MRO Technical Data Aid

Technical Assistance in Producing Data as Evidence for Quantitative Metrics

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1. Introduction

The purpose of this document is to provide technical assistance to MROs in producing data as evidence for the quantitative metrics in the applicable MoJ qualifying criteria ('QC'), the related MedCo Guidance on the MoJ QC ('Guidance') and MedCo Guidance FAQs ('FAQ') published on MedCo's website.

This document supplements the applicable MRO Qualifying Criteria Audit Guide: Cycle 1 ('Audit Guide') published on MedCo's website. It is not intended to rectify a weakness, but to assist MROs in managing their data and producing appropriate evidence of their compliance with the QC.

1.1. General disclaimer

The information in this document is provided strictly for guidance purposes only and is intended to be read in conjunction with the QC, Guidance, FAQ and Audit Guide. The information it contains has been produced only to indicate how the MedCo Audit Team may apply the evidence provisions set out in the Guidance and Audit Guide in given situations and in response to queries raised; this is not a legal document and may be revised from time to time. At all times, MROs must comply with the QC.

2. General Principles

a) This document does not contain any further requirements to those in the QC, Guidance, FAQs or Audit Guide.

b) The evidence requirements set out in the Guidance (general principles (d) and (e)) and Audit Guide (section 4) apply at all times. Should any point of evidence in this document conflict with either, then the Guidance and Audit Guide take priority.

c) It is up to each MRO to decide the time period(s) of evidence it wishes to submit. Anything less than the minimum time period set out in the QC and Guidance will result in an audit finding.

d) Where a MRO provides data in support of its compliance with the quantitative metrics that is solely "raw", "partial" or "selective" (see Audit Guide, section 4), less than the minimum requirements (see Guidance e.g. SLAs and Audit Guide, section 4) or has significant data integrity issues, the MedCo Audit Team will consider this evidence that the MRO does not know whether it complies with the QC as interpreted by MedCo and raise audit finding(s) accordingly.

e) As noted in the Audit Guide (section 3), the MedCo Audit Team is not authorised to advise MROs in meeting the QC and/or Guidance. Consequently, if the auditors find concerns with the calculation of the quantitative metrics these will be raised with the MRO and, if it can re-work the evidence during the audit fieldwork, it will be looked at again (see Audit Guide, section 4) but not a third time.

f) The quantitative measures set out in the Guidance and FAQ are such that any MRO should be capable of capturing the relevant data against which to measure its performance, thereby enabling MedCo to measure the performance of all MROs against the QC on a consistent basis. Should a MRO opt to use alternative (i.e. proxy) data sources:
   i. The onus will be on the MRO to demonstrate viability, consistency and reasonableness; and
   ii. A comparison of its performance using the proxy measure to that envisaged by the Guidance will be expected, to demonstrate that the proxy measure is not significantly different.

3. Technical Principles

a) The evidence expected for a quantitative metric comprises several layers:
   i. The MRO's **stated performance** per the QC and/or Guidance over the relevant time period;
   ii. **Supporting data** i.e. MRO's calculations (including explanations) that result in the above; and
   iii. **Raw data** i.e. the source transactions that have been used by the MRO to calculate the metric.
      a) The minimum data fields required for **individual case data** per sections 4 – 5 are:

Minimum Data Fields Required for INDIVIDUAL CASE DATA (MedCo and, where applicable, Non-MedCo)		
Case reference (MedCo)	Name of instructing party	Date instruction received
Case reference (MRO)	Name of expert instructed	Date of appointment
Date final report issued to instructing party		

b) For the purpose of calculating SLAs, business days are Monday to Friday excluding any statutory holidays. When calculating how many business days have elapsed, it is ideally calculated by 24 hour period i.e. for an instruction received at 10am today, business day 1 ends at 9:59am tomorrow. Should a MRO use a proxy alternative, it should satisfy general principle (f) above.

c) Significant data integrity issues identified during the audit will be raised as audit findings. MROs should therefore check their data integrity prior to the audit. The MedCo Audit Team will assess the integrity of the data MROs have used to calculate their quantitative metrics e.g. by:
   i. Reviewing the rationale for, and effect of, any genuine one-off data exclusions (see Audit Guide, section 4, para 4 'data sets', last 2 sentences);
   ii. Performing data validation checks e.g. appropriate data fields used, time period correct, no data gaps and no duplicate or "impossible" transactions e.g. reports issued before instructed;
   iii. Comparing raw data sets used for different metrics to ensure consistent application and, if inconsistent, reviewing the rationale for, and effect of, these;
   iv. Checking the accuracy of the logic behind the calculations; and
   v. Checking transactions back to source data (documents or case management system).

