CAS-13448-Y7N1

Ombudsman's Determination

Applicant	Mrs S
Scheme	NHS Pension Scheme (**the Scheme**)
Respondents	NHS Business Services Authority (**NHS BSA**)

Outcome

1. I do not uphold Mrs S' complaint and no further action is required by NHS BSA.

Complaint summary

2. Mrs S' complaint concerned NHSA BSA's decision not to award her an ill health early retirement (**IHER**) pension.

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. Mrs S worked for a University Health Board (**the Employer**) as a Chef within an industrial kitchen. By virtue of her employment, Mrs S was a member of the Scheme, a defined benefit occupational arrangement.

5. Regulation 90 of the NHS Pension Scheme Regulations 2015 (SI 2015/94) (**the 2015 Regulations**) applies to Mrs S' application for an IHER. Relevant sections are set out in Appendix 1.

6. On retirement from active service the 2015 Regulations, provide for two tiers of pension depending on the level of the member's incapacity for employment. Briefly, these are:-

   - Tier: 1 applies where the member is permanently incapable of efficiently discharging the duties of her/his NHS employment.

   - Tier 2: applies where the member is also permanently incapable of engaging in regular employment of like duration.

7. The expression 'permanently' means until the member attains normal pension age (**NPA**).

8. Regulation 91: Member's incapacity, states:

> "91.—(1) For the purpose of determining whether a member (M) is permanently incapable of discharging the duties of M's employment efficiently, the scheme manager must —
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> (a) have regard to the factors in paragraph (2), no one of which is to be decisive; and
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> (b) disregard M's personal preference for or against engaging in the employment.
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> (2) The factors mentioned in paragraph (1)(a) are—
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> (a) whether M has received appropriate medical treatment in respect of the infirmity;
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> (b) M's mental capacity;
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> (c) M's physical capacity;
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> (d) the type and period of rehabilitation it would be reasonable for M to undergo in respect of the infirmity, regardless of whether M has undergone the rehabilitation; and
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> (e) any other matter the scheme manager thinks appropriate."

9. The Secretary of State is the 'scheme manager' and is responsible for managing or administering the Scheme. The functions and responsibilities of the scheme manager may be performed on the Secretary of State's behalf by NHS BSA, or one or more persons/or corporate bodies that may include NHS BSA.

10. The decision on an application for IHER is made by the Scheme's Medical Adviser (**the MA**), Medigold Health (**Medigold**), in the first instance, and NHS BSA, on appeal, under delegated authority from the Secretary of State. The MA is required to provide an opinion on whether the applicant satisfies the Tier 1 and 2 conditions of the 2015 Regulations.

11. On 17 October 2017, Mrs S went on a period of long-term sickness leave due to an increase in the symptoms she experienced that were caused by her fibromyalgia.

12. On 1 December 2017, Mrs S was invited to attend a six week "Chronic Pain Health and Wellbeing Course". The purpose of the course was to enhance the effects of regular pain treatment by helping the participants to develop the skills necessary to manage their health.

13. On 31 January 2018, Mrs S attended an appointment with Dr Jones, a Consultant in Occupational Medicine appointed by the Employer. The appointment was organised at Mrs S' request due to her concerns about her condition and how it was impacting her ability to undertake the normal duties of her role.

14. On 14 February 2018, Dr Jones sent Mrs S a copy of his report (**the OH Report**). Dr Jones said:-

    - He noted that Mrs S' General Practitioner (**GP**) had prescribed amitriptyline 25mg. It was possible that this may need to be increased to ease the pain caused by fibromyalgia. However, it could increase the likelihood of tiredness/sleepiness during the day.

    - Mrs S could be prescribed nortriptyline, which worked in a similar way to amitriptyline, but without the same frequent symptoms of tiredness, lethargy, and lack of motivation.

    - He noted that some of her pain could be related to degenerative wear and tear arthritis in the lower end of her spine. Pain management specialists could offer facet joint injections; the effects were generally only temporary.

    - Mrs S was not well enough to return to the workplace, let alone carry out her normal duties. She may wish to discuss with her line manager whether she could work at a different site once her health had reached a level where she might be able to return to work on a regular basis. This was not a formal recommendation for Mrs S to be relocated to a new post/location.

