Ombudsman's Determination

Applicant	Dr A
Scheme	NHS Injury Benefit Scheme (**the Scheme**)
Respondents	NHS Business Services Authority (**NHS BSA**)

Outcome

1. I do not uphold Dr A's complaint and no further action is required by NHS BSA.

Complaint summary

2. Dr A's complaint concerns NHS BSA's decision to backdate his Band 5 Permanent Injury Benefit (**PIB**) award to 12 July 2019. He believes that he became entitled to a Band 5 PIB from 21 August 2017.

Background information, including submissions from the parties

3. The sequence of events is not in dispute, so I have only set out the salient points. I acknowledge there were other exchanges of information between all the parties.

4. The relevant regulations are the NHS Injury Benefit Regulations 1995 (as amended) (**the 1995 Regulations**).

5. The 1995 Regulations apply to a person who sustains an injury, or contracts a disease, before 31 March 2013. Briefly, in order to be considered for a PIB, the injury sustained, or disease contracted, must be deemed wholly or mainly attributable to the person's NHS employment or to the duties of that employment (Regulation 3). If the injury or disease is deemed to be wholly or mainly attributable to the NHS employment, the second eligibility criterion is that the person has suffered a permanent loss of earning ability (**PLOEA**) of more than 10% by reason of the injury or disease (Regulation 4).

6. Providing a PIB award has been granted, Regulation 13 provides the opportunity for a deterioration review. Briefly, if an individual's earnings ability is thought to have deteriorated further, their initial PIB award may be amended to a higher Band to account for the diminished earnings potential.

7. First instance decisions are provided by the Scheme's medical advisers, Medigold Health (**Medigold**), under delegated authority.

8. Relevant extracts from the 1995 Regulations are set out in the Appendix.

9. Dr A worked for the NHS as a GP registrar (GP in training). In 2011, he sustained a psychiatric injury that resulted in a depressive illness leading to a period of long-term sick leave.

10. On or around 20 April 2014, Dr A submitted an application for a PIB award

11. On 1 September 2015, NHS BSA agreed that Dr A had an injury that was wholly or mainly attributable to the duties of his NHS employment. He was awarded a Band 3 PIB as it was expected that, with treatment, he could return as a part time (60% of the full-time hours) GP registrar. This represented a PLOEA of 40%. Dr A's PIB award was backdated to 20 January 2014, his last day of full-time employment as a GP registrar.

12. The methodology used to calculate Dr A's initial PIB annual allowance is summarised below:-

    - A medical adviser (**MA**) for Medigold carried out an assessment of what Dr A was earning before the injury, and what he could earn after.

    - The Department of Health and Social Care confirmed that the average salary for a GP aged between 40-44, as of 19 September 2014, was £93,900. However, NHS BSA used a higher average salary of £122,045, to calculate Dr A's PIB annual allowance, reduced by 87% to account for the fact Dr A was a registrar grade GP.

    - This resulted in an average remuneration figure of £106,179.15 used to calculate his PIB annual allowance. His PLOEA was then based on a 40% loss of earning ability equating to a Band 3 PIB award.

13. On 26 October 2015, Dr A disputed the decision to award him a Band 3 PIB and began the process of appealing NHS BSA's decision. Subsequently, Dr Aston, a Consultant Occupational Physician wrote to Dr Bamrah, Dr A's Consultant Psychiatrist, for additional information.

14. On 4 November 2015, Dr Bamrah responded to Dr Aston and said:

    - Earlier in 2015, Dr A stopped taking his antidepressants, this was the likely caused of his recent depressive episode/relapse. Though, he was improving and in a much better position that he was three to four months ago.

    - Dr A saw a "fairly full recovery" with Escitalopram, however, if any other symptoms were to manifest, a second antidepressant might need to be introduced. Though, it was too early to judge whether this scenario would borne out in the future.

    - If Dr A's recovery was sustained for the next three months, with no additional biological symptoms of depressions, then a graded recovery to training could be considered.

- There was "quite a lot of tension within [Dr A] and the current Deanery[1], with some justification". An inter-Deanery transfer was turned down as [Dr A] appears to have burnt his bridges locally.

- In order to continue with his GP training, he (Dr Bamrah) recommended that Dr A was transferred to a neighbouring Deanery to allow for a "fresh start". Dr A would also require a mentor, with the support of a local psychiatric unit.

- Upon returning to any work/training, it was recommended that Dr A should not work more than 60% of fulltime hours as "60% [had not] worked in the past".

15. On 3 February 2016, Dr A's GP signed a Statement of Fitness for Work, where he said: "[Dr A's] consultant psychiatrist recommended a return to 40% work capacity. I agreed with that recommendation". Dr A sent a letter to NHS BSA regarding this on the same day.

16. On 22 February 2016, Dr A took up a post as a GP Speciality Registrar on a 32-month contract at 40% of full-time hours.

17. On 16 March 2016, Health Education England (**HEE**) wrote to the solicitors of the GP practice where Dr A was employed. HEE said, in summary:-

    - It was unable to approve his 32-month contract on 40% full-time hours as it did not meet the General Medical Council's (**GMC**) minimum requirements.

    - A position statement by the GMC, from 2011, referred to section 6.69 of the Gold Guide (6th Edition 2016), stated that anything less than 50% of full-time hours while training was not permitted except for in exceptional circumstances. Dr A's circumstances were not viewed as exceptional.

    - Even if it was approved for Dr A to continue as a GP registrar, at 40% full-time hours, he was only permitted to do so for 12 months. Anything after those initial 12 months would not be recognised by the GMC as counting towards his training.

    - It was prepared to support his employment with the GP practice; however, this was on the proviso that his 40% full-time hours subsisted for no more than 12 months and were subject to a review in 3 to 6 months.