d) MROs can present their data in whatever format they think most suitable e.g. spreadsheet with linked worksheets. Such data should be consistent with the 'information disclosure' provisions in the Audit Guide (section 4, para 5) e.g. "data dumping" or presenting disaggregated data that has to be amalgamated to produce the metric is not considered co-operation with the audit process. The sections that follow provide a suggested format, purely for clarification.

e) In relation to the MedCo SLAs (see Appendix 1 of the Guidance):
   i. Where a Tier 2 MRO applies for HVN status and has a sizeable non-MedCo business, evidence of meeting equivalent SLAs in its non-MedCo business will be considered in relation to QC 2.2.1 (capacity). Except for this, only MedCo business should be included in the SLA calculations;
   ii. Each SLA should be supported by a definition of how the report has been constructed. Any exclusion of data should be classified by transaction type and associated volume, with supporting data available e.g. should an exclusion type be valid but seem disproportionately high, the MedCo Audit Team may review supporting data to validate it; and
   iii. The MedCo Audit Team will check on whether MROs are monitoring their performance against the MedCo SLAs e.g. basis of production (e.g. on 1 month and 12 month bases), frequency e.g. monthly, indications that they are met or not and any explanatory comments.

4. Table 1: Minimum Qualifying Criteria

4.1. QC – 1.13: Direct Management of Panel of Experts

QC - 1.13: Geographical Coverage	
The data will show us	Whether the MRO serves the geographical regions it has claimed to cover on the MedCo Portal: • Postcode areas covered; • Active marketing conducted; • Classifications and coverage: urban vs. rural postcode areas and fixed vs. mobile venues; and • Minimum thresholds e.g. experts per postcode area and reports produced year-on-year.
Postcode area definition	The data is analysed by postcode AREA, not the full postcode. The postcode area is the first one or two letters of the full postcode.
Stated performance	Based on the calculations from the supporting data, how many postcode areas the MRO meets the minimum geographical coverage requirements as per the Guidance.
Supporting data: (Minimum data fields required)	Our suggestion is that Tables 1 and 2 (see below) are provided via a spreadsheet and then the spreadsheet's pivot table functionality is used to complete the analysis. However, in lieu of using the pivot table functionality the same result can be arrived at by providing Table 3. **Table 1** demonstrates those postcode areas where the MRO has an active marketing presence. A list of all postcode areas covered, each with two rows (with each row providing details about each instructing party), with the following columns of information: • Name of instructing party the MRO has an active marketing presence with in that area; • Name / Job title of individual at MRO responsible for engaging with that instructing party; • Nature of that engagement; and • Date active marketing activity started. **Table 2** demonstrates the classification of venues and experts, based on actual reports produced. A list of all MedCo cases identifies the following columns of information: • All the fields that constitute individual case data (see Technical Principle (a)); • Venue postcode; • Postcode area; • Designation of venue postcode as either urban or rural; • Designation of venue postcode as either fixed or mobile; • Date venue added to the MRO's panel (required to give visibility of year-on-year activity); and • Time period report falls into e.g. last 12 months, 13 – 24 months etc. **EITHER Pivot Table (using Table 2 data for all valid postcode areas identified in Table 1)** This facilitates the following calculations if performed separately for (1) all urban and (2) all rural postcode areas: i. Which postcode areas have the minimum number of experts; ii. Of the experts included in (i), which have produced reports year-on-year in each postcode area; • Adjust if venue is 'new' due to Guidance 1.13(e)(d)(iv)(c)(i); iii. For each expert meeting (ii), the number and % of his/her venues in that postcode area, which contributed to them meeting (ii), that are fixed; and iv. By aggregating expert results in (iii), which postcode areas have 60%+ venues that are fixed.