15. On 12 June 2018, Mrs S attended a long-term sickness meeting with the Operational Services Manager and a Senior HR Officer. The purpose of the meeting was to review Mrs S' current period of absence and to establish whether she required any additional support. During the meeting Mrs S said that:-

    - Her health had not improved; she had good and bad days due to the effects of fibromyalgia and lumbar spondylitis.

    - Her GP, Dr Evans, recommended that she might have to leave her role as her health was unlikely to improve.

    - She was willing to accept the proposal to terminate her employment, with her last day of service being 29 June 2018. She was aware that she was entitled to 12 weeks' pay in lieu of notice (**PILON**), which she would receive as a lump sum.

16. Mrs S acknowledged that she had been advised to contact NHS BSA, to discuss her pension options.

17. On 29 June 2018, Mrs S' service with the NHS was terminated and an application for IHER (**the AW33E Form**) was submitted to NHS BSA to refer onto Medigold. Mrs S was age 51 at the time of the application.

18. On 7 August 2018, Dr Evans completed part C of the AW33E Form. Dr Evans explained that:-

- Mrs S was suffering from fibromyalgia related symptoms. These included: variable widespread pain; fatigue; poor sleep; low mood; reduced appetite; and short-term memory issues.

- An x-ray indicated symptoms related to lumbar spondylitis in her lower spine, however, a copy of the x-ray was not included with the application.

- Mrs S had undergone physiotherapy, attended meetings with a chronic pain team, rheumatology, and neurological teams. She was taking 50mg of tramadol, paracetamol and 50mg of amitriptyline.

- Her symptoms were unlikely to improve; however, a combination of antidepressants, occupational therapy, physiotherapy, and cognitive behavioural therapy (**CBT**) may help improve her functionality.

- Mrs S had been told that her condition was progressive and that she may end up needing a wheelchair.

19. On 21 September 2018, a MA, appointed by Medigold, provided their opinion to NHS BSA on Mrs S' eligibility for IHER under the 2015 Regulations. The MA considered the AW33E Form, and a report dated 18 April 2017 by Dr Callaghan, a Consultant Rheumatologist. (A summary of Dr Callaghan's report is set out in Appendix 2).

20. The MA did not agree that Mrs S met the criteria for IHER under Tier 1 and provided a report explaining their opinion (**the First Report**).

21. The First Report said:-

- On the balance of probabilities, at the time Mrs S left NHS employment, she was suffering from a condition which prevented her from efficiently discharging the duties of her employment. The key issue to consider was whether her level of incapacity was permanent.

- Dr Evans confirmed that Mrs S was suffering from symptoms of fibromyalgia and lumbar spondylitis. The fibromyalgia symptoms included widespread variable pain; fatigue; poor sleep; low mood; reduced appetite; and short-term memory problems. Dr Evans' overall view was that Mrs S' symptoms were unlikely to improve.

- The treatments Mrs S had undergone included assessments with rheumatology and neurology, input from a chronic pain management team, as well as attending physiotherapy. Mrs S was prescribed pain relief medication and a pain modulator. Dr Callaghan's report explained that Mrs S had undergone pain relief injections in the thigh region, albeit with only a temporary relief in her pain.

- It was noted that adjustments had been made to help accommodate Mrs S' needs. These included reducing her working hours to 28 hours a week, and less heavy lifting. Dr Evans said that, with the benefit of antidepressant medication,

occupational therapy, physiotherapy, and CBT, Mrs S' functional ability could improve.

- It was unlikely, based on the medical evidence, that Mrs S was permanently incapable of undertaking her NHS role. This was in spite of the physical nature of the role. There was still further treatment available to Mrs S in the form of optimised control of additional pain modulation medication, a multidisciplinary approach to pain management, which would include physiotherapy, occupational therapy, and clinical psychology.

- The suggested treatments, that Mrs S had yet to undergo, would likely enable her to return to her NHS role, until she reached her NPA. So, Mrs S did not meet the criteria for IHER.

22. On 4 October 2018, Mrs S contacted the Pensions Ombudsman's (**TPO**) Early Resolution Service (**ERS**).

23. On 4 April 2019, an ERS adviser wrote to NHS BSA. A summary of the correspondence is provided below:-

- Mrs S wanted to appeal the outcome of her IHER application under stage one of the Scheme's Internal Dispute Resolution Procedure (**IDRP**).