    - After a maximum of 12 months, at 40% full-time hours, his training commitment would need to increase to at least 50% full-time hours, in line with the GMC guidelines.

18. Dr A disagreed with the method used to calculate his PIB award and submitted a complaint under stage one and two of the Scheme's Internal Dispute Resolution Procedure (**IDRP**). He also submitted additional medical evidence and said that his

[1] Deaneries are organisations in the UK that are responsible for all NHS postgraduate medical training. They are categorised by the different regions in the UK, with 20 in total.

PLOEA was greater than 40%. NHS BSA did not uphold Dr A's complaint at each stage of the IDRP.

19. Briefly, NHS BSA's stage two IDRP response said:-

- It was reasonable to expect that Dr A would complete his GP registrar training, before he reached age 65, enabling him to commence employment as a qualified GP. This was despite him only working 40% of full-time hours.
- Qualified GPs could potentially earn in excess of £100,000, or more, pro rata. So, when Dr A completed his training, working 40% full-time hours would provide a salary of £40,000, which, when compared to his full-time salary of £68,401.75, provided a PLOEA of between 25% and 50%.
- To assess a PLOEA, suitable alternative employment needed to be identified for the applicant. The income of the alternative employment was then compared with the applicant's income prior to any reduction/loss.
- To identify alternative employment, the applicant's ability to work across the general field of employment was taken into consideration, not just that of their role, field or within the NHS. To do this, the accepted condition, age, intellectual and academic ability, qualifications, and experience were considered. The availability of the alternative employment, or the applicant's willingness to undertake it, was not accounted for.

20. Dr A disagreed with NHS BSA's response and brought his complaint to The Pensions Ombudsman to consider (PO-13579[2]).

21. On 31 May 2017, Dr A's NHS employment was terminated.

22. On 21 August 2017, Dr A requested a deterioration review of his PIB award as he believed that his PLOEA had declined. NHS BSA referred Dr A's request to Medigold who appointed Dr G Williams as the MA responsible for undertaking the deterioration review.

23. On 29 September 2017, Dr Williamson gave his opinion that a Band 3 PIB remained appropriate for Dr A. In undertaking Dr A's deterioration review, Dr Williams considered Dr A's comprehensive letter of 21 August 2017; a consultant psychiatrist's report of 27 January 2016; letters from HEE regarding the termination of his registrar training post; and a notice of reassessment from the GMC.

24. Dr Williams said:-

- Dr A had not provided any new medical evidence in support of his deterioration review request.

[2] NHS Injury Benefit Scheme (PO-13579) | The Pensions Ombudsman (pensions-ombudsman.org.uk)

- He noted that Dr A has raised concerns with his consultant psychiatrist that undertaking an alternative choice of career would be very difficult. However, Dr A had recently completed an MBA in healthcare management. This indicated that Dr A had a considerable scope for employment, outside of the NHS, and that he was not limited to the role of a medical secretary as he had suggested.

- The consultant psychiatrist report of 27 January 2016 said that Dr A should return to work at 40% fulltime hours and then "build it up gradually over weeks". There were no statements that supported Dr A's assertion that he was incapable of working anything more than 40% fulltime hours.

- He noted that Dr A's national training number had been revoked by the GEE, and that the GMC required him to undergo a reassessment to maintain his medical license. As he understood it, the purpose of the reassessment was for Dr A to demonstrate that he could maintain his medical licence. It was likely that attaining an MBA could be seen as contributory in him demonstrating to the GMC that he met their requirements.

- Based on the evidence available, there was nothing to suggest that there had been any further deterioration in Dr A's health and subsequently his earning ability. Dr A had earned an MBA during the period in which he was not attending his role as a GP Registrar, which he believed added to Dr A's employability.

- It was accepted that there had been some changes in Dr A's personal circumstances. However, this did not mean that Dr A would be unable to pursue an appropriate course of action to maintain his medical licence with the GMC.

25. In November 2017, Dr A corresponded with NHS BSA asked for additional information to be provided regarding the decision not to increase his PIB award.

26. On 1 December 2017, Dr Williamson wrote to Dr A and explained that with his current qualifications, experience, and the MBA in healthcare management he completed, he could apply for a role in healthcare management. In this type of role, it was likely that he would attain a salary in the experienced bracket of between £26,000 to £41,000. There was also the potential to progress to the highly experienced bracket of £78,000 to £98,000. These figures were based on the National Careers Services pay scale.

27. On 9 January 2018, Dr A wrote to NHS BSA as he disagreed with the outcome of the review and asked for it to be reconsidered under the Scheme's IDRP. He submitted that:-

- Initially, he only took escitalopram (20mg a day) to manage his depression. However, from 2017 he was prescribed quetiapine (25mg a day), in addition to escitalopram. This was not a temporary measure as he was prescribed both drugs for the foreseeable future. This should act as evidence that his condition had deteriorated.

- The MA had suggested that he could obtain employment as an experienced healthcare manager with a salary between £26,000 and £41,000. Later, potentially earning between £78,000 and £98,000 as a highly experienced healthcare manager.

- The suggested roles required applicants to be experienced, or highly experienced, in the field of healthcare management. Applicants were also required to provide evidence of their recent work in that area of employment. However, he had been on continuous sick leave since 2011 and had not worked in healthcare management, despite having achieved an MBA in healthcare management between 2013 and 2016. So, it was impossible for him to obtain the required references/experience needed to apply.

- Dr Bamrah's (consultant psychiatrist) report of 27 January 2016 said:

  > "…his previous work level of 60% was unsustainable because he became somewhat depressed and anxious and therefore, I would recommend that he starts at a work level of 40%, building it up gradually over weeks".

- The MA had incorrectly interpreted this to mean he could, at some point, work over 40% full-time hours. He believed that Dr Bamrah actually meant he should start with a phased return to work gradually increasing his hours up to 40% full-time hours, nothing more.

