PO-15708

Ombudsman's Determination

Applicant	Ms Y
Scheme	NHS Pension Scheme
Respondents	NHS Business Services Authority (**NHS BSA**)
	Sheffield Health and Social Care NHS Foundation Trust (**The Trust**)

Complaint Summary

Ms Y's complaint is against NHS BSA and concerns its decision to refuse her MHO status from 1992 to 2016.

Ms Y's complaint against the Trust is that Sheffield Health Authority, Ms Y's employing authority in the 1990's, failed to:-

- Support her original MHO claim in 1992.
- Accurately report her job role between 1992-1994.
- Complete the MHO process in 1994.
- Inform her that her MHO status had not been resolved.

Summary of the Ombudsman's decision and reasons

The complaint should be upheld against NHS BSA because its stipulation that care must be "direct (hands-on)" to qualify towards MHO status is a restriction that Regulation 14 does not include. Consequently NHS BSA have failed to consider whether certain elements of the work conducted by Ms Y fall within the scope of treatment or care of persons suffering from mental disorder.

Detailed Determination

Material facts

1. MHO status was abolished from 6 March 1995, but those members who qualified for the status before that date are allowed to retain it providing they do not have a break in pensionable service of five years or more. Members with twenty years' MHO status are allowed to retire at age 55 and to count completed years of MHO membership twice.

2. MHO status is defined in clause R3(14) of The National Health Service Regulations 1995 (**the 1995 Regulations**):

   "(a) an officer working whole-time on the medical or nursing staff of a hospital used wholly or partly for the treatment of persons suffering from mental disorder, who devotes all, or almost all, of his time to the treatment or care of persons suffering from mental disorder;

   (b) any other officer employed in such a hospital who is within a class or description of officers designated by the Secretary of State as mental health officers for this purpose; and

   (c) a specialist in part-time NHS employment who devotes all, or almost all, his time to the treatment or care of persons suffering from mental disorder and who satisfies the requirements of paragraph (15)."

3. "almost all" is not defined in the 1995 Regulations, but NHS BSA said, in a response to a 2009 Freedom of Information (**FOI**) request, that in general terms a member would be considered as providing substantially the whole of their time with mentally disordered patients if they provided direct hands-on treatment for around 80% of their time.

4. To claim MHO status, NHS BSA require the member's employer to provide the person's job description and a breakdown of their duties, split between direct and indirect patient care and treatment with the percentage of working time spent on each. The final decision on whether to grant MHO status rests with NHS BSA.

5. Ms Y is a Senior Occupational Therapist (**SOT**). Her original employer was Sheffield Health Authority (**SHA**). SHA ceased to exist several years ago when the NHS was broken down into separate trusts. Mrs B became an employee of the Trust, formerly Community Health Sheffield (**CHS**). She remained with the Trust until 31 March 2016.

6. Ms Y commenced pensionable NHS employment on 1 October 1992. At that time the SHA indicated on her Scheme joiner form that MHO status was not applicable to the post (Psychiatric Unit, Northern General Hospital, Sheffield) . Ms Y ceased to be an active member of the Scheme on 30 April 1993.

7. On 15 November 1993 Ms Y started as a SOT at Yews Day Hospital, Sheffield. SHA indicated on her Scheme rejoiner form that MHO status should apply to the position.

8. A MHO status claim form (**SM1**) was submitted. The back of the form detailed Ms Y's duties under the form's headings 'Duties involving direct (hands-on) care and treatment of mentally disordered patients' and 'Duties not involving direct (hands-on) care and treatment of mentally disordered patients' and time spent on each as follows:-

Duties involving direct (hands-on) care and treatment of mentally disordered patients	Percentage of time spent per week on each
<u>Individual therapeutic work</u> e.g. counselling anxiety management domestic skills assertiveness social support	3 sessions per week
<u>Group work</u> anxiety management assertiveness social skills support	6 hrs (week in group itself) 3 sessions per week in total
<u>Assessments</u> Psychological, social, domestic and home visits on referral from other team…	1 session per week (on average)
Duties **not** involving direct (hands-on) care and treatment of mentally disordered patients	
Administrative / clerical requirements – Psymon Medical Records Letters etc	1 hour per day
Team (clinical + business) meetings Occupational Therapy Staff meetings Supervision (own + other staff)	2 hours per week (average) 3 hours per month 3 hours per week

9. It was noted on the form that the seven sessions under 'Duties involving direct (hands-on) care and treatment.' amounted to 3.5 days, which was equivalent to 70% ((3.5 / 5) x 100 = 70%) of Mrs Y's working time each week.