- The First Report only referred to Mrs S' job as a "support worker (chef)". It did not mention that she was employed in an industrial kitchen serving more than 1,000 meals at a time. The nature of her role was very physical.

- The OH Report explained that Mrs S suffered from fibromyalgia, a degenerative condition. The treatment of her condition was primarily focused on pain management, rather than providing a cure. She also suffered from ankylosing (lumbar) spondylitis.

- NHS BSA should reconsider its decision to decline Mrs S' IHER application.

24. On 26 April 2019, NHS BSA provided its response and explained that Mrs S' appeal was referred to a new MA (**the Second MA**) who was unfamiliar with her IHER application. The Second MA agreed with the initial MA's opinion that Mrs S did not satisfy the conditions for IHER under Tier 1. The Second MA considered the medical evidence Mrs S had submitted with her IHER application, including Dr Callaghan's report of 18 April 2017, as well as:

- a report dated 31 January 2018 by Dr Jones, a Consultant Occupational Physician;

- a report dated 9 October 2018 by Dr Kirmani, an Associate Specialist in Pain Management;

- a report dated 30 January 2019 by Dr Palaniswamy, Mrs S' GP

- a letter dated 1 December 2017 by S Lewis, an EPP Co-ordinator.

25. NHS BSA provided Mrs S with a copy of the Second MA's report (**the Second Report**) which said:-

- The Second MA needed to consider whether Mrs S' conditions were permanent. If so, what treatments might alter this.

- Some of the medical evidence Mrs S had submitted postdated her last day of NHS employment. Any changes in Mrs S' medical conditions, since her date of leaving service, were not relevant considerations when reviewing her case. Only evidence that was available as at 29 June 2018, or evidence that provided additional insight into Mrs S' health as at 29 June 2018, could be considered.

- The MA had considered a detailed job description for Mrs S' part-time role as a Chef, within an industrial kitchen. The MA acknowledged that it involved repetitive manual tasks, within a potentially dangerous working environment.

- The MA noted Dr Callaghan had commented in his report dated 18 April 2017, that Mrs S suffered from a long history of musculoskeletal pain, particularly in her lower back. She had also experienced problems with her left hip over the years. Her musculoskeletal symptoms were compatible with fibromyalgia, but there was no evidence of inflammatory arthritis.

- Dr Kirmani's report of 9 October 2018, said that Mrs S was first seen in the chronic pain clinic in April 2017, having suffered lower back pain for the last 20 years. At the time, Mrs S took amitriptyline, tramadol and used a versatis plaster to manage her lower back pain, which she found beneficial. A course of acupuncture resulted in an 80% improvement in Mrs S' pain levels. However, after the first "top up session", there was an overall increase in her pain over a period of three days. So, her GP recommended that she did not undergo any further acupuncture sessions.

- In his report, Dr Kirmani suggested that the GP should prescribe neuropathic medication. For example, pregabalin. However, he noted that after an appointment on 8 May 2018, having trialled pregabalin and gabapentin, Mrs S reported negative side effects and stopped using both drugs. Dr Kirmani prescribed Mrs S 0.025% capsaicin cream, and she was referred for a series of trigger point injections to her lower lumbar paravertebral muscles. A follow up appointment was scheduled with Dr Kirmani to consider ralvo plasters.

- Fibromyalgia is associated with widespread pain, the cause of which is unknown. The symptoms presented as hypersensitive pain responses with the sensory nervous system not working as it should. The condition could be triggered by physical trauma, inflammatory conditions or psychological stress. Many sufferers do gain some symptomatic/functional recovery in the long-term.

- The evidence-based treatments include:

> "appropriate pain medications (simple and compound analgesics, opioid and opiate drugs, neuropathic pain medications, some form of antidepressants and antiepileptic/mood stabilising agents), local anaesthetic injections, physiotherapy, other physical treatments (such as acupuncture), graded exercise therapy and psychological therapies (specifically cognitive behavioural therapy). These work best when overseen by a specialist in pain management and particularly when delivered as a pain management programme, via multi-disciplinary team".

- Prior to 29 June 2018, Mrs S had worked for some 20 years despite her chronic symptoms. It was noted that she had attended a pain management course and had reported a significant improvement in her pain levels and functional capabilities.

- Mrs S was due to start using caspian cream and was awaiting trigger point injections, in addition to a review of topical plasters. It did not appear that she had undergone CBT. Without the future treatments, it was more likely that her incapacity would persist beyond her NPA, which was age 67. However, it was unlikely to affect her capacity to undertake alternative less demanding work.

