Future Provision of Medical Reports in Road Traffic Accident related personal injury claims Consultation

RESPONSE

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1. INTRODUCTION

1.1 MedCo's Remit

MedCo was formed to develop, operate and maintain an electronic system to facilitate the allocation of medical experts and medical reporting organisations (MROs) to provide a first medical report in low value soft tissue injury road traffic accident claims. It was also tasked with developing and maintaining a system for accrediting medical experts who are requested to provide such reports.

Medco implements Government policy and whilst it liaises with the Ministry of Justice ("MoJ") it takes no part in the policy or Civil Procedure Rule making processes.

Its main aim is to ensure that all claimants are provided with a medical reporting service that is independent and of the highest quality.

1.2 MedCo Operations and Quality Control

MedCo is not a regulator but it does undertake a regulatory function over its registered users ("Users"). Those Users are MROs, Authorised Users ("AUTs"), who are compensators/legal representatives and Medical Experts ("MEs")[1].

In order to use the system all Users must sign an agreement annually which imposes a number of obligations, including the need to declare any direct financial links, that have to be complied with in order for the User to remain "operational".

MedCo was incorporated in November 2014 and commenced operations in April 2015. All Users were able to register and commence operating by self-certifying that they complied with certain formal requirements.

Since April 2016 MedCo has undertaken a lengthy programme of auditing MROs to ensure that they complied with the MoJ's Qualifying Criteria for MROs ("QC"). The initial audit programme of MROs has now been completed and a programme of re-auditing MROs will commence shortly.

Formal auditing of MEs has not yet been rolled out but the quality of their reports is monitored by MedCo's Expert Audit and Peer Review committee ("EAPR"). If necessary, the EAPR refers individual MEs to an independent Medical Advisory Board whose members provide expert advice on the quality of an expert's reports by way of peer review.

MedCo is in the process of planning a programme of targeted auditing of MEs.

Where there is sufficient evidence of unacceptable behaviour, breach of MedCo's user agreement ("Agreement") and associated rules by any User, or unacceptable quality of medical reports by MEs, MedCo can take appropriate action which, in serious cases, can result in the User's suspension and/or termination of their Agreement[2].

[1] AUTs may choose to either instruct a medical expert directly or instruct an MRO to indirectly arrange a medical report with a medical expert. Medical experts are therefore categorised as "Direct" or "Indirect" (DMEs and IMEs respectively).

[2] Paragraph 23 of the MoJ Consultation states "*up to and including suspension".* This is incorrect as MedCo can also terminate agreements in certain circumstances.

In April 2019 there were over 31,000 searches on the MedCo system resulting in the selection of an MRO and over 4,600 searches resulting in the selection of a DME[3]. Of all selections that result in a MedCo report approximately 94% are produced by GPs.[4]

1.3 Funding

MedCo is a "not for profit" company entirely funded by MROs and MEs. In 2018 approximately 95% of that funding came from MROs and their annual renewal fees are substantial in comparison to DME fees (which include the costs of their accreditation). MEs who only accept instructions via an MRO (known as IMEs) and AUTs pay nothing at all despite benefiting from use of the MedCo system and/or accreditation scheme. MedCo has therefore commenced a review of its funding policy with a view to moving to a "User pays" basis of payment with the intention of implementing this in 2020 in order to make it more transparent and fairer to all Users.

MedCo will therefore be dependent upon usage of the system and the ability of MROs and MEs to pay MedCo fees which is crucially important to its future sustainability.

During recent discussion forums that MedCo conducted with MROs and MEs it became clear that the unanimous concern of all who attended was that payment of medical report fees must be guaranteed in some way.

In cases where liability is admitted a compensator will be responsible for paying the claimant's reasonable disbursements – usually at the conclusion of the case – and it may be appropriate that arrangements be put in place for the compensator to pay the medical report fee direct to the MRO or ME. Ideally this should be set out in the new Pre Action Protocol. It is essential to ensure that MROs and MEs get paid for medical reports. In cases where liability is not admitted it is highly unlikely that unrepresented claimants will be given credit by MROs or DMEs.

For the avoidance of doubt, MedCo does not propose to guarantee payments to MROs/MEs or become embroiled in disputes over non-payment of medical report fees by unrepresented claimants.

