instructions made by the group.

d) Where a MRO remains in-house to a firm of claimant representatives and it is used by the latter for follow-up medical reports, the in-principle use of the in-house is considered to constitute multiple ethical concerns (see 1.8, Ethics Policy) and the onus is on the MRO to demonstrate to the contrary.

e) All the above requirements apply in full to a RB MRO applying for HVN status on the basis that it has not produced 40,000 medical reports historically, but has capacity to operate at HVN levels.

2.2.5 – Service Level Agreements

a) MedCo considers that the SLAs set out at Appendix 1, which include key definitions, relevant thresholds and notes are the minimum service standards for a high volume national MRO.

b) The SLAs, all of which have to be met to satisfy this criterion, are grouped into five areas:
   i. Efficiency, so that claimants receive their reports on a timely basis;
   ii. Customer service so that claimants are treated fairly and appropriately;
   iii. Quality, so that MROs perform their quality assurance role effectively over medical experts and claimants receive a fair and accurate report;
   iv. Data security, so that claimants' sensitive personal data is adequately protected at all times; and
   v. MedCo compliance, to ensure that areas of deficiency are addressed promptly

c) For clarity, these standards and service levels do not represent good or best practice, but acceptable practice for an organisation to operate at as a HVN MRO.
   i. Any HVN MRO looking to deliver good or best practice should aim to exceed these standards and service levels.
   ii. Monitoring performance against the SLAs on a monthly basis would be considered the minimum needed.

d) All the above requirements apply in full to a RB MRO applying for HVN status on the basis that it has not produced 40,000 medical reports historically. On this basis, it has to demonstrate that within 12 months it can sustain these operating levels at report volumes of at least 40,000 e.g. by:
   i. Meeting all the HVN SLAs in full at its current volumes, without relying on tolerance levels to "pass", on the basis that the SLAs are easier to meet with lower volumes of reports;
   ii. Conducting stress testing on the MRO's performance of these SLAs to assess how robust the MRO is at operating at its current volumes; and
   iii. Identifying and implementing plans to obtain new or utilise spare capacity within the existing teams / systems to maintain these standards at higher volumes.

2.3 – Financial Instrument

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

2.4 – Disaster Recovery Plan / Business Continuity Plan

a) MedCo considers the scope of the **disaster recovery plan** (DRP) as being limited to the IT systems and data but the **business continuity plan** (BCP) as applicable to the entire organisation.
   i. **Normal operation** is considered as being able to operate at the same volumes and standards as it was immediately prior to the DRP or BCP event.
   ii. **Testing schedule** incorporates annual tests of both the DRP and BCP with records retained of the testing performed, the results (in summary and detail) and any actions taken as a result.

2.5 – Chief Medical Officer

a) MedCo considers this to be an important indicator of a HVN MRO's ability to deliver medical reports at high volume to the required quality standards under criterion 1.13 (Direct Manage Medical Experts) and to the required SLAs under criterion 2.2 (Operational Capability). As

such, should this role not exist or operate only on a nominal basis, MedCo will consider this prima facie evidence that the MRO may not meet these two criteria.

b) Whether a MRO's Chief Medical Officer can also act as a medical expert is considered at QC 1.13.

2.6 – Caldicott Guardian

The same principle applies as for criterion 2.5 above, except in respect of information security rather than managing medical experts i.e. criterion 1.6 instead of criterion 1.13.

APPENDIX 1: MINIMUM SERVICE STANDARDS FOR MROs

No.	Minimum Service Level	High Volume National (HVN) MRO		Regional Based (RB) MRO	
		Standard (note ii)	% Met	Standard (note ii)	% Met
Efficiency (so that claimants receive their reports on a timely basis)					
0	Concerning the booking (as opposed to actual occurrence) of first appointments with a medical expert: a) Elapsed time from instructions being received to the date the MRO formally arranged first appointment b) Proportion of first appointments re-arranged (having been booked without any client contact)	Within 3 business days Less than 5%	90 100	Within 3 business days Less than 5%	90 100
1	Elapsed time from instructions being received to date of actual appointment (see note i): a) In all instances (includes e.g. “do not attends”, reschedules, “no shows”/abandoned & requested delays) b) Excluding instances where solicitors / claimants specifically request a delay in appointment	25 business days 20 business days	90 90	- -	- -
2	Overall case lifecycle from instruction received to first report despatched to solicitor / claimant (see note i): a) In all instances (includes e.g. all in SLA 1(a) above and where supplemental report required) b) Excluding instances where solicitors / claimants specifically request a delay in appointment	35 business days 25 business days	90 90	35 business days 25 business days	80 80
3	Expert response to concerns about original first report content raised within 6 months of it being issued: a) Proportion of reports returned by Instructing Parties requiring re-work related to SLAs 6 and 8, resulting in an amendment to the report or any addendum/supplement that is not a 2nd report b) Length of time to resolve queries / despatch any re-worked report to solicitor / claimant, whether the query relates to the QC or not	Less than 8% 15 business days	100 90	Less than 15% 15 business days	100 90

