CAS-43423-R8C4

Ombudsman's Determination

Applicant	Mrs N
Scheme	NHS Pension Scheme (**the Scheme**)
Respondent	NHS Business Services Authority (**NHS BSA**)

Outcome

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

Complaint summary

2. Mrs N complained that NHS BSA incorrectly decided in July 2018, to decline her application for ill health early retirement (**IHER**) benefits from the Scheme.

Background information, including submissions from the parties

3. The relevant regulations are the National Health Service Pension Scheme Regulations 2015 (as amended) (**the Scheme Regulations**).

4. On retirement from active service, regulation 90[1] of the Scheme Regulations provide for two tiers of pension depending upon the level of the member's incapacity for employment. Briefly, these are:-

   Tier 1 the member is permanently[2] incapable of efficiently discharging the duties of her/his NHS employment; and

   Tier 2 in addition, the member is permanently incapable of engaging in regular employment of like duration[3].

5. If a member satisfies the tier 1 condition, he/she is entitled to the retirement benefits that he/she has earned to date in the Scheme without actuarial reduction for early payment. If a member also meets the tier 2 condition, then his/her accrued benefits

[1]Relevant sections of this regulation have been set out in Appendix One below.

[2]"permanently" means the period until Normal Pension Age. In Mrs N's case, her Normal Pension Age is 67.

[3] "like duration" means, in summary, a regular employment for similar hours to a member's NHS job.

are enhanced by 50% of his/her prospective membership up to Normal Pension Age (**NPA**).

6. Tier 2 benefits are payable only if a member is accepted as permanently incapable of both doing his/her NHS job and regular employment of like duration to his/her NHS job, irrespective of whether such employment is available.

7. Mrs N was previously employed by the NHS as a full-time support worker.

8. Mrs N left NHS employment in April 2018 and applied for IHER benefits from the Scheme using form AW33E. At the time, she had been diagnosed as suffering from: (a) fibromyalgia, (b) bilateral shoulder impingement, (c) degenerative changes in her cervical and lumbar spine, and (d) some gastrointestinal symptoms.

9. Decisions on applications for IHER are made by the Scheme's Medical Adviser, Medigold Health (**Medigold**), in the first instance and by NHS BSA on appeal, under delegated authority from the Secretary of State, "the Scheme manager".

10. In its letter dated 5 July 2018, Medigold informed Mrs N that her application for IHER benefits had been declined. It quoted from its medical adviser (**MA**):

> "This is an initial application for ill health retirement benefits under the Scheme…
>
> Permanent incapacity is assessed by reference to the normal benefit age of 67 years…
>
> The medical evidence considered:
>
> - The referral documents;
> - AW33E. Parts A and B are completed…there is no entry at Part C but the following are offered as an alternative:
>
> - A report from Dr Vagadia, consultant rheumatologist, to the GP, dated 4 April 2017;
> - A report from the colorectal specialist registrar to the GP, dated 5 March 2018;
> - A letter from the consultant spinal surgeon, Mr R Kalyan, to the GP, dated 1 May 2018;
> - A further letter from Mr Kalyan to the GP, dated 10 April 2017;
> - MRI study dated 24 April 2018.
>
> Cases are considered on an individual basis and decisions are made on the balance of probabilities.
>
> Having considered the application and evidence there is, in my opinion, reasonable medical evidence that the member has a physical or mental infirmity as a result of which the member is currently incapable of efficiently discharging the duties of their employment. The key issue in relation to the