- Previous reports said that he was unable to work 60% full-time hours without an effect on his mental health. If he applied for and obtained a part-time role as an experienced healthcare manager, on 40 to 50% full-time hours, he would earn between £10,400 to £20,500. The salary currently used to calculate his PLOEA was £41,000, more than double the salary he could earn as a healthcare manager. Even if he secured the higher salary of £20,500 his PLOEA would be between 51% to 75%, or possibly over 75%.

- Due to the recurrent nature of his condition, and the pressures and stress related to employment, it was likely that he would need time off in the future. So, it was likely he would be unable to sustain and continue to work effectively in pressurised roles. Roles that he was unlikely to sustain should not be considered in deciding his PLOEA.

- His original Band 3 PIB award was made on the expectation that he could return to work on 40% full-time hours as a regular and effective employee. Over the past two and half years this had proven not be the case. So, his PLOEA should be increased.

28. On 27 December 2017, Dr A's license to practice medicine as a doctor in the UK was revoked.

29. In March 2018, Dr A and his wife separated. Subsequently, his wife moved overseas with their son. Dr A says that this acted to bring on a severe depressive episode.

30. On 11 June 2018, Dr A's GP, Dr Merry, provided him with a statement of fitness report and said:

> "Given the duration of [Dr A's] history, his lack of response to treatment, and the type of symptoms he gets, I think it is unlikely that for the foreseeable future he will be able to return to work full-time."

31. On 15 June 2018, NHS BSA provided its stage 1 IDRP decision. It explained that Dr A's case had been reviewed by a Medigold MA, Dr Evans. In arriving at his opinion, Dr Evans had considered/reviewed:

- Dr A's IDRP form of 9 January 2018;
- letters from Dr A dated 25 April 2017, 21 August 2017, 12 October 2017, and 9 January; Dr A's GP records;
- reports from Dr Bamrah of 18 October 2012, 27 November 2013, 24 June 2015, 4 November 2015, and 27 January 2016; and
- a report by Dr Ashton of 20 April 2014.

32. In summary, Dr Evans' report said:-

- Under the 1995 Regulations, the value of an applicant's PIB award was based on their capacity for work. There was no requirement to consider the availability of suitable work. He was required to consider Dr A's ability to work in the general sphere of employment. It was reasonable to assume that a prospective employer would comply with any requirements placed on them by equality/disablement legislation.
- It was noted that Dr A believed that the Pensions Ombudsman (**the PO**) had previously determined that only age, experience and qualifications already possessed could be considered in deciding an applicant's earning ability. This was not his (Dr Evans') understanding. It was his understanding that the experience and qualifications already held could demonstrate an ability to progress in employment. Any theoretical prospects for career progression would be based on the experience/qualifications possessed by the applicant, including any qualifications obtained after they stopped working for the NHS.
- It was noted that Dr A required additional medication to manage his conditions and that this was evidence of a deterioration. However, the question was not whether Dr A's medical condition had deteriorated, but whether his earning capacity had, and if so, to what extent.
- The MA that undertook the deterioration review, in September 2017, believed that Dr A was able to undertake a role in healthcare management. This was

reasonable as Dr A held an MBA in healthcare management that he achieved between 2013 and 2016.

- The annual starting salary for experienced healthcare managers ranged from £27,500 to £48,500, with higher salaries for managers who were highly experienced. Considering Dr A's experience and educational qualifications, and that he still had 20 years to progress a career before he reached age 65, it was reasonable to expect that he could aspire to a salary of £38,000 as an experienced healthcare manager.

- He was mindful that Dr A suffered from a recurrent depressive illness with expected future depressive episodes. The treatment Dr A received was likely to reduce the frequency, duration, and severity of these episodes. However, it was reasonable to suggest that these episodes, despite treatment, would affect his possible career progression.

- Medical literature indicated that functional recovery from a depressive illness was less complete than symptomatic recovery. This suggested that Dr A's earning capacity was likely lower than £38,000 a year. His former full-time salary of £71,392 was used to help determine his original PLOEA in 2014. In order to qualify for a Band 4 PIB his PLOEA would need to have declined to below £35,696, and for a Band 5 award, his PLOEA would need to be below £17,848.

- He interpreted Dr Bamrah's letter, dated 27 January 2016, to mean that Dr A could return to work on 40% full-time hours, gradually increasing his working hours from then on. He had attempted to contact Dr Bamrah for additional information, but Dr A did not provide his consent to do so.

- The original decision to award Dr A a Band 3 PIB, from 20 January 2014, was not unreasonable, albeit a little ungenerous. Given the chronicity of Dr A's recurrent depression along with the probable future depressive episodes he would likely experience, this would, at least temporarily, affect his ability to provide regular and efficient service to a future employer. On balance, Dr A's PLOEA was now between 51-75%, warranting a Band 4 PIB.

33. NHS BSA said it saw no reason to dispute the opinion of Dr Evans and agreed that Dr A was entitled to a Band 4 PIB. This would be backdated to 21 August 2017, the date of his deterioration review request.

34. In October 2019, Dr A requested another deterioration review as he believed that his PLOEA now warranted a Band 5 award. That is, he believed his PLOEA was more than 75%. He provided several medical reports to NHS BSA in support of his deterioration review, one of which was from Dr Merry, dated 12 July 2019, which said:

> "There is no doubt in my mind that despite medication [Dr A's] condition, if anything, is getting worse and I do not believe he is fit to work as a doctor currently and is unlikely to be able to for the foreseeable future."

35. On 29 October 2019, Medigold wrote to Dr A that he had been assessed as having a PLOEA of Band 5 and quoted its MA's advice. The MA said:-

- Dr A's licence to practice medicine had been revoked by the GMC in December 2017.