No.	Minimum Service Level	High Volume National (HVN) MRO		Regional Based (RB) MRO	
		Standard (note ii)	% Met	Standard (note ii)	% Met
Customer Service (so that claimants are treated fairly and appropriately)					
4	Elapsed time from receipt of solicitor / claimant / medical expert enquiry (not complaint) to final response made / despatched by MRO in respect of enquiries received via: a) Telephone b) In writing or email	 24 hours 48 hours	 90 90	 - -	 - -
5	Elapsed time from receipt of complaint (by parties below) to final resolution agreed by MRO, for complaints made by (see note iii): a) Solicitors or claimants b) Medical experts	 20 business days 20 business days	 90 90	 20 business days 20 business days	 90 90
Quality (so that MROs perform their quality assurance role effectively over medical experts and claimants receive a fair and accurate report)					
6	Proportion of medical reports produced by the MRO per annum that meet all the minimum non-clinical quality report standards as set out at 1.13(i)(i)(b)	95%	100	90%	100
7	Elapsed time from despatch of **final** medical report to solicitor / claimant to uploading DPA-compliant, anonymised full medical and management case data to the MedCo Portal. **NB. SLA7 equates to QC 1.15** • Final medical report means the first report or amended report, where an amendment request is received within 20 business days of the first report being issued	30 calendar days	100	30 calendar days	100
8	Proportion of medical reports produced by the MRO per annum that: a) Have been reviewed against all the clinical quality report standards as set out at 1.13(h)(iii), with the volume for review determined by the method of selection e.g. random or targeted at quality risks b) The MRO returned to experts for amendment (for not meeting the above) prior to being initially despatched to solicitors/claimants	 Targeted: >2% Or Random: >5% Less than 5% of those reviewed	 100 100	 Targeted: >2% Or Random: >5% -	 100 -

No.	Minimum Service Level	High Volume National (HVN) MRO		Regional Based (RB) MRO	
		Standard (note ii)	% Met	Standard (note ii)	% Met
Data Security (so that claimants' sensitive personal data is adequately protected at all times)					
9	An ISO27001 (Information Security) certification is in force or in progress, whose scope includes the entire MRO; where the risk assessment is commensurate with the processing of highly sensitive personal data (medical records); and the ISO Assessor finds that performance is: a) Number of major non-conformities found at MRO b) Number of minor non-conformities found at MRO	 Zero Less than 5	 100 100	 - -	 - -
10	a) The number of MedCo-related cases where personal data has been inappropriately disclosed in any 12 month period does not exceed (see note iii): b) Elapsed time from reporting breach (to ICO and/or individual as appropriate) since becoming aware of it	 0.05% of cases 72 hours	 100 90	 0.1% of cases 72 hours	 100 90

MedCo Compliance					
11	Number of audit recommendations rated either Red or Amber that have not been given the status of "closed – implemented" by the MedCo Audit Team within 6 months of the final audit report being issued	Zero	100	1	100
12	Number of breaches of MedCo's User Agreement (including individual ethical standards) made collectively by the MRO and its individual shareholders and directors in any capacity under any MedCo registration that the MRO either did not identify or act upon as required by 1.8 cumulatively in the last 24 months *Note:* *a) Any ethical breaches identified by the MRO and satisfactorily addressed by it, as set out in 1.8, do not need to be included within the calculation of this SLA.* *b) A breach period is 3 months i.e. if the same breach continues unidentified or not acted upon over a 6 month period, it constitutes 2 ethical breaches for the purposes of this SLA, not 1. This ensures that MROs are encouraged to promptly address any issues that arise, even where belatedly.*	1	100	2	100

No.	Minimum Service Level	High Volume National (HVN) MRO		Regional Based (RB) MRO	
		Standard	% Met	Standard	% Met
Definitions Applicable to These SLAs					
a	"Instructions" and "reports" relate to the first fixed cost medical report for a soft tissue injury claim as defined in the Pre-Action Protocol for Low Value Personal Injury in Road Traffic Accidents from 31 July 2013 only. All other types of report should be excluded in measuring performance against these SLAs.				
b	"High volume" is calculated based on the number of reports produced per annum by each MRO, where all MROs (whether classified as HVN or RB) are ranked by MedCo in descending order of number of reports produced. High volume is defined as being within the top 20% by volume.	Bottom of the top 20% of all MROs (HVN and RB)		No minimum volume applies	
c	The above service standards have to be sustainable over a period of time rather than be achievable only at a point in time. The minimum period of sustainability is defined as:	12 months on a continuous basis		As HVN, but waived during first 12 months' trading	
d	When assessing a MRO's performance against these service standards, no reports or related data can be excluded from the period under consideration for any reason. • If any information needed to produce the service level standards is not available, lost or compromised, the residual information available will be considered incomplete and the MRO will be deemed to have failed to meet each service standard affected. • Sampling of the available data is not considered an acceptable alternative.				