QC - 1.13: Geographical Coverage	
	OR Table 3 If an MRO does not wish to utilise this pivot table method then the same results can be reached via Table 3. This requires the following columns (in order) **by postcode area**: • Classification as to whether each postcode area is considered to meet the minimum geographical coverage requirements, as per the Guidance; • Classification as either urban or rural (as per MedCo FAQ); • List each expert who has produced reports in this postcode area (each on their own row); • The venue address this expert produced the report in; • Identification of whether that venue is fixed or mobile; • Number of reports produced by that expert in that venue within the last 12 months; • Number of reports produced by that expert in that venue from 13-24 months previous; • List of venues in each postcode area, with each venue classified as either fixed or mobile (as per MedCo FAQ); and • Number of medical experts that have fixed venues in each postcode area, where each expert has produced at least 1 report in that postcode area in the last 2 years. **Explanations (required whether use pivot table or Table 3)** A clear explanation of how the MRO has classified fixed and mobile venues including where the data has come from to do this.
Raw data	Two sets of raw data: • List of panel experts includes their venue locations; and • Individual case data.
Reference	QC 1.13, Guidance on QC 1.13(e)(d) and any applicable FAQs.

The above data is also used for the 2.2.3 (national coverage) calculation.

4.2. QC – 1.16: MedCo Minimum Standards and Service Levels

See section 5 (QC 2.2.5) but only for those SLAs applicable to regional MROs per Appendix 1 of the Guidance.

5. Table 2: Additional Qualifying Criteria

5.1. QC – 2.2.1: Capacity

QC 2.2.1 – Capacity to produce at least 40,000 reports each year.	
Basis of evidence	Individual case data for all medico-legal reports, for the 12 month period (within the time periods set out in the Guidance) where the MRO produced the most medico-legal reports (MedCo and non-MedCo).
Supporting data (Minimum data fields required)	The individual case data should be clarified for each medico-legal report as follows: • Number within each medico-legal report category; i.e. Medco or non-Medco; and • Within each medico-legal report category, further split between type: GP, Orthopaedic, Psychiatric, Physio etc.
Raw data	Individual case data where a report has been issued.
Reference	QC 2.2 and Guidance on 2.2.1 and any applicable FAQ.

5.1. QC – 2.2.2: Active Medical Experts

QC - 2.2.2: Contractual arrangements with at least 250 individual active MedCo accredited medical experts	
The data will show us:	The number of **active contracted** medical experts (ME) who are **regularly used** by the MRO.
Stated performance	Based on the calculations from the supporting data, how many medical experts on the MRO's panel are active within the timeframe under consideration (pro-rated to reflect time on panel).

Supporting data: (Minimum data fields required)	Our suggestion is that one table is provided with the following fields (in order):
	• Name of medical expert;
	• Where expert joined or left the panel during the period:
	  • Date expert first joined the MRO's panel (and left panel, if temporarily – see below);
	  • An expert that left the panel temporarily (e.g. on maternity leave) may be included (provide reason);
	  • The pro-rated minimum reports to be met to be considered active;
	• Confirmation of a contract in place with the medical expert;
	• Confirmation of MedCo accreditation;
	• Classify expert as 'Urban' or 'Rural'. Where an expert covers urban and rural postcode areas, the threshold for urban areas should be used;
	• Classify expert as 'Generalist' or 'Specialist':
	• Number of reports produced per expert per 12 month period
	• Confirmation as to whether the expert meets the definition of active.

Raw data:	Individual case data where a MedCo or non-MedCo report has been issued by a MedCo accredited expert. Where possible, the system extraction should include identification of the postcode venue used as urban or rural and whether it is fixed or mobile.
Reference:	QC 2.2, Guidance on QC 2.2.2, and any applicable FAQ.

5.2. QC – 2.2.3: National Coverage

QC 2.2.3(a) – MRO has contracted medical experts in 80% of the postcodes in England & Wales.	
Stated performance	The proportion of 105 English and Welsh postcode areas where the MRO has contracted, MedCo-accredited medical experts.
Supporting data (Minimum data fields required)	• See "QC 1.13 – geographical coverage" in this document (one of its supporting data requirements, marked with a red asterisk, can also be used to calculate this metric). • Full list of the 105 postcode areas, noting which of these areas the MRO covers.
Expected data exclusions	None
Raw data	As 1.13 – geographical coverage
Reference	QC 2.2, QC 1.13, and Guidance on 2.2.3 and any applicable FAQ.
QC 2.2.3(b) – In 80% cases the injured party has to travel <15 miles to attend an appointment with an expert.	
The data will show us:	The distance travelled by the injured party by public highways from the injured party's residential (or equivalent) address to the expert's consulting room.
Supporting data (Minimum data fields required)	Our suggestion is that one table is provided with the following fields (in order): • MedCo reference; • Instruction date; • Date attended appointment; • Complete postcode for the injured party; • Complete postcode for the venue (consulting room); • Venue classification (fixed/mobile) and, if mobile, the expert's residential postcode; • Calculation of distance per appointment.
Expected data exclusions	None
Raw data	Individual case data where an appointment has been held.
Reference	QC 2.2, Guidance on 2.2.3 and any applicable FAQ.