- A psychiatrist's assessment report, dated 12 August 2019, explained that triggers behind Dr A's depressive condition were related to "whistleblowing and his relationship with Health Education England and the Deanery". However, there were also triggers associated with the breakdown of his marriage, with his ex-wife and son moving overseas. This resulted in a loss of contact with his son. Dr A's mood was rated a three out of 10. This was slightly better than in previous years and the psychiatrist elicited ongoing constitutional symptoms of depression.

- In summary, Dr A suffered from a recurrent, ever present, background level of depression. This could become severe due to the triggering factors associated with whistleblowing, the collapse of his career, the way in which he identified with his professional status and factors associated with his personal life.

- His psychiatrist and GP said while additional medication and psychological treatment options existed, Dr A had already tried a number of antipsychotic and antidepressant medications, albeit it with poor results and with low levels of tolerance.

- Consideration needed to be given to whether Dr A could return to sustained employment in the future, and at what level of sustained employment he might be able to maintain. Previous MAs assessed that Dr A could return to a role in health management. Whilst Dr A had demonstrated higher educational competence in relation to his medical and post graduate training, and management competence with his MBA, his psychological status would likely prevent him from sustaining the demands of a health management role at any time in the future. This bore in mind Dr A's, Dr Merry's and the psychiatrist's comments on trigger factors for recurrence.

- So, when considering future employment, it would need to be at the level of non-specific administrative duties. It was likely though that Dr A would be unable to sustain this type of duties as they would represent a trigger for further depression in their own right highlighting his loss of professional status and impacting his self-esteem. This was evidenced by the psychiatrist's report which said that Dr A felt "ashamed and a failure".

- Reviewing current medical literature, an article published on 15 February 2019 in the Journal of Occupational Rehabilitation, entitled 'Sustainable Return to Work: A systematic Review Focusing on Personal and Social Factors, identified 79 studies which met the quality criteria of the review. Positive factors were those of attitude; high self-efficacy; a younger age; higher educational status; and support from leaders and co-workers. Other than a higher educational status, Dr A possessed

none of these factors. It was also less likely for an individual to successfully return to sustainable employment after an absence period of two years or more.

- Whilst Dr A had potential for a return to employment the likelihood was that he would be unable to return to any form of sustained employment.

36. Dr A was duly paid arrears for the period 12 July 2019 to 7 October 2019 plus interest.

37. On 23 December 2019, the PO provided his decision on the complaint that Dr A raised in 2016 (see paragraph 20 above). The PO determined that whilst NHS BSA had considered the ramifications of Dr A working at 40% of full-time hours it had failed to consider information that he might not complete his GP training programme.

38. The PO said:-

- Dr A's own doctors said that he was only able to work 40% of a GP registrar's hours to help reduce the risk of a relapse in his depressive condition. However, the HEE had clearly and unequivocally said that it would not support his GP training on a basis of 40% full-time hours for more than 12 months. NHS BSA was aware of this during Dr A's initial assessment.

- NHS BSA had failed to consider what Dr A' prospects would be, if after 12 months, he remained in a position whereby he was only capable of working 40% full-time hours.

- If Dr A was unable to complete his GP training on reduced hours, he would fail to qualify as a GP. So, it was remiss of NHS BSA to have considered various GP roles that Dr A could have undertaken when there were clearly challenges to him completing the training required to secure these roles.

39. The PO directed that:

> "NHS BSA shall reconsider [Dr A's] PIB application, taking into account the challenges presented to the completion of his GP training, then communicate its decision in writing to Dr A…"

40. On 27 January 2020, NHS BSA wrote to Dr A and explained that, in accordance with the PO's Determination, his initial PIB award had been reassessed by Dr Evans. In summary, the Dr Evans said:-

- In line with the PO's Determination, the reassessment was based on Dr A's circumstances, as of 20 January 2014, while taking into account information that was, or could have been, available at that time. Later changes in Dr A's health were not relevant regarding the PO's directions.

- An occupational health report, dated 20 November 2013, recommended that Dr A not work more than 60% of his full-time hours (on a phased basis), albeit in a different location. There were no concerns, at the time, about whether he would

be able to complete his GP training. A review was scheduled for six months' time, which suggested that it was anticipated that Dr A's return to work would be successful.

- A medical report dated 27 November 2013, by Dr Bamrah, agreed that Dr A's return to work should be on a phased basis. Dr Bamrah was of the opinion that Dr A should "shelve his MBA aspirations and concentrate on his medical career". But Dr A's intention to restart training was "a move in the right direction". There was no indication that Dr A's return to work would be unsuccessful, or that he was unlikely to complete his training.

- Dr A's contract of employment was for a fixed term from 13 January 2014 to September 2015, which would cover the time required for him to complete his GP training. When the contract was agreed, it was believed it would be fulfilled. It was unlikely that either party would have agreed to a contract that was unachievable.

- While depression was a long-term condition and typically recurrent, the majority of individuals did respond to appropriate treatment and with such treatment were able to continue in employment. in January 2014, it would have been considered likely that Dr A would, at some point, experience a relapse. But based on various medical reports from 2014, it appeared that Dr A responded well to treatment with escitalopram medication. There was also the option of a variety of antidepressants and mood stabilising agents that could be introduced in the future, if required. So, as of January 2014, it was more likely that any relapse of Dr A's depressive illness that might occur would only give rise to temporary incapacity.

- When Dr A left NHS employment it was certainly possible that he might not complete his GP training because of his depressive illness, and unfortunately this occurred. However, this only became apparent with the passage of time and the benefit of retrospection. The evidence available in January 2014 indicated that this was an unlikely scenario.

- So, the extent to which Dr A had sustained a PLOEA had to be made based on his circumstances in January 2014, when he commenced lower paid employment, and that he would successfully complete his training and become a GP. Consequently, there was no need to revise the initial assessment/award of Band 3.