1.4 Experts' Accreditation

Since June 2016 all MEs, whether direct or indirect, have to be accredited by MedCo in order to become operational and available in searches to be chosen to provide a medical report for personal injury claims which fall within the provisions of the Pre-Action Protocol for Low Value Personal Injury Claims in Road Traffic Accidents[5] ("PAP").

The current accreditation scheme expires after 3 years and in June 2019, when existing accredited MEs will need to renew their accreditation, MedCo will be introducing a new scheme. This will involve them in undertaking new "compulsory modules" and continuing professional development each year ("CPD").

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[3] see http://www.medco.org.uk/media/1510/medco-mi-q1-2019.pdf

[4] Based on case data uploads between 1st January 2018 and 1st May 2019. The remaining 14% are produced by A&E consultants, orthopaedic consultants and physiotherapists.

[5] See http://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

Any new ME who wishes to become operational and deal with soft tissue injury claims will need to undertake the full course, including the compulsory modules. The compulsory modules have been designed to inform MEs of their legal duties as an expert witness to the court and their contractual obligations to MedCo.

1.5 Current Scheme

Currently AUTs can choose to search for a MRO or a DME to provide their clients with medical reports. Having made that decision, the MedCo Portal then produces a random list of either 12 MROs or 7 DMEs. The randomisation is based on an algorithm defined by the MoJ.,

The list of 12 MROs is made up of 10 "Tier 2" and 2 "Tier 1" organisations.[6] The list of DMEs is provided by linking the list of practising addresses they enter to the postcode as requested by the AUT. Having made the choice, the AUT then forwards instructions, outside of the MedCo system, direct to the MRO or DME. It is for the relevant medical provider and the AUT to agree terms of business.

1.6 Stakeholder Engagement

MedCo representatives have attended stakeholder groups organised by the MoJ. MedCo has also undertaken several discussion forums for MROs and MEs and received very helpful feedback from all those who attended.

Several workshops have been undertaken involving MedCo directors and members of its managed services staff.

MedCo's response to this Consultation has therefore been informed by representatives of many of those who are, and will be, involved in personal injury claims following the implementation of the Government's reforms in April 2020.

1.7 Additional Comments and Options for Future Medical Reporting

1.7.1 Prior to publication of this consultation MedCo considered a number of options which could be adopted to provide a high quality and easy to use medical reporting service specifically for unrepresented claimants. Whilst some of the options considered would achieve this aim they were deemed potentially problematic for various reasons and therefore unlikely to be viable, or achievable before April 2020.

Consequently, MedCo's response to this consultation will, by necessity, concentrate on adapting the current MedCo "portal" to make it "user friendly" for unrepresented claimants and ensuring that they receive a service of the highest quality from MedCo and its operational MROs and MEs.

1.7.2 If it is the case that the MoJ does not propose to implement any changes to the system of sourcing medical reports where a claimant is represented in an SCT claim then, in MedCo's opinion, the following points have to be considered: -

- Should the options be the same for all claimants in an SCT claim whether represented or not? For example, only GPs should be

[6] MROs who are classified as high volume national (HVN) and satisfy both the minimum and the additional MoJ qualifying criteria are commonly referred to as "Tier1". Those who do not fall within that category are commonly referred to as "Tier2".

authorised to provide initial medical reports in such claims (see answer to question 3 below). Were the MoJ minded to make such a requirement mandatory for all it would avoid represented and unrepresented claimants being treated differently. It would also avoid issues which may arise as a result of AUTs marketing their services in a way which may indicate, either expressly or impliedly, that a more "specialist" medical reporting service would be available if they are instructed to act in the matter.

- There needs to be clear definitions of what "represented" and "representative" actually means which are unambiguous and capable of being enforced where there is a clear breach of the PAP.

1.7.3 Currently medical reports for **all** road traffic accident ("RTA") soft tissue injury claims up to £25,000, have to be sourced through MedCo. When the reforms are implemented, there will be a situation where claimants with non-soft tissue RTA injuries over £5,000 will not have to source medical reports through MedCo but those with a similar injury valued at less than £5,000 will have to. This is confusing and is also likely to lead to exploitation.

For consistency, consideration should therefore be given to extending the scope of MedCo accordingly. However, MedCo appreciates that this is unlikely to be achievable prior to April 2020 but it recommends that the issue is reviewed as soon as possible.

1.7.4 The current definition in relation to MedCo does not need to be amended in respect of soft tissue RTA injury claims. However, it will need to be amended if **all** SCT RTA claims are to be include within its remit.