Notes to the SLAs	

i	• Where a MRO can **demonstrate** that it meets part (b) of the SLA but not part (a) due specifically to a high level of Instructing Party requests to delay booking appointments to enable the injuries sustained to manifest themselves, it may be deemed to meet the SLA. MedCo however will consider the circumstances of each case.
	• Exclusions means the following situations which the MRO can demonstrate with evidence:
	  • Cases where the delay occurred at the instruction phase of the case; was specifically requested by solicitor or claimant; and the delay reduced the window of instruction by 14 days or more.
	  • Liability becomes contested and the solicitor requests the case be put on hold despite an appointment having been arranged.
	  • The Claimant declines an appointment where all of the following apply: The Claimant was offered at least 3 appointents (on separate days); the distance to travel to all 3 appointments was less than 20 miles by road; and the appointment times offered suited any parameters requested by the Claimant e.g. available times.
	  • The Claimant is ill on the Appointment Date and an alternative must be scheduled post recovery, where the post recovery time requires a fit note or equivalent.
	  • The Claimant requests an alternative venue and date, as a result of work commitments.

ii	The standards do not represent average measures, but **actual** measures.

iii	MRO assertions that no complaints or data breaches have arisen will only be accepted where the MRO can **demonstrate** robust processes to identify and capture these.

APPENDIX 2: URBAN/RURAL POSTCODE AREAS

MedCo assesses urban and rural postcode areas using the Office for National Statistics (ONS) usual resident population density measure persons per hectare ('PPH'). The data below is from the 2011 census where postcode areas with PPH densities of 4.0 and below (highlighted in amber) are considered rural.

Postcode Area	Density (PPH)	Postcode Area	Density (PPH)	Postcode Area	Density (PPH)
AL - St Albans	8.1	HD – Huddersfield	8.0	RM - Romford	17.7
B - Birmingham	14.7	HG – Harrogate	1.5	S - Sheffield	7.4
BA – Bath	2.4	HP - Hemel Hempstead	4.9	SA - Swansea	1.3
BB - Blackburn	4.9	HR – Hereford	0.9	SE - London SE	73.8
BD - Bradford	4.4	HU – Hull	4.7	SG - Stevenage	3.1
BH - Bournemouth	5.7	HX - Halifax	5.5	SK - Stockport	5.2
BL – Bolton	12.5	IG – Ilford	36.2	SL - Slough	9.0
BN - Brighton	7.3	IP - Ipswich	1.6	SM - Sutton	39.6
BR - Bromley	20.8	KT - Kingston upon Thames	15.7	SN - Swindon	2.1
BS – Bristol	8.1	L - Liverpool	16.0	SO - Southampton	4.4
CA – Carlisle	0.6	LA - Lancaster	1.3	SP - Salisbury	1.4
CB - Cambridge	2.3	LD - Llandrindod Wells	0.2	SR - Sunderland	18.5
CF – Cardiff	6.7	LE - Leicester	4.2	SS - Southend-on-Sea	13.5
CH - Chester	6.7	LL - Llandudno	1.0	ST - Stoke-on-Trent	4.3
CM - Chelmsford	3.6	LN - Lincoln	1.2	SW - London SW	83.5
CO - Colchester	3.1	LS - Leeds	8.5	SY - Shrewsbury	0.6
CR - Croydon	26.6	LU - Luton	8.8	TA - Taunton	1.5
CT - Canterbury	5.3	M - Manchester	30.1	TD - Galashiels	0.5
CV - Coventry	4.5	ME - Medway	6.1	TF - Telford	2.6
CW – Crewe	3.3	MK - Milton Keynes	3.7	TN - Tonbridge	2.6
DA - Dartford	16.2	N - London N	77.9	TQ - Torquay	2.4
DE – Derby	4.1	NE - Newcastle upon Tyne	2.4	TR - Truro	2.1
DH - Durham	4.3	NG - Nottingham	4.4	TS - Cleveland	5.8
DL - Darlington	1.1	NN - Northampton	3.5	TW - Twickenham	29.7
DN - Doncaster	2.7	NP - Newport	3.0	UB - Southall	28.0
DT - Dorchester	1.3	NR - Norwich	2.2	W - London W	94.3
DY – Dudley	6.9	NW - London NW	69.1	WA - Warrington	8.8
E - London E	81.7	OL - Oldham	12.4	WC - London WC	100.8
EC - London EC	80.4	OX - Oxford	2.6	WD - Watford	13.8
EN – Enfield	15.3	PE - Peterborough	1.6	WF - Wakefield	10.6
EX – Exeter	1.1	PL - Plymouth	1.9	WN - Wigan	14.7
FY - Blackpool	17.3	PO - Portsmouth	7.5	WR - Worcester	2.3
GL - Gloucester	2.2	PR - Preston	5.4	WS - Walsall	9.8
GU - Guildford	4.5	RG - Reading	4.0	WV - Wolverhampton	7.0
HA - Harrow	42.6	RH - Redhill	3.8	YO - York	1.1