- Subsequently, Dr A's mental health deteriorated, and he was unable to complete his GP training, his contract ceased in September 2015 and later his training number was withdrawn. Following the withdrawal of his training number it was unlikely that he would have qualified as a GP, which would clearly have affected his earning ability.

- Dr A requested a deterioration review. The review did not assume that Dr A would be able to work as a GP, but instead on his developing the capacity to work as a manager in healthcare before he reached age 65. There was nothing in the PO's

determination to indicate that his (Dr Evans') advice that a Band 4 award was, at that time, appropriate or needed to be revisited.

- In 2019, Dr A requested a further deterioration review. The review concluded that Dr A had suffered a further deterioration in his health and earning capacity and that a Band 5 award was now appropriate. The recommendation implicitly accepted that Dr A had not completed his GP training and would be unable to work as a GP. So, the level of the award did not need to be revisited. However, it was reasonable to accept that Dr A met the criteria for a Band 5 award on 12 July 2019, when Dr Merry commented that Dr A's mental health was getting worse, as there was no indication that it had improved between July 2019 and October 2019.

41. NHS BSA accepted Dr Evans' recommendation that the decision to award Dr A Band 3 PIB from 20 January 2014, and Band 4 PIB from 21 August 2017 remained appropriate and that Band 5 PIB should be backdated to 12 July 2019.

Adjudicator's Opinion

42. Dr A's complaint was considered by one of our Adjudicators who concluded that no further action was required by NHS BSA The Adjudicator's findings are summarised below:-

- Dr A believed that he should have been awarded Band 5 PIB award as early as 21 August 2017, the date of his initial deterioration review request.

- Dr Williamson's report of 1 December 2017 did not agree that Dr A's PLOEA had increased. A report by Dr Bamrah, of 27 January 2016, said that Dr A could return to work at 40% of his fulltime hours, gradually increasing his hours over a period of time. Dr Williamson believed that Dr A could, based on his skills, qualifications, and a recently obtained MBA, apply for a role as an experienced Healthcare Manager, with median salary of £38,000. When tested against the salary (£71,392) used to determine his PLOEA, his PLOEA was still between 25% and 50% (Band 3).

- On appeal, Dr Evan's report of 15 June 2018 said the decision to initially award Dr A a Band 3 PIB was not unreasonable, if a little ungenerous. He understood that Dr A suffered from a recurrent depressive illness and was likely to experience future depressive episodes that would, despite treatment, affect his possible career progression. Dr Evans considered that functional recovery was less likely than complete symptomatic recovery, which suggested that Dr A's earning capacity was likely lower than £38,000 putting him into the Band 4 category.

- The Adjudicator agreed that NHS BSA had acted in accordance with Regulation 13(1)(b) in reviewing Dr A's PLOEA. The fact that Dr Williamson and Dr Evans disagreed on the severity of Dr A's PLOEA was not a sufficient means to refer the matter back to NHS BSA to reconsider. There was nothing to suggest that, at the

time, Dr A was prevented from undertaking an alternative role, with the pressure of completing his GP training.

- In October 2019, Dr A's request for an increase to his PIB award, from a Band 4 to 5 was successful. The MA's report of 29 October 2019 said that the increase in his PIB award was due to the long-term likelihood that Dr A would be unable to return to any form of sustained employment. This was backdated to 12 July 2019, based on a report by Dr Merry, which said that Dr A was incapable of working as a Doctor for the foreseeable.

- The Adjudicator noted that during the course of Dr A's complaint, NHS BSA had also responded to the PO's determination (PO-13579) regarding Dr A's initial PIB application. Dr Evan's report, 27 January 2020, said that, based on the evidence available at the time, there was nothing to indicate that Dr A would be incapable of completing his GP training. Dr A's sustained PLOEA had to be based on his commencing lower paid employment and that he would successfully complete his training and become a GP. So, there was no need to revise the initial assessment/Band 3 award.

- The Adjudicator was satisfied that Dr Evans considered the relevant evidence and sufficiently explained why a Band 3 PIB, from 20 January 2014, was appropriate. There was no identifiable reason why NHS BSA should not have accepted the opinion of Dr Evans. The Adjudicator appreciated that Dr A's mental health had worsened after the Band 3 and Band 4 awards/reviews; however, this did not mean that either decision was improperly made. Each decision could only be, and was, based on the evidence available, at the time, and without the benefit of hindsight.

43. Dr A did not accept the Adjudicator's Opinion and the complaint was passed to me to consider. Dr A provided his further comments which do not change the outcome. I agree with the Adjudicator's Opinion and note the additional points raised by Dr A, which are summarised in paragraphs 44 to 56.

44. A substantial level of emphasis had been placed on the MBA he held, in relation to his employment prospects. However, despite holding an MBA in health management, since 2014, he was unable to secure employment. Nor was NHS BSA able to refer him to any particular role that he may be suitable for, based on his credentials and experience.

45. Dr Bamrah's report of 4 November 2015, provided to HEE and NHS BSA, said that to enable an effective return to work, while mitigating any possible depressive relapses, he should be transferred to another Deanery to complete his training. This was due to Dr A's view that the current Deanery held a negative view of him due to activities he was involved in during 2011. He was prevented from transferring to another Deanery, despite recommendations to do so, and NHS BSA failed to offer him and his family the required level of support. This directly contributed to the decline in his mental health resulting in an increasing PLOEA between 2014 and 2015 onwards.

46. The link between a relapse in his depressive disorder and the inability to transfer to another Deanery was known to NHS BSA in 2015 and also in 2018 when a decision was made to increase his PIB to a Band 4. So, it should have been clear that his PLOEA was greater than 50% in 2015. He believed it was incorrect for Dr Evans to say in his report of 15 June 2018, that there was no evidence that the initial decision to award a Band 3 PIB was inappropriate. He provided a detailed overview of his relationship and feeling towards the Deanery/the local NHS Trust (see Appendix 2) to NHS BSA on 25 June 2015, which did not appear to have been considered.