1.7.5 Unrepresented claimants should not be required to enter into individual agreements with an MRO or ME. This will create unnecessary complication for them in what is intended to be a simple online SCT claims system. Service level agreements ("SLAs") for all MROs and MEs will be vital, especially in cases where there is any dispute with the medical report provider.

1.7.6 Whilst MedCo performs a quasi-regulatory function in respect of its registered users it is has no formal regulatory powers. The majority of its Users (e.g. medical experts, insurers, solicitors etc.) are regulated by their own relevant regulatory bodies. However, MROs are not regulated.

Since MedCo commenced operations in April 2015 it has encountered significant problems with many MROs who initially self-certified that they complied with the relevant QC. There has been evidence of misrepresentation, dishonesty and, in some cases, suspicions of fraud. Where identified these issues have been dealt with by MedCo and appropriate action taken (e.g. termination of Agreements).

MedCo has recently completed auditing of all registered and operational MROs and as at 14th May 2019 the current position is as follows: -

Operational MROs

Tier 1	10
Tier 2	44

To ensure that unrepresented claimants receive a medical reporting service of the highest quality serious consideration should be given to formal regulation of MROs, especially as they will be required to deal with such claimants direct when the reforms are introduced.

2 CONSULTATION RESPONSE

Question 1: *The Government proposes to extend the scope of MedCo so that all initial medical reports for all RTA related PI claims under the SCT are provided under a single system. Do you agree with this proposal? Please provide any evidence and further information in support of your answer.*

Response: MedCo believes that its scope should be extended as this would be the most sensible option to ensure that all related personal injury claims under the SCT are provided under a single system

MedCo already has built in quality controls through its MRO audit programme and the work of the EAPR. Through this work it can provide extensive data management information which is constantly monitored as part of the quality control process for medical reports.

Question 2: *If you have suggestions for alternative approaches please provide details and, in particular, how they would work in practice.*

Response: MedCo does not consider that there is an alternative approach at this stage. It is essential that unrepresented claimants are able to obtain medical reports of the highest standard. MedCo is the only organisation which can currently provide this service and at the same time ensure independence and consistency for all claimants.

As referred to above at paragraph 1.7.3 on page 4 - there is a strong case to argue that all non-soft tissue injuries over £5000 and up to £25,000 should also be included within MedCo's remit so as to avoid confusion and ensure similar quality controls for all small claims track ("SCT") and Fast Track claimants in RTA claims.

Consideration should also be given to requiring "second" medical reports for unrepresented claimants to be sourced through MedCo for quality assurance, avoidance of confusion and simplicity reasons.

Question 3: *If MedCo is extended to cover all types of medical reports for RTA related personal injury claims under the SCT, should other types of medical expert be added to those currently available for the purpose of providing medical reports?*

Response Insofar as unrepresented claimants are concerned, giving them a wider choice of experts would be confusing. Simplifying the process for them is crucial and too many choices would defeat this aim. In fact, recently it has come to the attention of MedCo that insurers have begun to see increasing examples of the wrong type of expert being chosen in the first instance to provide a medical report for claimants who are represented. This problem is likely to be exacerbated should a wider choice of medical experts be available to unrepresented claimants. This would add additional and unnecessary costs for both parties.

MedCo considers that allowing more "specialists" to register with MedCo to deal with SCT injury claims is unnecessary but also problematical and likely to impinge on its ability to be ready for implementation of the reforms in April 2020.

Changes to MedCo's I.T. system could be extensive due to the number of different specialists who might wish to register and allocating them into the random search/selection process which it operates. It is also likely that the more choice available to unrepresented claimants the more complicated the process will become for them and therefore a greater level of operational support will be required.

MedCo is of the opinion that all GPs are likely to have sufficient experience and skills to give an opinion and diagnosis in such claims. All GPs should be able to seek access to claimant's medical records if necessary and, after examination, should be able to give an opinion in most SCT injury claims. Should a further report be required from a "specialist" the GP would record this as a recommendation in the report accordingly. That GP report will enable the claimant to proceed with the claim as it would be classified as a "first medical report" for the purposes of the RTA PAP.

MedCo's comments above have been confined to GPs as on average they are instructed in approximately 94% of all claims where a MedCo report is required.

GPs would have undertaken at the very least a 5 year medical degree, a 2 year foundation course in general medical training and 3 years specialist training in general practice involving a great deal of direct patient contact.