- On the balance of probabilities, with the benefit of the treatments that Mrs S was due to undergo, it was likely that she would recover to the extent that she would be able to return to her NHS role. This also took into account the fact that Mrs S had continued to work within her NHS role for 20 years despite her chronic pain symptoms.

26. On 17 December 2019, the ERS adviser asked for Mrs S' appeal to be considered under stage two of the IDRP and submitted that:-

- Up until 17 April 2017, Mrs S has worked full-time. However, she reduced her hours to 28 hours a week to help mitigate the effect of her symptoms on her ability to undertake her duties. Her IHER application should be judged against whether she could return to her role, based on her full-time hours, following future treatments.

- The future treatments that Mrs S was due to undergo would not cure her medical conditions and would only alleviate her pain/symptoms over the short term. Her current conditions were exacerbated by asthma, which she had suffered from since age 19, and hematosis which she had suffered from since age 28. Neither of these conditions were acknowledged at the time her IHER application was considered.

- Mrs S had not attended any in-person assessments with a Medigold MA. So, the opinions provided by the MAs, which NHS BSA had relied on, were limited because the MAs had only reviewed the available medical evidence.

- NHS BSA's decision, that Mrs S would be able to recover to the extent that she could return to work, for the next 14 years until her NPA, was perverse. Given the physical nature of her symptoms, and her former role as a full-time Chef working in an industrial kitchen, he questioned whether the decision was reasonable.

- If NHS BSA was aware of any future treatments that would allow Mrs S to recover sufficiently to enable a return to work, those treatments should be disclosed to Mrs S. Mrs S could discuss those options with her GP.

- The process undertaken to review Mrs S' IHER application was flawed. It appeared that NHS BSA had made its decision based on the expectation that sufficient medical advances, in the treatment of Mrs S' conditions, would occur during the period between 29 June 2018 and Mrs S' NPA.

27. On 27 January 2020, NHS BSA provided its response under stage two of the IDRP but did not uphold Mrs S' complaint. It explained that:-

    - A decision made by an NHS employer to terminate an individual's employment did not automatically mean that the member would be entitled to IHER benefits under the Scheme.

    - In accordance with the 2015 Regulations, NHS BSA obtained advice from professionally qualified and experienced occupational health doctors. All of whom had access to expert resources.

    - Mrs S' appeal under stage two of the IDRP was considered by a new Medigold MA who had no previous involvement with her case (**the Third MA**). Based on the evidence available, the Third MA did not agree that Mrs S met the criteria for IHER under Tier 1. NHS BSA saw no apparent reason why it should disagree with the opinion of the Third MA.

28. The Third MA who reviewed Mrs S' case under stage two of the IDRP provided a report to NHS BSA (**the Third Report**). The Third MA's comments are summarised below:-

    - He/she had reviewed the medical evidence and reports from Mrs S' IHER application and her application under stage one of the IDRP. He/she also considered a report dated 2 July 2019 from Dr G Evans, which postdated the last day of Mrs S' NHS employment. However, elements of the reports that provided further insight into Mrs S' circumstances at the time were taken into account.

    - There was no dispute that Mrs S suffered from fibromyalgia. It was noted that Dr Evans had indicated on the AW33E Form that Mrs S had symptoms associated with lumbar spondylitis. However, the medical reports did not confirm a diagnosis of a specific spinal condition. Dr Callaghan's report dated 18 April 2017, confirmed that Mrs S suffered from a long history of musculoskeletal symptoms, particularly in her lower back region. He concluded that her symptoms were compatible with fibromyalgia.

- There was no medical evidence to suggest that her asthma had limited her capacity for employment. He/she did not recognise 'hematosis' as a medical condition. The IHER application indicated that Mrs S had a B12 deficiency at age 28 and was taking B12 vitamins at the time. There was no reason to assume that the deficiency had led to any loss of capacity for work.

- The medical reports available to the MAs were sufficient to reach an opinion on Mrs S' IHER application and subsequent appeals. There was no requirement for Mrs S' specialists to be made aware of the Scheme's IHER criteria. While the MAs acted as advisers to NHS BSA, they were aware of the relevant provisions in the 2015 Regulations that needed to be considered in her case.