47. There was a difference between a PLOEA due to a deterioration in mental health, as opposed to a PLOEA due to a physical accident. With a physical accident there was a date and time for the injury causing the PLOEA. However, a deterioration in mental health was generally experienced long before the date of any psychiatric report or injury benefit application. This was ignored by the NHS BSA and the MAs.

48. Following his first deterioration review, he should have been awarded a Band 5 PIB instead of the Band 4 award he received. Any increase in his PIB award should also have been backdated to May 2014, instead of 21 August 2017. His NHS employment was terminated despite multiple warnings, since 2015, that working under the current Deanery would continually deteriorate his mental health. He believed that NHS BSA selected MAs that would provide opinions in favour of NHS BSA, that is, not recognising the severity of his PLOEA, as far back as 2015, as warranting a Band 5 award.

49. Dr Evans' report of 15 June 2018 specifically said that the initial decision to award his Band 3 PIB, based on a PLOEA of between 26-50% was "a little ungenerous". Dr Evans commented on the chronicity and recurrence of his condition, and considered a substantial amount of information that was available when he (Dr A) was initially awarded the Band 3 PIB in September 2015. Further, at no point in Dr Evans' report did he recommend that his increased Band 4 PIB award should only be backdated to 21 August 2017. So, it was NHS BSA's decision to backdate his Band 4 PIB award to 21 August 2017.

50. Correspondence from the Dean, in May 2015, said that because there was no prospective date for him to return to his GP training, it might be necessary to cancel his GP training number. So, evidence to suggest that he would be unable to complete his GP training was available as far back as May 2015, before a decision was made to award him a Band 3 PIB award in September 2015.

51. He understood that his Band 5 PIB award was backdated to 12 July 2019, the date of on Dr Merry's report. However, Dr Merry also provided a report of 11 June 2018, which said "Given the duration of [Dr A's] history, his lack of response to treatment, and the type of symptoms he gets, I think it is unlikely that for the foreseeable future [Dr A] will be able to return to work full-time". This was similar to Dr Merry's report of 12 July 2019, so, his Band 5 PIB should have been backdated to 11 June 2018.

52. Overall, he believed that there was compelling evidence available, between 2014 and 2015, demonstrating that his condition, or its recurrence, would not improve unless he was transferred to a neighbouring Deanery to have a fresh start. This was available via correspondence from the Deanery confirming that it seemed like a forgone conclusion that he would lose his GP registrar job, meaning he was unable to complete his training, losing his GMC registration. Further, Dr Bamrah said a transfer of Deanery was recommended to achieve a return to work. This information was ignored by NHS BSA and the MAs when considering his PIB application and subsequent deterioration reviews. He submitted that this was all in relation to activities that he undertook in 2011 in raising concerns he had with the local NHS Trust he worked for.

53. NHS BSA's report of 27 January 2020, in response to the PO's determination (PO-13579), did not adequately respond to the findings outlined in the Determination. Despite the PO's recommendation that NHS BSA should reconsider his PIB application, it appeared that Dr Evans, the author 27 January 2020 report had disregarded a substantial amount of evidence as it postdated 20 January 2014. Dr Evans said "Many of the documents post-date 20 January 2014. As I have indicated, changes to [Dr A's] health took place subsequent to this date are not relevant. I have therefore taken into account only elements of the documents that relate to, or provide insight into [Dr A's circumstances as of 20 January 2014]". This acted to ignore the period between January 2014 and September 2015 when his condition relapsed and deteriorated which highlighted the challenges he faced in completing his GP training.

54. He (Dr A) believed that Dr Evans' report of 27 January 2020 was biased, in favour of the NHS BSA, upholding the original Band 3 PIB award in September 2015. This was all in relation to the negative view his previous Deanery, and by association the NHS and NHS BSA, had in regard to the activities he engaged with in 2011.

55. In response to NHS BSA's report of 27 January 2020, he submitted complaints under stages one and two of the Scheme's IDRP, neither of which NHS BSA upheld. He disagreed with the approach taken by the MAs in responding and upholding the view of Dr Evans through his report of 27 January 2020.

56. He believes that his Band 5 PIB award should be backdated to 30 May 2014, the date that he began a period of continuous sick leave, from which he did not return. This was evidence that his return to part-time work was unsuccessful. NHS BSA should pay him £100,000 in recognition of the distress and inconvenience the process had caused him over the past 10 years.

57. NHS BSA accepted the Adjudicator's Opinion and did not provide any further comments.

Ombudsman's decision

58. Dr A's complaint concerns NHS BSA's handling of the two deterioration reviews for his PLOEA between 2017 and 2019. Dr A also contends the way in which NHS BSA

responded to my predecessor's Determination (PO-13579), which dealt with a separate complaint that Dr A raised about the handling of his initial injury benefit application and the way in which his Band 3 PIB award was calculated.

59. Briefly, the Ombudsman in PO-13579 found that NHS BSA did not consider the likelihood that Dr A could complete his GP training, while working 40% of his full-time hours, when considering the requirement of the HEE for Dr A to work at least 50% of his fulltime hours. See paragraph 40 for a summary of NHS BSA response, based on directions under PO-13579.

60. I consider NHS BSA's response to Determination (PO-13579), and the subsequent comments from Dr A on this matter as a separate issue, which I will put to one side, as it was not a part of the original complaint accepted for investigation. Instead, I will focus on the complaint that was accepted for investigation. That is, whether the correct process was followed by NHS BSA, and the MAs during the two deterioration reviews that occurred between 2017 and 2019, and whether the revisions to Dr A's PIB award were supported by the evidence available.