> application is whether the member's incapacity is likely to have been permanent.
>
> Dr Vagadia…gives a diagnosis of fibromyalgia and chronic mechanical low back pain. The consultant reports that the applicant has had symptoms for approximately 1 year with widespread aches and fatigue which have been "extensively investigated". He concludes "I do agree her symptoms are of a soft tissue nature and I do not think that I can offer any additional intervention".
>
> The colorectal problem appears to be related to a previous history of piles but further investigations are to be made to confirm this. As far as the back pain is concerned two MRI studies have shown that there is moderate disc and facet arthrosis at the level of L5/S1 but otherwise degenerations are of a mild nature. There is evidence of nerve root irritation but not of neurological compression either relating to the spinal cord or the nerve roots.
>
> Mr Kalyan, in his letter dated 10 April 2017 reports that there has been no significant change in the MRI appearance and that the pathology shown was not really suitable for surgical intervention.
>
> The applicant has 21 years to run to the normal benefit age…
>
> With regard to the fibromyalgic symptoms, this condition tends to have a relapsing-remitting course and therefore, even without treatment, there is a reasonable prospect of the applicant being able to return to her substantive post at some time prior to her 67th birthday for at least one period of time and possibly several periods of time.
>
> As far as her low back pain is concerned this is described as posturo-mechanical and the consensus for treatment of this condition is that of activity, performing regular postural and core stability work, swimming or exercising in water, and, if appropriate loss of weight.
>
> On current evidence, therefore, I do not find that the criteria for a tier 1 award are met in this case at this time."

11. Mrs N was dissatisfied with the outcome of her IHER application and made a complaint under the Scheme's Internal Dispute Resolution Procedure (**IDRP**).

12. At both stages of the IDRP, NHS BSA informed Mrs N that her complaint was not upheld because it agreed with the medical advice given by its MA that she did not satisfy the tier 1 condition at the time she left NHS employment in April 2018.

13. The MAs at each stage of the IDRP did not have any previous involvement with Mrs N's case.

14. Relevant paragraphs from the Stage One and Stage Two IDRP decision letters dated 3 October 2018 and 11 June 2019, including the opinions expressed by the MAs, are set out in Appendix Two.

Mrs N's position

15. When considering her IHER application and subsequent appeals under IDRP, NHS BSA improperly disregarded:

    - all the medical evidence and her statements proving that her conditions are chronic and lifelong; and

    - the information which she provided about her circumstances at work.

16. The medical evidence included a letter from her GP, Dr Williamson, who had the most knowledge about her medical conditions. This letter clearly stated that she will be unable to work again at any time. NHS BSA ignored this letter and a letter from Dr Russell which later confirmed that her conditions are incurable and lifelong.

17. If NHS BSA considered that the evidence provided by Dr Williamson and the specialists treating her was lacking, it should have contacted them (through her) for further information. At no point did NHS BSA do this. It also did not contact her former employer for details on why she left her job due to ill health or obtain the reports from the occupational health nurse and doctor who saw her. The failure of NHS BSA to obtain more information before making its decision is a "massive error" on its part.

18. It is unacceptable for NHS BSA to dismiss her IHER application on the basis that the evidence presented was, in its view, deficient.

19. NHS BSA did not look at her separate health issues as a whole and how they collectively impacted on her daily life and had prevented her from continuing to work.

20. NHS BSA did not consider her personal circumstances and simply accepted the advice of a MA that was based on "text-book generalisations" of her conditions which were not supported by her medical history. The MA did not medically examine her or ask her GP and the specialists any questions about her conditions before providing its recommendation.

21. There is nothing in her medical history which supports the MA's view that her spinal issues will resolve themselves over the next 10 years and she can return to work. Her spinal injuries have deteriorated over time and not improved.

22. NHS BSA did not consider her application on an individual basis. In reaching its decision, NHS BSA used "a general assumption" that it applied to everyone who had to stop working due to spinal injuries. It did not take into account that the severity of her spinal injuries meant she could never return to work.

23. In its Stage Two IDRP decision letter, NHS BSA only commented on her rota cuff injury and disregarded: (a) the bulging discs in her neck and lower back, (b) the herniated and split discs, (c) the spinal stenosis, and (d) the nerve damage to her spine. She was unable to work because of these injuries since her job involved heavy lifting and moving of equipment. The physiotherapy and exercise recommended for her rota cuff injury were ineffective and did not cure the issue.