- The Second MA, at stage one of the IDRP, outlined several treatment options for fibromyalgia that were available to Mrs S. It was noted that Mrs S had taken part in a pain management programme that had resulted in a significant improvement in her symptoms.

- As previously acknowledged, in the absence of future treatment Mrs S' incapacity would likely persist beyond her NPA. However, on the balance of probabilities, at the time Mrs S left NHS employment future treatment would have altered the permanence of her incapacity, to allow a return to her NHS role. Mrs S did not meet the criteria for IHER under Tier 1.

Adjudicator's Opinion

29. Mrs 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 in paragraphs 30 to 46 below.

30. The relevant scheme rules or regulations will determine whether a member can take early retirement due to ill health. The rules or regulations will also determine the circumstances in which members are eligible for ill health benefits, the conditions which they must satisfy, and on occasion the way in which decisions about ill health must be taken.

31. Mrs S applied for IHER as an active member of the Scheme. So, her application was governed by regulation 90 of the 2015 Regulations. To be eligible for IHER pension under Tier 1, regulation 90(2)(c) states that the member must be deemed by the scheme manager to be permanently incapable of efficiently discharging the duties of his/her employment. In addition, regulation 90 states that the member must not have attained NPA and must have ceased to be employed in NHS employment.

32. If the Tier 1 criteria are met, the member's application is considered under regulation 90(3)(b) to determine whether he/she was entitled to immediate payment of ill health pension at Tier 2.

33. The decision on whether Mrs S met the eligibility requirements of regulation 90 was for Medigold to decide under delegated authority from the Scheme Manager. NHS BSA acts on behalf of the Secretary of State for the Department of Health and Social Care, the decision maker under the 2015 Regulations. The Adjudicator was satisfied that the decisions reached in Mrs S' case were made by the correct decision-maker, so the decision could not be challenged on that basis.

34. Mrs S either met the conditions set out in regulation 90, or she did not. This was a finding of fact, as opposed to an exercise of discretion. Medigold, in its capacity as the appointed Scheme MA, was required to determine whether at the date Mrs S left NHS employment, she satisfied the ill health conditions.

35. The decision must be made without the benefit of hindsight. So, any progression in Mrs S' condition, after her NHS employment had ceased, was not a relevant consideration for the purposes of that decision. However, this does not preclude the MA from considering reports that provide further insight into any medical conditions, or symptoms, which were present at the time.

36. It was accepted by all three MAs that, at the time Mrs S' NHS employment ended, she was unable to undertake her NHS duties. In April 2018, Mrs S reduced her working hours to 28 hours a week to help mitigate the effects of her symptoms on the duties of her employment. The question for the MAs to consider was whether her level of incapacity was likely to be permanent. In other words, whether Mrs S was likely to recover before her NPA to enable her to undertake her NHS duties efficiently. That assessment had to be made by reference to the medical evidence available at the time her employment ended.

37. The First MA noted that Mrs S had undergone assessments with rheumatology, neurologists, and attended a pain clinic for treatment of symptoms associated with fibromyalgia. Mrs S was prescribed pain relief and pain modulator medication. The First MA noted that Mrs S had experienced positive results in the management of her pain levels through these treatments.

38. The First MA noted the comments Dr Evans made in the AW33E Form. Specifically, that Mrs S' symptoms were: "unlikely" to improve up until her NPA with therapeutic treatment; her illness was progressive; and she could end up using a wheelchair. However, Dr Evans also said that there were a number of future treatments including antidepressants, pain medication, CBT, and occupational therapy, that "may" help improve Mrs S' functional capabilities before her NPA.

39. Overall, the First MA considered that, with the benefit of the available future treatments that Mrs S was yet to undertake, it was likely that she would regain sufficient functional ability, within the next 15 years and 11 months, that is up until her NPA, to undertake the duties of her NHS role.

40. Under stage one and two of the IDRP, Mrs S' appeal was considered by NHS BSA, with the input of the Second and Third MAs. The Second and Third MA agreed with the decision of the first MA. The Second Report noted that Mrs S took amitriptyline

50mg to help manage her pain levels. She was briefly switched to neuropathic medications: pregabalin; and gabapentin. However, due to adverse side effects, the pregabalin and gabapentin were stopped.