5.3. QC – 2.2.4: Clients

QC 2.2.4 – No client represents more than 40% of the total instruction volume (MedCo & non-MedCo).	
The data will show us:	The percentage share of MedCo and non-MedCo instructions the MRO has received and accepted from each client on a rolling 1 month and 12 month period.
Supporting data (Minimum data fields required)	Our suggestion is that one table is provided with the following fields (in order): • MRO reference; • MedCo reference for MedCo cases only • Date instruction received; and • Name of instructing party.
Expected data exclusions	Instructions that have been rejected (see Guidance 2.2.4)
Raw data	All instruction case data (MedCo and non-MedCo) as 2.2.1 (above).
Reference	QC 2.2, Guidance on 2.2.4 and any applicable FAQ.

5.5. QC – 2.2.5: Minimum Standards and Services Levels

All the following are applicable to HVN MROs and all but four apply to regional MROs, as set out in Appendix 1 of the Guidance. Additional clarification is provided in the FAQ at QC 1.16.

5.5.1. Efficiency SLAs

SLA 1a – Elapsed time from instruction being received to date of appointment in all instances (including e.g. do not attends, reschedules, "no shows"/abandoned and requested delays).	
The data will show us: Start Point: End Point:	Number of actual business days taken from: • Date of instruction being received at the MRO; to • **Last** appointment booked with the medical expert (e.g. 2nd appt if 1st is a DNA).
Stated Performance	Based on the calculations from the supporting data, the % the above are met over a rolling 12 month period within the stated SLA timeframe for all MedCo business.
Supporting data (Minimum data fields required)	Our suggestion is that one table is provided with the following fields (in order): • MedCo reference; • Name of instructing party; • Instruction date; • Name of expert instructed; • Last appointment date (if no appointment booked, use date MI report run); • Number of business days; • Details of all excluded transactions, by reason, should be available.
Expected data exclusions	Cancelled instructions closed permanently.
Raw data	Individual case data of which the rolling 12 months is based on instruction received date and not report issued date.
SLA 1b - Elapsed time from instruction being received to date of appointment excluding instances where solicitors/claimants specifically request delay in appointment.	
The data will show us	As 1(a), without being distorted by legitimate delays (see exclusions below)
Stated Performance	• As 1(a), without being distorted by legitimate delays (see exclusions below); and • MROs should also provide detail regarding how delayed cases are identified within their systems, extracted and subsequently reported on.
Supporting data	As 1(a), excluding individual cases that meet the exclusion criteria below.
Expected data exclusions	• As per the Guidance (Appendix 1, notes to the SLAs) • Delays for any other reason should be INCLUDED in the SLA calculation.
Raw data	As SLA 1(a), but with non-delayed and delayed cases separately identifiable (including reasons for delayed cases): • If this is a manual process, the distinction and reasons for delay should be identifiable in the supporting data.

SLA 2a – Overall case lifecycle from instruction being received to final report despatched to solicitor/ claimant in all instances (including all in SLA 1 above and where supplemental report required).	
The data will show us: Start Point: End Point:	Number of actual business days taken from: • Date of instruction being received at the MRO; to • The **latter** of the date of the final/supplementary report being despatched to either solicitor or claimant.
Stated Performance	Based on the calculations from the supporting data, the % the above are met over a rolling 12 month period within the stated SLA timeframe for all MedCo business.
Supporting data (Minimum data fields required)	Our suggestion is that one table is provided with the following fields (in order): • MedCo reference; • Name of instructing party; • Instruction date; • Name of expert instructed; • Final appointment dates (if no appointment booked, use date MI report run); • Date initial report sent to solicitor / claimant; • Date last report despatched to solicitor / claimant (if report is yet to be despatched, use date MI report run; and • Number of business days.
Expected data exclusions	Cases cancelled permanently before report issued
Raw data	As SLA 1(a)
SLA 2b – Overall case lifecycle from instruction being received to final report despatched to solicitor/claimant, excluding instances where solicitors/claimants specifically request a delay in appointment.	
The data will show us	As 2(a), without being distorted by legitimate delays (see exclusions below)
Stated Performance	• As 2(a), without being distorted by legitimate delays (see exclusions below); and • MROs should also provide detail regarding how delayed cases are identified within their systems, extracted and subsequently reported on.
Supporting data	As 2(a), excluding individual cases that meet the exclusion criteria below.
Expected data exclusions	• As per the Guidance (Appendix 1, notes to the SLAs) • Delays for any other reason should be INCLUDED in the SLA calculation.
Raw data	As SLA 2(a), but with non-delayed and delayed cases separately identifiable (including reasons for delayed cases): • If this is a manual process, the distinction and reasons for delay should be identifiable in the supporting data.