At this stage MedCo considers that restricting the provision of first medical reports to GPs would be the most effective way for unrepresented claimants to obtain the medical report they need and to ensure a higher quality of service.

Consideration should also be given to making provisions that a "second" report from a specialist can only be obtained upon the recommendation of a GP (i.e. as indicated in the first medical report) and that, for unrepresented claimants, those second reports should also be sourced through MedCo.

At this stage MedCo does not currently have an opinion one way or the other on orthopaedic consultants and it would need to consider this further before giving a view on them. However, it is highly likely that A&E consultants may have similar skills as GPs and sufficient experience to cover the vast majority of injuries within the SCT but this may also have to be considered further.

The one possible exception could be dental experts. However, and whilst it has not undertaken any research on this, MedCo has made an assumption that RTA injury claims below the proposed SCT limit of £5,000 where the only resulting injuries are dental are likely to be very rare in comparison to other injury claims.

In any event, great care needs to be exercised before allowing medical experts who have not received the same training or have the same qualifications as GMC members to undertake MedCo reports.

Question 4: *If additional specialists are added, should they be restricted to providing initial reports for claims which involve their specialisms or should they be allowed to*

complete the full accreditation process and be allowed to provide all initial reports?

Response MedCo cannot see how this could be implemented by April 2020 as it involves a significant number of factors, not limited to accreditation issues, which will have to be considered in much further detail by relevant stakeholders.

Restricting "specialists" to providing reports in their own field of expertise will add additional complications requiring major changes to the MedCo IT platform and may pose challenges to the system being developed by the MIB and MoJ. Both services will need to operate in a way that enables the unrepresented claimant to be presented with, and make a selection of, an expert with relevant experience to report on their injury. This could result in unnecessary complication and confusion for unrepresented claimants when choosing a medical report provider and may lead to extensive operational support being required by the IT services.

Any "specialist" MEs who wish to become operational on MedCo, but restrict their medical reporting services to non-soft tissue injuries, will need to complete the mandatory accreditation modules at the very least. It is not certain at this stage if any further accreditation modules will be required in those cases and this, if necessary, will have to be considered in due course.

Question 5: *Do you agree that other types of practitioner (such as osteopaths or chiropractors) be included in the list of experts who can provide medical reports for claims subject to the new RTA SCT limit?*

Response It is crucial that all MedCo registered MEs are effectively regulated and have the relevant knowledge, training and experience necessary to undertake MedCo work. This will become even more essential for unrepresented claimants when dealing with MEs direct and, in some cases, with an MRO.

Whilst it may be the case that, for example, registered Chiropractors and Osteopaths might be able to provide reports involving certain RTA injuries, MedCo does not understand how a claimant would be able to distinguish which type of expert would be appropriate for the injuries they have sustained.

Unrepresented claimants in particular should not be required to choose from a list of "specialists" when they are more likely to be satisfied with a medical report from a GP.

Earlier in this response MedCo has set out its views on allowing only GPs to provide first medical reports for unrepresented claimants.

The training, qualifications and experience of MEs who are regulated by the GMC cannot be over emphasised. "Alternative treatment" providers do not have the same skill sets, qualifications, experience or standard of regulation in MedCo's opinion. It is because of these limitations that MedCo does not recommend allowing other treatment providers to provide MedCo reports.

Question 6: *Should the current fixed recoverable cost regime for initial soft tissue injury medical reports be extended to cover initial reports for all RTA related PI claims under the SCT?*

Response MedCo's response to this question is restricted to views on how any changes to the current fixed recoverable cost (FRC) regime might impact on unrepresented claimants and medical report providers.

The current FRC regime ensures certainty of the cost of a medical report (currently £180 plus VAT for a "first report"). This creates certainty for claimants. MedCo therefore sees no reason why all initial medical reports in SCT claims should not remain as a fixed cost.

Whilst the actual cost is an issue for others to debate, in so far as MedCo is concerned, it must be an amount which does not create imbalance in the current medico legal reporting market. There is currently concern amongst MROs and MEs as to how the reforms in 2020 will impact on their businesses. They will need to prepare budgets based upon estimated claims numbers (as is the case with MedCo). Only time will tell how the reforms will impact on claims numbers but it is very important that the actual income per medical report is certain.