41. The Second Report also noted that Mrs S was due to start using 0.025% caspian cream, was awaiting trigger point injections and a review on a new topical plaster to help treat her pain. At the time, she had not undergone CBT, which the GP considered would be beneficial, with the First MA also agreeing with the GP on this point. The Second and Third MA also agreed that, on the balance of probabilities, with the benefit of future treatments, Mrs S would be able to continue in her NHS role until her NPA.

42. The Adjudicator considered the matter in detail, and based on the evidence available, it was clear that the MA's understood and acted in accordance with the applicable regulations. Mrs S did not meet the Tier 1 90(2)(c) criteria, so there was no requirement to consider her application against the Tier 2 criteria, regulation 90(3)(b).

43. The contention with regard to whether or not Mrs S' lumbar spondylitis had been considered by the MA was noted by the Adjudicator. The Third MA acknowledged that the IHER application referred to an x-ray for lumbar spondylitis but did not indicate that the condition had been formally diagnosed. Further, the medical evidence submitted with the IHER application, and during the subsequent appeal under the IDRP, did not provide any insight into this condition or any associated symptoms. The Adjudicator's view was that the MAs likely placed less weight on this condition when assessing Mrs S' capacity to continue in her NHS role until her NPA.

44. Based on the positive response Mrs S had shown to previous treatments, the Adjudicator thought that it was reasonable for the MA's to infer that any future planned treatments would also provide positive results for Mrs S. It was accepted that the treatments would not cure Mrs S of her medical conditions but would likely alleviate her symptoms or help her manage them in the long term.

45. Overall, the Adjudicator was satisfied that the MAs applied the appropriate test for IHER. The MAs considered the type of role Mrs S undertook and the reduction in her working hours. The MAs also considered the fact that the Employer had made reasonable adjustments to the workplace. There was no evidence that the MAs erred in their medical opinions, or in their approach to reviewing Mrs S' IHER application. The Adjudicator had not identified any reason why NHS BSA should not have relied on the advice it received from the MAs. So, there was no requirement to remit the matter back to NHS BSA to reconsider.

46. While it was understood that Mrs S' health had deteriorated since leaving NHS employment, this did not automatically invalidate NHS BSA's decision that she was not eligible for a IHER benefit. While Mrs S would be disappointed with the outcome there were no grounds to say that NHS BSA's decision-making process was flawed.

47. Mrs S did not accept the Adjudicator's Opinion, and the complaint was passed to me to consider. Mrs S provided her further comments which do not change the outcome.

I have considered the additional points raised by Mrs S, which are set out below, but I agree with the Adjudicator's Opinion. They are that:-

- She underwent an MRI scan in 2016; however, it was not until 2023, when she received confirmation that the discs in her neck and back were the cause of her spinal problems (lumbar spondylitis).
- Her GP, Dr Evans, had said that it was unlikely that her health would improve to allow her to return to her NHS role, let alone any other form of employment. Dr Evans had also commented that she may end up in a wheelchair due to the symptoms she experienced as a result of her conditions.
- She received a sum of £1,777.61, which amounted to 12 weeks of her salary; however, the Employer said that she was required to repay £986.15. She repaid this amount in July 2019, while incurring significant financial hardship as a result.
- It was her decision to ask the Employer to reduce her working hours.

48. NHS BSA accepted the Adjudicator's opinion and did not provide any additional comments.

Ombudsman's decision

49. I note that one of Mrs S' comments relate to a payment she received, part of which she had to repay, following the termination of her NHS employment. I am unable to review matters which relate to an individual's employment. If Mrs S wishes to pursue the matter of the re-payment of £986.15, she should contact the Employer directly about this.

50. At the outset, it is important to highlight my role in this process. I am not tasked with reviewing the medical evidence and deciding whether Mrs S should in fact receive an ill-health pension, that decision is made by NHS BSA in accordance with the 2015 Regulations. Rather, my role and that of TPO is to look at the process followed by NHS BSA.

51. When considering how a decision has been made by NHS BSA, I will look at whether:

- the appropriate evidence had been obtained and considered;
- the applicable scheme rules and regulations have been correctly applied; and
- if the decision was supported by the available relevant evidence.

52. Providing that NHS BSA has acted in accordance with the above principles and within the powers given to it under the 2015 Regulations, I cannot overturn its decision merely because I might have acted differently. It is not my role to review the medical evidence and come to a decision of my own as to Mrs S' eligibility for IHER Scheme benefits. I am primarily concerned with the decision-making process.