SLA 3a – Expert response to questions/ Supplementary report provision after original report has been issued: Proportion of instructions requiring re-work and/or follow up.	
The data will show us:	Percentage of issued MedCo reports requiring follow-up / supplementary work out of total MedCo reports issued
Stated Performance	Based on the calculations from the supporting data, whether the % of total MedCo cases that involve re-work and/or follow-up work after a report has been issued over a rolling 12 month period is within the stated SLA % for all MedCo business.
Supporting data (Minimum data fields required)	Our suggestion is that one table is provided from all the instructions received requiring follow up work with the following fields (in order): • MedCo reference; • Date original report received from expert; • Date initial version of report was sent to the solicitor; • Date follow-up work / supplementary report requested from solicitor / claimant; • Date follow-up work / supplementary report issued to solicitor; and • Reason for follow-up work / supplementary report.
Expected data exclusions	• MedCo instructions where no final report has been issued; and • Addendum reports i.e. the final report did not require amendment or follow-up work, but the claimant's injuries required an additional report (covering non-MedCo matters) due to the length of the prognosis.
Raw data	Individual case data of which the rolling 12 months is based on the date the medical report was produced.
SLA 3b – Expert response to questions/supplementary report provision after original report has been issued: Length of time to resolve queries/ despatch any supplemental report to Solicitor/Claimant.	
The data will show us: Start Point: End Point:	Number of actual business days taken: • From date query received requesting supplementary / follow-up reports from Solicitors/Claimants; to • The despatch of supplementary / follow-up reports to Solicitors/Claimants.
Stated Performance	Based on the calculations from the supporting data, the % the above are met over a rolling 12 month period within the stated SLA timeframe for all MedCo business.
Supporting data	As 3(a) including the following field: • Calculation of business days from when a request for additional report was requested by the solicitor/claimant to when the report was issued to the solicitor/claimant.
Expected data exclusions	MedCo reports with no questions or supplementary report provision.
Raw data	As SLA 3(a)

5.5.2. Customer Service SLAs

SLA 4 – Elapsed time from receipt of Solicitor/Claimant/ Medical Expert enquiry (not complaint) to final response made/despatched by MRO for queries received (a) via telephone and (b) in writing or email.	
The data will show us: Start Point: End Point:	Time elapsed (in hours) between the time when: • Queries are received from Solicitors/Claimants/Medical Experts by (a) or (b); and • Final responses are made to such queries by the MRO.
Stated Performance	Based on the calculations from the supporting data, whether the % of total MedCo cases resolved over a rolling 12 month period is within the stated SLA % for all MedCo business for queries received (a) via telephone and (b) in writing or email.
Supporting data (Minimum data fields required)	Our suggestion is that a separate table is provided for (a) and (b) with each containing the following fields (in order): • MedCo reference; • Source of query (Solicitor/Claimant/Medical Expert); • Date and time of query; • Nature of query; • Format of query e.g. telephone, letter, email • Format of response; and • Date and time of final response to (Solicitor/Claimant/Medical Expert).
Expected data exclusions	Open complaints where they have been open for less time than the SLA target measure.
Raw data	Records of client interaction