Question 7: *Should the fixed recoverable cost regime be extended to all initial reports for claims that fall under the revised SCT in the new IT platform, if additional experts are added to and sourced through MedCo?*

Response Yes – refer to response to Question 6 above.

Furthermore, claimants should not be prevented from making a claim at the outset because of the uncertainty of the actual cost of a medical report. FRC should therefore apply to all reports sourced through MedCo.

Question 8: *When extending the current MedCo search system to unrepresented claimants, what, if any, changes should be made to the current MedCo Qualifying Criteria?*

Response A new category ('New') of QC, in addition to the Minimum and Additional QC, should be created for those MROs that specifically wish to service unrepresented claimants. This is because the Minimum and Additional QC are based on the premise of business-to-business ('B2B') interaction, which has notable differences to business-to-consumer ('B2C') interaction, which will be the case when dealing with unrepresented claimants.

The new category of QC should focus on the significant differences between B2B and B2C interaction and significant safeguards required for dealing with the public direct. As such, an MRO that wanted to service unrepresented claimants should need to satisfy both the Minimum QC and the New QC.

There are also benefits in making selected amendments to the existing Minimum QC to:

- Accommodate additional differences and safeguards between B2B and B2C environments that are less significant, whose inclusion would not have a detrimental impact on MROs only seeking to operate on a B2B basis; and

- Counter attempts by certain MROs/new applicants to either circumvent or artificially lower the minimum standard envisaged by the MoJ. The QC concerned are illustrated by the "MRO Audit Progress Update" published on MedCo's website in December 2018.

- Protect unrepresented claimants from unknowingly choosing an MRO that has strong links to a claims management company ("CMC") (and not necessarily financial links) which might in turn pass the claimant onto that CMC.

See Appendix for MedCo's suggestions as to what needs to be taken into account when considering changes to the existing QC and/or implementing any new QC.

It is essential that any new QC applied to MROs, or any MedCo Rules applicable to MEs, prevents an unrepresented claimant receiving a service from an ME that uses a non-Medco authorised admin agency[7].

Question 9: *When extending the current MedCo search system to unrepresented claimants, what changes would you like to see as to how the information returned should be presented (i.e. currently only contact details are returned, but should more information about the provider and their service offering be provided)?*

Response The current search criteria, if applicable to unrepresented claimants, will be too wide and should be limited. It is likely that the description of MRO tier will be meaningless to them and would be complicated even further by giving them a choice of an MRO or DME and the necessity to explain the distinctions will be too complicated.

It is essential that the system enables the claimant to make informed decisions as simply and effectively as possible. The more complicated the process becomes the more confusion will occur. Detailed guidance will therefore be necessary but this in turn could add more complication.

However, it will be important to inform claimants about pricing and their liability for payment, especially in cases where liability is not admitted

Whilst providing links to websites and CVs could be helpful to some it could add to the confusion for many.

Reviews by previous claimants (e.g. akin to "Trust Pilot") could be an advantage to claimants - although it could be open to abuse and sufficient protection will need to be built in to prevent this.

Contact details would require permissions of DMEs (GDPR requirements) but MedCo assumes that they would consent if they are going to agree to accept direct instructions from unrepresented claimants.

Appointment availability is likely to be a significant relevant factor for unrepresented claimants when choosing a medical report provider. However,

[7] See Appendix

MedCo would not be able to provide this information as part of the current search/selection process.

Travel distance is also likely to be a factor as well as preferences for chaperone services and language requirements.

The reforms are designed to create a simple process capable of navigation without legal representation. A bewildering array of choice could drive unrepresented claimants into the hands of CMCs, or other "non solicitor" representatives, as they may be forced to seek advice on which MRO/expert to instruct. Safeguards to prevent this need to be devised and built into the new portal service. MedCo is working to safeguard the quality of medical reports and the only matters the claimant should need to worry about should be restricted to choice on such matters as date and location of appointment.

Question 10: *If you are an MRO or a DME will you be opting into the new service providing medical reports for unrepresented claimants at £180 (plus VAT) rate?*

Response No comment – not applicable to MedCo

Question 11: *When extending the current MedCo search to unrepresented claimants, do you think it should include a standardised set of service level agreements?*

Response Yes - but separate standardised SLAs will need to be developed for MROs and MEs who agree to deal direct with unrepresented claimants.

SLAs for MEs will have to be standardised and should have the same status as the QC for MROs.