53. NHS BSA was required to assess Mrs S' IHER application in accordance with the 2015 Regulations, and to do so in consultation with the MAs.

54. I note that Mrs S has said that since her IHER application was declined on 21 September 2018, her conditions, and their associated symptoms, have not improved, and have in fact declined further. She has said that in 2023, additional scans revealed that the problems she experienced with her spine, thought to be lumbar spondylitis, were the result of disc problems in her neck and back.

55. I have every sympathy for Mrs S that her conditions have worsened since she left NHS employment. I do not doubt that the incapacity she experiences has increased. However, given that I am only permitted to review the way in which NHS BSA handled Mrs S' IHER application, made on 29 June 2018, I am unable to comment on the progression of her incapacity thereafter.

56. I am aware that further up to date medical evidence is now available regarding Mrs S' conditions. In this regard, I agree with the Adjudicator in that the progression in Mrs S' condition, after her NHS employment had ceased, is not a relevant consideration for the purposes of my review of NHS BSA's decision making process. However, this does not preclude the MA from considering reports that provide further insight into any medical conditions, or symptoms, which were present at the time.

57. I have considered the relevant evidence, including the medical evidence pertaining to Mrs S' condition at the time she applied for IHER and also when she appealed the decision. For the same reasons as given by the Adjudicator, outlined in paragraphs 30 to 46 above, I find that NHS BSA's decision, based on the MA's opinion, in the first instance, and then on appeal, was reached in a proper manner based on the evidence available. That is, the MAs, and subsequently NHS BSA, asked themselves the right questions, considered all of the relevant factors, while disregarding any irrelevant ones. NHS BSA did not arrive at a perverse decision that any other decision maker, properly directing itself, would make, based on the evidence available to it.

58. I appreciate that this outcome will be disappointing for Mrs S; however, the MAs and NHS BSA have acted in accordance with the relevant 2015 Regulations. At the time of her IHER application Mrs S did not meet the conditions for a Tier 1 IHER benefit.

59. If Mrs S wishes to, she may submit a new IHER application to NHS BSA, for the early release of her deferred pension on the grounds of ill health which will take into consideration Mrs S' current health.

60. I do not uphold Mrs S' complaint.

Anthony Arter CBE

Deputy Pensions Ombudsman

11 September 2024

Appendix 1

The NHS Pension Scheme Regulations 2015

61. At the time Mrs S' NHS employment ended Regulation 90 provided:

"(1) An active member (M) is entitled to immediate payment of—

(a) an ill-health pension at Tier 1 (a Tier 1 IHP) if the Tier 1 conditions are satisfied in relation to M;

(b) an ill-health pension at Tier 2 (a Tier 2 IHP) if the Tier 2 conditions are satisfied in relation to M.

(2) The Tier 1 conditions are that—

(a) M has not attained normal pension age;

(b) M has ceased to be employed in NHS employment;

(c) the scheme manager is satisfied that M suffers from a physical or mental infirmity as a result of which M is permanently incapable of efficiently discharging the duties of M's employment;

(d) M's employment is terminated because of the physical or mental infirmity;

and

(e) M has claimed payment of the pension.

(3) The Tier 2 conditions are that—

(a) the Tier 1 conditions are satisfied in relation to M; and

(b) the scheme manager is also satisfied that M suffers from a physical or mental infirmity as a result of which M is permanently incapable of engaging in regular employment of like duration."

Appendix 2

Medical evidence

Dr R Callaghan, Consultant Rheumatologist report dated 18 April 2017

"…Many thanks for asking me to see this 49-year-old lady who has had a long history of musculoskeletal pain, particularly in the low back region, for which she has seen the pain team in the past. There have been problems with her left hip over the years and in fact her referral to me came from Mr Evans who could not find an obvious surgical target. Looking back a few years ago, … saw her regarding neuralgia paraesthetica in the left thigh and I believe injections were of some benefit at that point although they did not tend to last. She is still under the pain team but I cannot see any recent letters on CWS.

Her musculoskeletal symptoms today are very compatible with fibromyalgia. She is tender in 14/18 fibromyalgic trigger spots. No evidence of inflammatory arthritis.

…

I have explained the diagnosis of fibromyalgia to [Mrs S] and increased her Amitriptyline to 20gm a night. I would be grateful if you could titrate this up gradually to a maximum of 50mg…"