24. The job description for her is basic and did not mention all the heavy lifting involved in her role. She supplied photos showing the physically demanding nature of her work. NHS BSA did not take this into account.

25. She was seen about 10 times by an occupational health nurse and also by an occupational health doctor. NHS BSA did not request their relevant reports for consideration when assessing her application.

26. She has supplied NHS BSA with letters showing that her fibromyalgia is lifelong and chronic. It has ignored this evidence. Her fibromyalgia has also deteriorated over time.

27. Her job also required "a great deal of mental capacity and concentration". She explained to NHS BSA that she had to stop working because she could no longer "cope both physically and mentally with the pain, fatigue and brain fog that was so debilitating". NHS BSA dismissed her explanation.

28. In her view, the MAs were not qualified to make decisions on every illness. They misdiagnosed fibromyalgia in her case and did not consider it can affect people in different ways. Some people can manage to live a relatively normal life and work but others (like her) are affected so badly that they can no longer do this.

29. She says that:

> "Fibromyalgia is a very misunderstood disability and I have advised them of this, they are choosing wrongly, to quote to me that I would still be able to work with this condition, their facts are wrong and letters from my GP have quite clearly shown I am not able to work and my condition is lifelong and that I am unable to work or be employed…I have also explained I am unable to function normally in my everyday life any longer and my family have to assist me everyday of my life, they have ignored this completely, that is unacceptable."

NHS BSA's position

30. NHS BSA refutes any allegation of maladministration on its part. It has correctly considered Mrs N's application for IHER benefits. It took into account all the available evidence that was relevant and weighed it appropriately. In making its decision, it followed a proper process and considered the advice of its MAs.

31. NHS BSA and its MAs took into account Dr Williamson's medical opinion at each stage of the decision-making process. That NHS BSA drew a different opinion about Mrs N's permanent incapability to undertake the duties of her NHS employment is a finding for it to make based on the available evidence.

32. Evidence which post-dates a member's last day of employment will be taken into consideration but only to the extent that it relates to or provides an insight into the medical condition and circumstances as at the date employment terminated. Any deterioration in a medical condition after this date cannot be taken into consideration.

33. In medical matters, decisions are seldom "black or white". A range of opinions may be given from various sources, all of which must be considered and weighed appropriately. The fact that Mrs N does not agree with the conclusions drawn in this case, and the weight attached to individual pieces of evidence, does not mean that the conclusion NHS BSA reached is flawed.

34. NHS BSA says that:

> "…the role of the [Scheme] MA is quite different from that of a treating doctor in several aspects; there is first of all a fundamental requirement to assess an applicant's capacity/incapacity for work, in the context of the scheme rules. They must carry out a forensic analysis of the available relevant medical evidence provided by the various treating doctors and consider that against the tightly prescribed requirements of the relevant Scheme regulations. Occupational health physicians are the specialists in this field…and their training and experience in this field will exceed that of any particular specialist.
>
> Recognising that they must be generalists, and thus not specialists in any particular medical condition or speciality, occupational health physicians have expertise in seeking, evaluating and using the evidence of clinical specialists. While a clinical specialist's focus will be on their patient's medical condition, its clinical management and outcome, the focus of occupational health physicians is on the functional consequences of the medical condition and how that change in function impacts on the patient's capacity/incapacity for work."

Adjudicator's Opinion

35. Mrs N'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 36 to 58 below.

36. Under regulation 90 of the Scheme Regulations, tier 1 IHER benefits were available to Mrs N if NHS BSA, acting on medical advice, formed the opinion that her medical conditions would prevent her from permanently discharging the duties of her NHS employment efficiently. Its decision was made on the balance of probabilities.

37. So, for Mrs N to meet the criteria for tier 1 IHER benefits, she must be considered by NHS BSA to be permanently incapable of undertaking efficiently the duties of her NHS post until her NPA of 67.