10. The same month NHS BSA notified SHA that Mrs Y was not entitled to MHO status as "they do not spend all or nearly all of their time caring for patients who are mentally disordered".

11. In June 1994 CHS wrote to the Pensions Officer asking whether it was possible to submit a second application stating,

    "This staff member's application was rejected on the basis that she does not spend nearly all of her time caring for mentally disordered patients.

    At the time, because of a temporary base, this was the case. She is now located in the Yews Day Hospital and contact with day patients has greatly increased."

12. NHS BSA issued to SHA a further SM1 for completion and return with a copy of the job description. Receiving none, NHS BSA chased SHA in August 1994 (the correspondence was misdated 12 August 1995) and in October 1994 notified CHS,

    "As you have not replied to our form [SM1] we must assume that you no longer want to claim MHO status for this member. Please tell the member they are not entitled to MHO status."

13. The matter was next raised in 2015 by the Trust when it emailed NHS BSA that Ms Y should have MHO status from 1 October 1992 and asked that her record be amended to reflect this. NHS BSA asked the Trust to arrange the completion of form SM1 and return this with Ms Y's job description. The Trust attributed 70% of Ms Y's working time to direct hands-on care and treatment.

14. NHS BSA duly turned the MHO status request down. The Trust requested that the matter be reviewed because:-

    - Ms Y's current job description clearly demonstrated the traits required for MHO status.

    - 70% of time spent on duties involving 'hands-on' care and treatment of mentally disordered patients constituted a majority.

    - Ms Y's employment history (an extract of which was submitted) demonstrated her ongoing employment in mental health and provided further evidence of her continuing entitlement to MHO status.

15. NHS BSA replied that Ms Y's MHO status had been investigated and rejected in respect of her first and second post in 1994. The 2015 completed form showed that Ms Y spent 70% of her time in direct 'hands-on' contact with mentally ill patients, which it did not consider constituted the whole or substantially the whole of Ms Y's time. Consequently, MHO status had again been rejected.

16. Ms Y unsuccessfully appealed the matter through the Scheme's two-stage internal dispute resolution (**IDR**) procedure.

17. At IDR stage 2 the Trust provided revised job descriptions and SM1s for Ms Y's posts commencing 1 October 1992 and 15 November 1993. On the latter it specified that 100% of Ms Y's duties related to hands on provision of treatment and care. In respect of care it cited as examples, "MDT's, record keeping, clinical supervision, liaison with other services, CPD".

18. Attached is the SM1 that NHS BSA received in March 1994 and CHS' 1993 job description for a Community Occupational Therapist, grade Senior 1.

Summary of Ms Y's position

19. Ms Y says:

- She understands the opinion of her local Pensions Manager (at Sheffield Teaching Hospitals) and the Trust that her roles since 1993 should attract MHO status was formed based on their experience of other staff holding MHO status, many of them her own Occupational Therapist peers.

- There is an absence of guidance on what constitutes "all or almost all" and "direct and hands-on" patient care and whether the phrases mean the same thing. Pension Managers and employers are therefore forced to make their own interpretation in applying for MHO status.

- The 70% figure for direct hands-on treatment and care was revised by the Trust in 2016 as a result of new information arising from the FOI 2009 response. This indicates that case conferences, consultations and writing reports relating to clinical work are viewed as "direct care" and therefore needed to be more clearly identified in her role in addition to the "hands-on" in the original submission. While the FOI relates to Psychology it presumably equally applies to other professional groups to avoid potential inequality.

- The duties of a SOT involve day long responsibility for acutely mentally ill patients. NHS BSA has failed to take into account the "stresses and strains" in making its judgement to refuse her MHO status.

- It is not reasonable for NHS BSA to exclude the Trust's revised job descriptions as "less reliable" than the job description previously provided. In particular because the latter have been submitted in the context of a better understanding of how NHS BSA interpret the information given on the SM1 form.

Summary of NHS BSA's position

20. NHS BSA says:-

- It does not believe it has erred in its application of the Scheme Regulations. It has previously been in contact with the Pensions Ombudsman about how the Regulations are applied. Determination PO-5361 did not find against its interpretation and application of the Regulations in respect of 'treatment and care'.