61. There is no dispute that during the course of Dr A's employment, he sustained an injury that was wholly or mainly attributable to his NHS employment. As Dr A is in receipt of a Band 3 PIB award, Regulation 13(1) allows for a deterioration review to be undertaken if it is believed that there has been a "further reduction of the person's earning ability by reason of the injury".

62. If, with the input of an MA, it is found that the member's PLOEA has increased to more than 50% or 75%, then there is scope for NHS BSA to increase the members initial PIB award to either a Band 4 or 5. In Dr A's case, he was awarded a Band 4 PIB award from 21 August 2017, and latterly a Band 5 award from 12 July 2019.

63. It is not my role to review the medical evidence and come to a decision of my own regarding an increase in Dr A's PLOEA and any subsequent increases to his PIB award. My role is to consider the decision-making process undertaken by Medigold and NHS BSA. If I were to find that the decision-making process was flawed, the appropriate course of action would be for me to remit the decision to NHS BSA for it to be retaken.

64. In order to determine whether the decision not to increase Dr A's PIB, at each review, was made in the proper manner, I have considered whether Medigold and NHS BSA have: (i) gone about making the decision in the right way; and (ii) made a decision which is supported by evidence.

65. With regard to making the decision in the right way, Medigold and NHS BSA were required to interpret and apply the relevant regulations correctly, and obtain and consider appropriate advice. I find that NHS BSA and the MAs have acted in accordance with Regulation 13(1) in that, upon receipt of each of Dr A's deterioration review requests, the matter was referred to a Medigold MA to consider whether Dr A's PLOEA had increased.

66. The first deterioration review was conducted by Dr Williamson with three reports provided between October 2017 and December 2017. It was noted that: Dr A was no longer training to be a GP; his national training number was removed; his license to practice medicine in the UK was due for a reassessment; and he was no longer in active employment. Dr Williamson believed that Dr A's PLOEA remained between 26 and 50% and that a Band 3 PIB remained appropriate.

67. In reviewing Dr A's PLOEA, Dr Williamson said that it was likely Dr A could work within a healthcare management role, with the potential to earn up to £98,000 (highly skilled band). Based on Dr A's skills and qualifications (an MBA in healthcare management), it was likely Dr A could aspire towards the highly skilled salary band. Dr Bamrah's report of 27 January 2016, said that Dr A should initially work at 40% of full-time hours, incrementally increasing his hours when possible. While Dr Williamson accepted this, he did not agree that this was evidence that Dr A was permanently incapable of working full time hours, at some point in the future.

68. The matter was referred, on appeal, to Dr Evans to consider. Dr Evans supported Dr Williamson's opinion, and his interpretation of Dr Bamrah's report of 27 January 2016. While in agreement with Dr Williamson's opinion, Dr Evans believed that Dr A's PLOEA was now more than 50% necessitating an increase to Band 4. This was based on the chronicity of Dr A's condition and the high probability that he would experience depressive relapses in the future which would affect his ability to provide regular and efficient service to an employer.

69. Dr A's Band 4 PIB award was backdated to, and payable from, 21 August 2017, the date of his application for a deterioration review. Dr A did not provide any new contemporaneous medical evidence/reports to support his claim that his PLOEA, or capacity for employment had changed substantially since September 2015. Based on the evidence available, I agree with date on which Dr A's Band 4 PIB became payable from.

70. I note Dr A's concerns that Dr Williamson and Dr Evans may not have considered the comments from Dr Bamrah's report of 4 November 2015, when determining his PLOEA. That is, it was recommended that he should transfer to a neighbouring Deanery to help facilitate his return to work as a GP. Dr Williamson and Dr Evans respective reports make clear that Dr A no longer worked as a GP for the NHS. It is also clear that the MA's assessment of Dr A's PLOEA was based on his potential to secure employment as a healthcare manager, not as a GP. Further elaboration on the matter of a transfer to a new Deanery was unlikely to affect the outcome of the first deterioration review.

71. Dr A has also made a number of comments in relation to the MA's reliance on his MBA, and how it could help secure further employment opportunities, which Dr A disputes. I find that the consideration of Dr A's employment prospects, in healthcare management, based on his MBA in same the field, were legitimate and relevant to determining the scope of his employment potential. Further, while the MAs are

required to consider Dr A's capacity for employment, there is no requirement to consider the availability of such work.

72. I am satisfied that both Dr Williamson and Dr Evans have acted in accordance with Regulation 13(1). That is, each MA considered whether or not there had been an increase in Dr A's PLOEA subsequently affecting his employability. The fact that there was a difference of opinion between the MAs does not act to undermine the fact that the correct process was followed during the deterioration review.

73. In October 2019, Dr A's second request for a deterioration review resulted in an increase of his PIB award to Band 5, as his PLOEA had increased to more than 75%. The MA responsible for the review noted that, based on a psychiatric assessment on 12 August 2019, a breakdown in Dr A's marriage, along with his son moving overseas, with limited contact, triggered a severe depressive episode.

74. The MA commented that despite Dr A's educational competence (i.e. his MBA), his psychological state prevented him from undertaking any demanding forms of employment. While he could consider employment of a non-specific administrative nature, this would likely act to trigger further depressive episodes due to the loss of his professional status. It was now unlikely that Dr A could return to any form of employment and that he had been out of work for more than two years.

75. Again, I am satisfied that the MA responsible for the second deterioration review had acted in accordance with Regulation 13(1). The MA provided clear and unambiguous comments on why Dr A's PLOEA increased. I find that there is no reason why NHS BSA should not have relied on the MA's opinion that Dr A's PLOEA was now greater than 75%.

76. NHS BSA made the decision to backdate, and pay, Dr A's Band 5 award from 12 July 2019, the date of Dr Merry's, Dr A's GP, report which said:

> "There is no doubt in my mind that despite medication [Dr A's] condition, if anything, is getting worse and I do not believe he is fit to work as a doctor currently and is unlikely to be able to for the foreseeable future."