It should also be a mandatory requirement for compensators to sign up to SLAs. Whilst there are a number of reasons for this, the main beneficial reason to MROs and MEs is that the SLAs should specify that any medical report fees must be paid direct to the provider and not to the unrepresented claimant. The SLAs should also provide a requirement for compensators to promptly reimburse claimants for medical report fees paid in cases where liability was originally denied but the claimants were subsequently successful in winning the case.

Question 12: *What other changes do you think would need to be made to the current MedCo system for unrepresented claimants to be able to obtain a medical report?*

Response The MedCo Board is convinced that the current "search and selection" criteria operated by MedCo (see paragraph 1.5 on page 3) is too complex for unrepresented claimants and would not fulfil the stated intention of simplifying the user journey. MedCo therefore suggests that there should be a complete review of the current offer, QC and MedCo processes specifically for unrepresented claimants. It may also become necessary to review the viability of continuing the random search/selection process of medical report providers at the same time.

Question 13: *Please provide with supporting evidence the average cost of an initial medical report for non-soft tissue RTA related PI injuries.*

Response MedCo does not have any information in relation to this question so is unable to comment.

Question 14: *Do you agree with an assumption that around 400,000 claims would be processed through the MedCo portal; and of these, around 10,000 (5%) would be non-soft tissue claims.*

Response MedCo is unable to comment on this issue.

Question 15: *Do you agree with the assumptions that around two thirds of claims processed on the MedCo system would be with legal representation (made up of just under 50% of claims with BTE insurance and under 20% with other legal representation) and one third of claims without legal representation?*

Response MedCo is unable to comment on this issue.

APPENDIX

A. CONSIDERATIONS FOR POTENTIAL NEW QC INCLUDE:

1) Requiring MROs to provide a level of service that is above that set out in the Minimum Qualifying Criteria ("QC") standards i.e. an MRO is substantive (not transitory), with a demonstrable and consistent track record of operational delivery, financial stability and compliance as a MedCo-registered MRO over a continuous period of 3 years, where:

I) Substantive

i. MRO is incorporated – a small minority of MROs and new applicants are unincorporated businesses;

ii. Operates from standalone, physical and professional business premises – a number of MROs choose to operate from:

(a) Residential homes;

(b) Virtual offices;

(c) Retail space (e.g. above shops);

(d) Offices of fellow group companies related to the insurance industry e.g. GP practices;

(e) Offices of legally separate companies that are related to the insurance industry e.g. claims management companies;

(f) Offices of fellow group companies unrelated to the insurance industry e.g. property management and car hire;

(g) General co-working offices (e.g. Regus) hired out as and when needed; and

iii. Has dedicated contact details i.e. its own email address, telephone number and address (not a post office box number).

II) Operational delivery

i Its selection rate (i.e. percentage of its selections by users and unrepresented claimants from its total number of presentations) exceeds x% pa on average, as determined by MedCo; and

ii It meets the B2C SLAs, as determined by MedCo.

III) Financial stability = based on own profitability and positive cashflow.

IV) Compliance = not been suspended as an MRO by MedCo for any reason (compliance or administrative) nor had occasion to receive more than 1 warning letter for its compliance with the Minimum QC.

2) Requiring MROs to be operated by owners/directors that provide a standard of management that is above that set out in the Minimum QC standards:

I) All the MRO's controlling shareholders, directors (including non-executive and shadow directors) and officers should be subject to and meet the standards of an applicable "fit and proper persons" regime e.g.:

i. Be of good character, which includes consideration of previous convictions, removal from professional registers and ethical conduct;

ii. Have the qualifications, competence, skills and experience necessary for their office; and

iii. Be capable (once reasonable adjustments have been made) of performing tasks intrinsic to their job by reason of their health, location and other business interests.

II) Note: The rationale for including controlling shareholders and shadow directors is set out in the comments on QC 1.12 below.

3) Requiring MROs to have sufficient, knowledgeable, competent, reliable and flexible structures, staff and resources available to provide a high level of customer service consistently to multiple one-off clients simultaneously e.g.:

I) MRO has a **good working knowledge** of the MedCo processes including QC and MedCo Guidance. This can be assessed by a Compliance Check that would be the MRO equivalent of a DME passing the expert accreditation training and which would also need to be passed at regular intervals to ensure the MRO remains up-to-date.