- The term MHO originates from the NHS (Superannuation) Regulations 1947, but its foundations are found in the special pension terms available in the Asylums Officers Act 1909**,** covering the arduous mental and physical strain of caring for mentally ill patients.

  The Superannuation (Prison Officers) Act 1919 provided for those who were employed in criminal asylums to retire at 55 instead of 60 and receive benefits calculated at double the normal rate. These provisions were incorporated into the NHS Pension Scheme at its inception.

  The definition of a MHO in Regulation 1 Citation and Interpretation was:

  "mental health officer" means an officer on the medical or nursing staff of a hospital used wholly or partly for the treatment of mental patients or an institution so used for the treatment of defectives who devotes the whole or substantially the whole of his time to the treatment or care of such patients or defectives, and such other classes or descriptions of officers employed in such hospitals or institutions as aforesaid as the Minister may designate;"

  The National Health Service (Superannuation) (Amendment) Regulations 1948 extended the description of those employees who may qualify for MHO status provided they spent the whole or substantially the whole of their time in the treatment or care of mentally ill patients.

- While there is no definition of "treatment" and "care" of mentally ill patients in the regulations governing the NHS Pension Scheme, The Mental Health Act 1959 confirms in Section 147 (1) that:

  ""medical treatment" includes nursing, and also includes care and training under medical supervision".

  And the Mental Health Act 1983 confirms in Section 145 (1) that:

  ""mental treatment" includes nursing, and also includes care, habilitation and rehabilitation under medical supervision…"

In the case of the *Minister of Health v Royal Midland Counties Home for Incurables, Leamington Spa General Committee (1954 Ch.530),* Lord Evershed said that treatment,

"includes not only medical treatment … in the sense that the patient or subject is looked after or attended by a doctor, but also nursing in the sense that the subject or patient is looked after and attended to by persons professionally trained to look after and attend to the sick".

- Until the Mental Health Act 1959, custodial treatment in mental health hospitals was predominant and often demanded staff whose levels of physical fitness was comparable to that of a prison officers or policemen. After the Mental Health Act, when the treatment or care of the mentally ill began to be moved away from mental hospitals into smaller units and into the community it became necessary to clarify that time spent must be with the patient and therefore "direct" was added to the requirement for MHO status to distinguish between time spent undertaking treatment or care of mentally ill patients directly with the patient and those that were consequential to the treatment or care of mentally ill patients and were away from direct contact with a patient.

- As a result of the Mental Health Act and developments in treatment it is considered that the stresses and strains involved in treating the mentally ill has become comparable with that of other places providing intensive care.

- MHO status for nursing staff is defined in the 1995 Regulations under regulation R3(14)(a), whereas allied health professionals (including Occupational Therapists) are considered for MHO status under R3(14)(b).

- The concept of treatment and care of mentally ill patients rests largely with the physical and mental demands on staff having mentally ill patients continually in their care and the stresses and strains resulting from this. MHO status is granted in recognition of the additional stresses and strains associated with the physical presence, contact or 'face to face' interaction with mentally ill patients.

- It acknowledges that duties that are administrative, clinical meetings and case conferences may be integral to a patient's treatment and care. But these activities may or may not be undertaken with the patient present. Report writing, drawing up treatment plans, interviews/meetings with relatives/carers/other health professionals, training and travel do not qualify towards MHO status because it is not time spent in the direct treatment or care of a mentally ill patient. Its view is that such duties are comparable to (and no more demanding than) similar duties required of other NHS staff who do not work with the mentally ill. For instance, NHS staff treating the terminally ill, or patients with life changing injuries/illnesses.