38. If NHS BSA considered that Mrs N was, more likely than not, also incapable of regular employment of "like duration" to her NHS role, she would be entitled to tier 2 IHER benefits. This was irrespective of whether employment of this nature was available to her.

39. It is not the role of the Pensions Ombudsman (**the PO**) to review the medical evidence and come to a decision of his own as to Mrs N's eligibility for IHER benefits from the Scheme.

40. The PO is primarily concerned with the decision-making process. Namely, whether NHS BSA's decision was supported by the available medical evidence and any other evidence relevant to the case. The PO would consider: (a) whether the applicable scheme rules or regulations had been correctly interpreted, (b) whether appropriate evidence had been obtained and considered, and (c) whether the decision was supported by the available relevant evidence.

41. If the PO finds that the decision-making process is flawed, or that the decision reached by NHS BSA is not supported by the evidence, the case is normally remitted to NHS BSA to reconsider. The PO cannot overturn the decision just because he might have acted differently.

42. It was for NHS BSA (Medigold in the first instance) to decide the weight to attach to any of the evidence, including whether to give some of it little or no weight. It was open to NHS BSA to prefer evidence from its own MAs; provided, that is, there was no good reason why it should not do so. The kind of things the Adjudicator had in mind were errors or omissions of fact or a misunderstanding of the relevant regulations. The reason would have to be obvious to a lay person; NHS BSA was not expected to challenge medical opinion. It might, however, be expected to seek an explanation if its own MA's opinion was at variance to that held by Mrs N's own doctors, if one had not already been provided. The Adjudicator noted that the MAs at both stages of the IDRP acknowledged that their views differed to that expressed by Mrs N's treating doctors and they explained why this was.

43. The initial decision was made by Medigold in July 2018, under delegated authority from the Secretary of State who was the decision maker under the Scheme Regulations.

44. On reviewing the evidence, the Adjudicator was satisfied that Medigold's decision, to decline Mrs N's IHER application, was taken after its MA had considered the medical evidence provided with the application, which it listed in its letter dated 5 July 2018. Medigold had to weigh the evidence and take a decision based on the balance of probabilities.

45. At the time her employment ended, Mrs N suffered from: (a) fibromyalgia, (b) bilateral shoulder impingement, (c) degenerative changes in her cervical and lumbar spine and (d) some gastrointestinal symptoms. The MA was required to consider whether Mrs N's incapacity for her NHS role was at that time likely to be permanent; that is, whether it was likely to last until her 67th birthday.

46. In Mrs N's case the MA said:-

- Fibromyalgia tended to have "a relapsing-remitting course". So even without treatment, it was reasonable to expect that Mrs N would be able to return to her post prior to her 67th birthday for at least one, and possibly several, periods of time.

- The consensus for treatment of low back pain was that of: (a) activity, (b) performing regular postural and core stability work, (c) swimming or exercising in water, and (d) if appropriate, loss of weight.

47. Based on the evidence presented, the MA concluded, on the balance of probabilities, that:

- Mrs N's conditions did not permanently prevent her from efficiently discharging the duties of her NHS employment up to age 67; and so

- the tier 1 condition for IHER had not been met.

48. Mrs N was dissatisfied with the outcome of her IHER application and appealed it twice under the IDRP. On each occasion, after carrying out a thorough assessment, NHS BSA informed Mrs N that her appeal had been unsuccessful because it accepted the view of its MA.

49. Mrs N said that NHS BSA: (a) disregarded the medical opinions expressed by her GP and the specialists supporting her IHER application, and (b) did not obtain evidence from them, her former employer or the occupational health experts who saw her. She contends that it just accepted the advice of its MA who had neither medically examined her nor asked her GP and the specialists any questions about her conditions. In her view, this was a massive error on the part of NHS BSA.