77. Dr A has queried why his Band 5 PIB was only backdated to Dr Merry's report of 12 July 2019, when a similar report from Dr Merry of 11 June 2018 was provided, which said:

> "Given the duration of [Dr A's] history, his lack of response to treatment, and the type of symptoms he gets, I think it is unlikely that for the foreseeable future he will be able to return to work full-time."

78. I note the similarities between the reports; however, there are differences in the way in which each report has been worded. Specifically, the report of 11 June 2018 indicates that Dr A's ability for full time work was unlikely, this does not account for his ability to undertake part-time work.

79. The report of 12 July 2019 makes clear that Dr A is no longer fit to work as a Doctor due to a decline in his condition despite treatment. This, in addition to the comments that the loss of Dr A's professional status would impact his ability to undertake any non-specific employment in any capacity. Overall, I agree with the decision to backdate the Band 5 award to the date of Dr Merry's report of 12 July 2019.

80. I am satisfied that each of the MAs followed the correct process, and that their decisions were supported by the available evidence. There is no reason why NHS BSA should not have relied on any of the reports/opinions provided by the MA during the deterioration review process.

81. While Dr A's PIB award was increased from a Band 3 to a Band 5, This does not mean that he was always eligible for a Band 5 award, since the initial deterioration review. It simple means that between 2017 and 2019, there is demonstratable evidence to suggest that his PLOEA increased incrementally necessitating an increase to his PIB award Band.

82. There are no grounds to remit the decision back to NHS BSA. I do not uphold Dr A's complaint.

Dominic Harris

Pensions Ombudsman

28 June 2024

Appendix 1

The National Health Service (Injury Benefits) Regulations 1995 (SI1995/866) (as amended)

83. Regulation 3 provides:

> "3 Persons to whom the regulations apply
>
> (1) Subject to paragraph (3), these Regulations apply to any person who, while he –
>
> (a) is in the paid employment of an employing authority … (hereinafter referred to in this regulation as "his employment"), sustains an injury before 31st March 2013, or contracts a disease before that date, to which paragraph (2) applies.
>
> (2) This paragraph applies to an injury which is sustained and to a disease which is contracted in the course of the person's employment, and which is wholly or mainly attributable to his employment and also to any other injury sustained and, similarly, to any other disease contracted, if –
>
> (a) it is wholly or mainly attributable to the duties of his employment; …
>
> (3) These Regulations shall not apply to a person -
> (a) in relation to any injury or disease wholly or mainly due to, or seriously aggravated by, his own culpable negligence or misconduct;
> (b) eligible to participate in a superannuation scheme established under section 1 of the Superannuation Act 1972."

84. Regulation 4 provides:

> "4 Scale of benefits
>
> Benefits in accordance with this regulation shall be payable by the Secretary of State to any person to whom regulation 3(1) applies whose earning ability is permanently reduced by more than 10 per cent by reason of the injury or disease and who makes a claim in accordance with regulation 18A …"

85. Regulation 13 provided:

> "13 Review and adjustment of allowance
>
> (1) The Secretary of State shall review the amount of an allowance payable under Part II of these Regulations in the light of--
>
> (a) a further reduction of the person's earning ability by reason of the injury or disease;
>
> (b) the commencement or cessation of payment to the person of a benefit mentioned in regulation 4(6)(b), by reason of the injury or disease; or

(c) the commencement of a pension payable to the person under a relevant pension scheme or an increase in such a pension not being an increase under the Pensions (Increase) Act 1971; and for this purpose such pension shall be deemed to be reduced proportionately by the amount by which an official pension, that began on the date at which the average remuneration used in the calculation of the allowance was calculated, would have been increased under the Pensions (Increase) Act 1971 by the date of the increase or commencement of the first mentioned pension.”

Appendix 2

Extracts of Dr A's letter to NHS BSA of 25 June 2015

"The Psychiatrist believes that the feeling of injustice (done to me by local NHS) is acting as a constant trigger, which is propelling the low feelings, and this trigger is getting worse.

This injustice is further aggravated now because I have been given notice of a termination of my job as a GP registrar. As said before, it has been a struggle with employing authority as they are resistant to funding my TIA. The date of termination has been advised as 25 September 2015 and I've been served three-month termination notice on 19 June 2015.

…

Another effect of this situation will be my own GMC registration – both due to the illness, and due to the fact, I will not be able to re-validate with GMC due to no pathways of re-validation (after losing this job).

GMC revalidation requires that candidate should have 5 years of appraisals preceding an application for re-validation.

My last "satisfactory outcome" from ARCP (which is appraisal during training posts) was in July 2010. The latest appraisal during (ARCP) in July 2011, which related to my employment at [SFH] NHS Foundation Trust, was returned as "unsatisfactory" due to problems in that posting. This employment was later agreed to be the cause of my psychological injury and illness due to all the bullying I faced there as a result of raising whistleblowing concerns about the patients and doctors' safety.

The [SFH] NHS foundation Trust conceded to safety issues during the investigations by the Department of Health in 2012 and 2013 and was later placed under special measures as a result of investigations from Sir Bruce Keogh, Care Quality Commission and Monitor due to high death rates, governance failures, not being well led, and other issues. The Trust also conceded that their whistleblowing policy was faulty (the Trust changed it in September 2013); however, damage to me was already done in 2011. Recently, the Trust agreed with me, and Monitor, to look into why my whistleblowing was not investigated in 2011, and a further investigation is expected shortly.

Although difficult to prove, I believe that the constant struggle I have faced (and continue to face) with regards to getting my TIA funded from Local Area Team of NHS England, despite determination from NHS BSA and approval by Department of Health, has also been due to the local inter-connections of officers of local NHS bodies, and "club culture" making it difficult for me to procure any meaningful help within the NHS."