- In order to satisfy the criteria for MHO status an employee who is not on the nursing or medical staff must have an association with mentally ill patients that is comparable to that of a nurse/doctor/patient relationship.
- For allied health professionals (including Occupational Therapists) it considers the amount of time spent in direct 'hands-on' contact with patients, the types of duties performed and the employee's job description.
- The key eligibility requirement for MHO status is that the post-holder spends all or almost all of their time in the direct care and treatment of patients that are mentally ill. Any change to this requirement would contradict the spirit and intention established by the Asylums Officers Act 1909 and Superannuation (Prison Officers) Act 1919 which were designed to give individual recognition to those subjected to the stress and strain of having mentally ill patients constantly in their care.
- Where persons progress to senior positions it can be expected that they will spend progressively less time undertaking hands-on care and treatment duties in the presence of patients and more time on other management duties.
- Its decision is made on a cases by case basis. It does not take into account the outcomes of any similar applications.
- In making its decision it considers each of the duties an employee provides and whether the employer has appropriately classed each duty as direct treatment and care or otherwise. Further enquiries are made with the employer if necessary.
- It is not required to provide guidance to employers on what constitutes "all or almost all" in terms of time spent in direct treatment and care. This does not prevent a member or their employer providing an accurate breakdown of their duties.
- Whilst it is reliant on the employer for details of the member's full range of duties and time spent on each, and considers the employer's classification of duties as direct treatment and care or not, the final decision rests with it as to the proportion of time the member spent in direct and indirect care.
- The Trust did not provide a job description or a breakdown of Ms Y's duties when MHO status was requested following its June 1994 letter.
- The Trust indicated that Ms Y's contact with patients had greatly increased from 15 November 1993. The breakdown of duties it provided in 2015 for that post confirmed that Ms Y spent 70% of time in direct care, which indicates that before then she spent less time. The Trust's letter of 2 June 1994 agreed that MHO status did not apply to her first post.

- The Trust's 2016 revised breakdown of Ms Y's duties for her first and second post indicates that she spent 100% of her time in direct care. But the assessment included duties such as administrative matters, record keeping and liaison with other services etc, as direct hands-on care. Given that the forms were completed some 23 years after the posts ended, it is unlikely that sufficiently detailed employment records would still be available for the Trust to accurately account for Ms Y's duties at that time. The forms conflict with the information provided in 1994 and 2015 and also appear to be inconsistent with Ms Y's 1993 job description.

- The FOI response lists six categories of duties that it requires an applicant's percentage of time spent. Namely:

  interviewing / testing patients;
  participating in group psychotherapy or group behaviour;
  participating in case conferences and consultations;
  writing reports relating the clinical work;
  other duties; and
  other duties that would be classed as indirect care.

  Only the first three duties are likely to be classed as direct treatment and care.

- The FOI response is consistent with its normal practice as percentage times are requested for the member's full range of duties of an employment.

Conclusions

21. NHS BSA does not believe it has erred in its application of the Scheme Regulations. and refers to Determination PO-5361, which it says did not find against its interpretation and application of the Regulations in respect of 'treatment and care'….

22. Under regulation R3(14) to qualify for MHO status Ms Y must spend "all or almost all" of her time in the "treatment or care" of persons suffering from a mental disorder.

23. The words "all or almost all" and "treatment or care" are not defined in the 1995 Regulations. Consequently, the general rule of statutory interpretation applies, that is that words are given their plain and ordinary meaning unless that would produce an absurd result.

24. It is reasonable to say, by using the words "almost all", regulation 14(3) recognises that most MHO staff will have an element of their work which is not related to patient treatment or care. For example, attending a business meeting, continuing professional development, training, etc.

25. NHS BSA says for MHO status an employee who is not on the nursing or medical staff must have an association with mentally ill patients that is comparable to that of a nurse/doctor/patient relationship. It says duties which are administrative or where there is no direct contact with patients, such as drawing up treatment plans, report

writing or interviews/meetings with relatives/carers, do not qualify towards MHO status.

26. NHS BSA seem to apply an 80% benchmark for “almost all”. I do not consider that unreasonable, given that the ordinary meaning of “almost all” is very nearly so. For allied health professionals (including Occupational Therapists) NHS BSA applies the words “direct hands-on” to categorise treatment and care duties that qualify for MHO status.

27. The question is whether NHS BSA’s interpretation is consistent with the wording of and intention of regulation R3(14)?

28. By using the words “treatment or care” the regulation is referring to two different activities. It is therefore fair to say that “care” encompasses those things which are necessary in looking after a patient but which do not constitute treatment.

29. NHS BSA says “direct” was added to the requirement for MHO status after the 1959 Act. But the word has never been inserted in all the amendments to the NHS Scheme regulations. In fact, the definition of MHO reads much the same now as it did in 1919.

30. If the draftsman of R3(14) intended that only “hands-on” care and treatment could qualify for MHO status he or she could have used the term ‘attendance’. But it does not. While treatment or care which is direct in the sense of “hands-on” is plainly within the scope of the regulation it does not follow that time spent in any practice which is not hands-on is by definition outside it. The Regulations ask whether or not time was ‘devoted’ to care and treatment. That carries the sense of dedicated to or taken up by it rather than any particular method of administering it.