II) **MRO's availability** suits members of the general public both in terms of opening hours and methods of communication.

i. A claimant may well pursue his/her claim outside his/her normal working hours and so wish to contact the MRO before or at the end of the working day as well as at the weekend. The more restricted the opening hours, the less suited the MRO will be to service unrepresented claimants; and

ii. Claimants may well wish to contact an MRO by multiple methods e.g. telephone, email, online messaging or video calls. The more restricted the communication methods, the less suited the MRO will be to service unrepresented claimants.

III) MRO can demonstrate a **robust end-to-end claimant customer service capability** in terms of services offered; resources (people, processes and technology) deployed to fulfil them; and the quality of

the outputs (response times, resolution and customer satisfaction feedback). Particular customer services skills required include:

i. **Timeliness** i.e. questions answered timely, problems resolved quickly and specific details given of when something will happen.

ii. **Attitude** i.e. treated with respect, courtesy and professionalism.

iii. **Empathy** i.e. treat claimants how you would like to be treated.

iv. **Ownership** i.e. take responsibility; do not bounce claimant around.

v. **Active Listening** i.e. listen first, act second.

vi. **Expertise** i.e. know your service. If you don't know the answer — say so, and quickly get the information from someone who does.

vii. **Dependability** i.e. do what you say; never leave it up to the claimant to follow-up and if you don't have a solution, don't leave the claimant hanging.

viii. **Follow up** i.e. to make sure everything is OK.

IV) **Advertising / marketing** that is clear, accurate and not misleading. Given unrepresented claimants would have to choose an MRO from the selection presented to them, MROs should not distort the choice by portraying themselves to be materially different to their capabilities e.g. on their websites, social media or any other media.

V) **No key person dependency** i.e. the MRO can provide a high level of customer service irrespective of owner availability and employed staff (including director) turnover, holidays and sickness, with all key functions, activities and knowledge available to the MRO through multi-skilled or multiple members of employed staff. No key person can work for the MRO on a temporary, self-employed or a consultancy basis.

VI) **Transparency** i.e. the MRO should document its report production process step-by-step and make this available to all unrepresented claimants e.g. on its website, via email and/or in the post at the earliest opportunity so that the claimant has a clear understanding of how it works, what is expected from the MRO and the outcomes and their rights should something not be satisfactory etc.

B. CONSIDERATIONS FOR AMENDING THE EXISTING MINIMUM QC ARE AS FOLLOWS:

1) QC 1.1(iii)(d):

This begins "Oversee and quality assure ….." but does not elaborate on the scope of quality assurance, which is the most common area for QC material non-compliance in MRO audit reports to date. Adding the following clarification stated in bold "Oversee and quality assure **(both clinical and non-clinical content)** ….." would remove any ambiguity.

2) QC 1.8:

This is the 2nd most common area for QC material non-compliance in MRO audit reports to date. The QC currently emphasises commitment to, and compliance with, an ethics policy. However, in practice, attempts to circumvent this are occurring on two fronts, where the QC's current emphasis on MRO policy is not as effective a deterrent as it should be:

a) The policy only applies to the MRO, not the individuals (shareholders, directors and officers) controlling it. Consequently, where MedCo takes action against an MRO for non-compliance with ethics, those same controlling individuals can re-register or acquire another MRO and the only evidence that can be assessed under the QC is what is applicable to the MRO seeking re-registration or being acquired at the point in time. Adding the following clarification stated in bold "Commitment to, and compliance with, a business ethics policy **by (i) the MRO and (ii) those individuals controlling it (taking into account their roles as shareholder, director or senior manager of any MedCo-registered entity in the last 3 years)**" would pre-empt such problems.

   This provision would also address another problem i.e. where MROs are suspended and are in run-off, their level of support can drop significantly. If such behaviour would be taken into account as part of any future re-registrations to MedCo that they might be part of, it might incentivise them to complete their existing cases properly and timely.

b) Mind-set and conduct are key both to demonstrating and circumventing compliance e.g. a number of MROs have claimed during their audits that no ethical issues have arisen to date and therefore their evidence of compliance is necessarily minimal. In a number of these cases, the MROs have been in denial about ethical issues. Adding the following additional sentence in bold to the QC would make it clear that MROs need to objectively think about their conduct "**Mind-set and conduct indicate that ethical compliance is understood and embedded**".

3) QC 1.9:

This puts the emphasis on a complaints handling process being documented, which may be sufficient for the MRO's business clients to act upon, but not the general public. Adding the following clarification stated in bold "Documented, **communicated and implemented** a complaints handling process" would make clear the additional expectations.