SLA 5 – Elapsed time from receipt of complaint to final resolution agreed by MRO for complaints made by (a) Solicitor/ Claimant and (b) Medical Experts.	
The data will show us: Start Point: End Point:	Number of actual business days taken from the date when: • Complaints are received from (a) or (b); to • Final resolution being agreed by the MRO.
Stated Performance	Based on the calculations from the supporting data, whether the % of total MedCo cases resolved over a rolling 12 month period is within the stated SLA % for all MedCo business for complaints made by (a) solicitors/claimants and (b) experts.
Supporting data (Minimum data fields required)	Our suggestion is that two tables are provided (one for solicitors/claimants and one for medical experts) with the following fields (in order): • MedCo reference; • Source of complaint (Solicitor/Claimant/Medical Expert); • Date and time of complaint; • Nature of complaint; • Format of response; • Date and time of final response to (Solicitor/Claimant/Medical Expert); • Calculation of business days taken from date complaint received to final resolution; and • If applicable, explanations and evidence for anomalies leading to the SLA not being met.
Expected data exclusions	Open complaints where they have been open for less time than the SLA target measure.
Raw data	Records of client complaints from receipt to resolution. If no such records are available as the MRO asserts no complaints have been received, evidence of a robust process to identify and capture any complaints should they be made.

5.5.3. Quality SLAs

SLA 6 – Proportion of medical reports produced by the MRO per annum that meet all the minimum standards as set out by AMRO in its Protocol C.	
The data will show:	Number of reports returned by solicitors because the report contained errors or omissions relating to AMRO Protocol C as a percentage of the total reports issued during the year.
Supporting data (Minimum data fields required)	As 3(a) including the following field: • Calculation of % of reports returned by solicitors for AMRO protocol C errors or omissions.
Expected data exclusions	As 3(a)
Raw data	As SLA 3(a). If the MRO asserts that no reports have been returned for this reason, evidence of the MRO's robust process to identify and correct any AMRO Protocol C errors / omissions prior to despatch of the final report should be provided, and of its implementation in practice.
SLA 7 – Elapsed time from dispatch of medical report to Solicitor/ Claimant to uploading DPA compliant, anonymised full medical and management case data to the MedCo Portal.	
The data will show: Start Point: End Point:	Number of calendar days taken to upload completed reports to the MedCo Portal. • Date of despatch of medical report; to • Date all information has been uploaded to the MedCo portal.
Stated Performance	Based on the calculations from the supporting data, the % the above are met over a rolling 12 month period within the stated SLA timeframe for all MedCo business.
Supporting data (Minimum data fields required)	Our suggestion is that one table is provided with the following fields (in order): • MedCo reference; • Date of despatch of report to solicitor / claimant; • MedCo Portal upload date; and • Number of calendar days between the above two dates
Data anomalies	• See Guidance 1.15. • Details should be provided of which cases have not been uploaded with reasons.
Raw data	As SLA 3(a)
SLA 8 – Proportion of MRO's MedCo reports produced by MEs suspended / disciplined for reports.	
The data will show:	The number of reports produced by the MRO during the period authored by experts with poor medical performance, as determined by a relevant registration/accreditation body
Supporting data (Minimum data fields required)	Our suggestion is that one table is provided with the following fields (in order): • Medical Expert name; • Source of poor medical performance e.g. GMC or HPCP; • No. of reports completed in period; • Action taken by the MRO.
Raw data	As SLA 3(a)

5.5.4. Data Security SLAs

SLA 9 – Non-conformities associated with ISO27001 certification.	
Basis of evidence	• **ISO 27001 certification:** The scope of this certificate should cover all the MRO's MedCo operations for the relevant period; and • The metric is not obtaining the certification, but the number of major and minor non-conformities identified in the **ISO Assessor Risk Assessment** report at the time of certification and subsequent monitoring visits.
SLA 10 – The proportion of MedCo cases where sensitive personal data has been inappropriately disclosed in any 12 month period and reported to the appropriate parties within prescribed timescales.	
The data will show:	• The number of breaches that have occurred where sensitive personal data from MedCo cases has been inappropriately disclosed in the previous 12 months as a proportion of the total number of MedCo cases; and • Whether such breaches that occurred were reported to the appropriate party in time.
Supporting data (Minimum data fields required)	Our suggestion is that one table is provided with the following fields (in order): • MedCo reference; • Nature of breach, • Date occurred, • Date identified, • Date resolved; • Date reported to ICO (if applicable); • Date reported to individual/body whose data was disclosed (if applicable); • Calculation of elapsed time from reporting breach to ICO since date identified; and • Calculation of elapsed time from reporting breach to individual/body whose data was disclosed since date identified.
Data exclusions	Security breaches that have not involved the disclosure of sensitive personal data.
Raw data	• Log of security breaches. • If the MRO asserts that no breaches have occurred, evidence of the MRO's robust processes for managing information security and their implementation should be provided.