31. Turning now to NHS BSA’s decision to refuse Ms Y MHO status.

32. In making its decision NHS BSA noted the Trust’s (then called Community Health Sheffield) acceptance, in June 1994, that Ms Y did not spend nearly all of her time caring for mentally disordered patients prior to her transfer to Yews Day Hospital. It preferred the form it received from Mrs Y’s employer in 1994 and the Trust’s 1993 job description for a Senior Community Occupational Therapist to the revised SM1s received in 2016. For the purpose of understanding Mrs Y’s actual job content, I consider that it was reasonable to prefer documents which were contemporaneous with when Ms Y (and the Trust) claims her MHO status should commence. However, as NHS BSA note, no classification by an employer can be definitive on the issue of whether or not a member should be awarded MHO status. The decision is ultimately one for NHS BSA to make having considered all available evidence about what the member’s job was and how it was carried out.

33. Whilst the job description lists the ‘Key Result Areas’ of a Grade 1 Senior Occupational Therapist, it is the proportion of her working time that Ms Y spent on treatment and care that is of importance; and that is difficult to ascertain purely from a role description. The form SM1 is designed to capture further detail in order that NHS

BSA can make its decision. This form asks the employer to document duties either under the heading direct 'hands on' or not direct 'hands on'. However, significantly to my mind, both of those categories are described as 'care and treatment of mentally disordered patients'. There is no indication to employers completing the form that because a duty is listed under the second section rather than the first, it will automatically not count as time devoted to care and treatment. There is no direction that in giving information for this purpose they should turn their minds to the stresses and strains which NHS BSA consider characteristic of the duties which should qualify for MHO status. The only distinction is about whether duties are direct (hands-on) or not. Plainly activities which are direct (hands-on) are more likely to satisfy the definition; and if there is very little activity listed in section 1 it might not be necessary to look very much further to reach a valid conclusion. But in cases where it is not obvious whether the member devotes all or nearly all of their time to care and treatment, and the classification of a certain type of activity could tip the balance, it is necessary to look more closely at those elements of the role to determine whether or not they fall within the definition as it is understood within the particular discipline. To immediately discount (without further enquiry) anything recorded as non-hands on care and treatment fails to take all relevant information into account and applies an overly fettered policy which is not mandated in the regulations.

34. Looking at the SM1 form from 1994 and the duties entered under 'Duties not involving direct (hands-on) care and treatment'. It seems that "Administrative / clerical requirements – Psymon (the clinical recording system at the time which recorded all patient treatment activity), Medical Records, Letters etc 1 hour per Day", "Supervision (own and other staff) 3 hours per week ", and the "clinical", but not the "business" aspect of "Team Meetings" fit under the wider term of patient care and some of those meetings may in fact have been devoted to determining the correct treatment of particular patients. "Occupational Therapy Staff Meetings" appear less likely to be devoted to care and treatment, but the latter only accounted for 3 hours per month of Ms Y's working time. There appears to have been no consideration of these elements of the role and how they should be classified in terms of whether any of them were treatment or care.

35. NHSBSA have referred to a previous case where no error of interpretation or application of the Regulations was found to have occurred, in support of their interpretation and application of the Regulations in this case.

36. However, I have to consider each case on its facts and merits and the Regulations must be applied to the facts as they present. The fact that no error of application was identified on the facts which were presented in a previous case cannot determine the outcome on the facts of Mrs Y's case. Mrs Y is able to produce a detailed breakdown of the content of the role to which the Regulation must be applied and I am not satisfied that NHS BSA assessed the elements identified in paragraph 34 against the twin criteria of treatment and care. I make no finding about whether these activities as

undertaken by Mrs Y in fact fell within either category. That is an assessment for NHS BSA to make.

37. Consequently, taking all of the above into consideration, I am not satisfied that NHS BSA's decision to refuse Ms Y MHO status has been properly made. I therefore remit the matter back to NHS BSA to consider again.

Directions

38. Within 28 days NHS BSA shall:-

- Reconsider Ms Y's eligibility for MHO status from 15 November 1993 to date.
- Provide Ms Y with its decision with reasons.

Karen Johnston

Deputy Pensions Ombudsman
5 January 2018