4) QC 1.1(iii):

This is the 3rd most common area for QC material non-compliance in MRO audit reports to date. A notable trend in these results is the involvement of third parties in ways that either challenge the idea that the MRO is fully functioning on a standalone basis or seek to circumvent MoJ policy. This common objective is affected through a variety of different ways each exploiting potential "gaps" in the following existing QC i.e. 1.2, 1.3 and 1.12 that make it more difficult for MedCo to detect breaches of the QC and hence enforce them. Each of these is set out below.

5) QC 1.2:

The scope of individuals and organisations covered by the MRO direct financial links provisions set out in the MoJ's Statement on Direct Financial Links is too narrow. There is merit in expanding the statements to cover:

i) People:

a) **Company officers** e.g. company secretaries and Chief Medical Officers (who may be contractors or self-employed consultants);

b) **Family members** (linear, sibling and extended) to identify e.g. family networks of MROs and members of the same family with collective interests in both law firms and MROs;

ii) Organisations i.e. rather than just a law firm, insurer and claims management company, include:

a) **Reciprocal arrangements** between vertical groups of lawyers and MROs, where law firm A (owning MRO A), agrees to instruct MRO B (owned by law firm B) in return for law firm B instructing MRO A, as this seeks to undermine MoJ policy;

b) **MRO**, as this would help differentiate between those MROs attempting to register potential shell entities and genuine common third party ownership models;

c) **IT firms offering** commercially available case management, appointment booking and/or medical report writing software **to MROs**, as some of their owners/directors have interests in MROs and vice versa; and

d) The organisation is part of a group containing an **administrative agency**.

6) QC 1.3:

MROs should manage experts directly. A key means of ensuring this is for MROs to pay experts directly. This is implied in QC 1.1 but not explicitly stated. Adding the following clarification stated in bold "Commitment to pay medical experts **directly (i.e. into a bank account in the expert's name that the expert has full control over)** on set credit terms irrespective of the outcome of the case ….." would remove any ambiguity:

i) Evidence has arisen during MRO audits of at least one administrative agency setting up bank accounts in the names of individual experts that the agency (and not experts) control, with the experts being paid by the agency after deducting its fee. As such agencies are outside MedCo's scope, our visibility on the scale of such practices is limited;

ii) Another agency has proposed an invoice discounting arrangement that would see the agency pay the expert's fee upfront and collect the expert's fee directly from the MRO when it is due. As above, MedCo would have no visibility of this arrangements, as such organisations are outside its scope; and

iii) Consideration should be given to disclosure being required by MROs and experts for:

a) The amount of any fees due to an administrative agency;

b) The services provided; and

c) Which (MRO or expert) is due to pay them.

7) QC 1.12:

This only covers Directors and Officers. It should be extended to **include controlling shareholders and shadow directors**:

i) In a number of Tier 2 MROs, the shareholders and directors differ and the directors act according to the direction of shareholders; and

ii) In certain instances, individuals seek to influence MROs behind the scenes i.e. they are not listed on Companies House as shareholders or directors but maintain control by being signatories of the bank accounts, with their nominees listed as shareholders and/or directors rather than themselves.

C) ADDITIONAL QC

No changes should be made to the current Additional QC for MROs.

D) QC FOR MEs

There should be no need for equivalent ME Minimum QC. MedCo has reflected the relevant elements from the Minimum QC into its draft MedCo Rules for MEs, which it proposes to introduce prior to the reforms, compliance with which forms part of the ME User Agreements.

There would also be a very significant resource and cost implication of auditing all MEs against any equivalent QC created for MEs. A more effective method of compliance would be to undertake risk-based audits of MEs, which MedCo plans to commence.

The proposed New QC for unrepresented claimants should apply to all who intend to operate in a B2C environment, whether MROs or MEs, because it is their ability to service the general public that is paramount. However:

- It is hard to see how logistically MEs could do this on their own in a multi-client environment without entailing the support of others, whether their employees or third party administrative agencies; and

- Should MEs involve others to interact directly with unrepresented claimants rather than themselves, then the arrangement moves closer to one of an MRO contracting with an expert to service an unrepresented claimant. In this scenario, the third parties (e.g. admin agencies) used by the ME should be registered with MedCo and subject to the Minimum and New QC.