50. There was a difference between disregarding medical evidence and attaching little or no weight to it. NHS BSA listed the medical evidence which its MAs considered in its IDRP decision letters. The medical evidence submitted by Dr Williamson and the specialists supporting Mrs N's application were on these lists. The Adjudicator was satisfied that the medical evidence was considered that pertained to Mrs N's conditions at the time her NHS employment ended.

51. There was no requirement in the Scheme Regulations for an applicant to be seen by the MA. It was for the MA to decide whether it was necessary to see the applicant and whether they had sufficient medical evidence to give their opinion or require further information from the applicant's treating doctor(s), occupational health or Mrs N's former employer.

52. Mrs N also contended that the MA's advice to NHS BSA was based on "text-book generalisations" of her conditions which were not supported by her medical history. There was a need, when referring to research/statistics, to relate such information to the case under review. In the Adjudicator's view, the MAs did this in Mrs N's case.

53. It should also be noted that a difference of opinion between doctors, in and of itself, is not usually sufficient for the PO to find that by preferring the opinion of its MA meant that NHS BSA's decision was not properly made.

54. The Adjudicator had not identified any obvious error or omission of fact, irrelevant matters or misunderstanding of the Scheme Regulations in the MA's advice which NHS BSA should have queried.

55. So, it was the Adjudicator's view that there was no reason why NHS BSA could not rely on the advice it received from its MAs in reaching its decision in Mrs N's case.

56. The fact that Mrs N was still suffering from the same medical conditions did not, in and of itself, invalidate NHS BSA's decision. NHS BSA could only be expected to make its decision based on the medical opinions expressed at the time pertaining to her health when her employment ended. NHS BSA chose to prefer the opinion of its MAs, who are experts in occupational health. Its MAs were only being asked to give opinions on the balance of probabilities. There will always be an element of uncertainty in any prognosis.

57. It was consequently the Adjudicator's opinion that NHS BSA took appropriate action at both stages of the IDRP after obtaining further medical opinions from its MAs. He was also satisfied that NHS BSA: (a) gave proper consideration to Mrs N's application at the time by assessing all the relevant medical evidence available, and (b) acted in accordance with the Scheme Regulations and the principles outlined in paragraph 40 above.

58. If Mrs N was not already in receipt of her deferred pension, she might apply for ill health retirement from deferred status. Consideration would then be given to medical evidence pertaining to her health since leaving the NHS.

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

60. Essentially Mrs N said that the issues which she raised in her complaint, as summarised in paragraphs 15 to 29 above, had not been properly considered and she wanted "a full response" to her concerns.

61. I note Mrs N's comments, but I agree with the Adjudicator's Opinion.

Ombudsman's decision

62. At the outset, it is important to highlight my role in this process. The Pensions Ombudsman is not tasked with reviewing the medical evidence and deciding whether Mrs N should in fact receive an ill-health pension – that decision is made by NHS BSA (as set out in paragraph 9 above) in accordance with the Scheme Regulations. Rather, my role and that of my office is to look at the process followed by NHS BSA.

63. When considering how a decision has been made by NHS BSA, I will generally 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.

64. Providing NHS BSA has acted in accordance with the above principles and within the powers given to it by the Scheme 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 N's eligibility for IHER benefits from the Scheme. I am primarily concerned with the decision-making process.

65. NHS BSA was required to assess Mrs N's IHER application in accordance with the Scheme Regulations, and to do so in consultation with the MAs.

66. Mrs N said that it is unacceptable for NHS BSA to:

- disregard the medical opinions expressed by her GP, Dr Williamson, and the other specialists supporting her IHER application; and

- decide not to obtain additional evidence from the above medical professionals, her former employer or the occupational health experts who saw her.

67. She also contended that it was improper for NHS BSA to accept the advice of its MA when they had not medically examined her or asked her GP and the specialists any questions about her conditions.

68. However, there is no requirement in the Scheme Regulations for an applicant to be seen by the MA. Moreover, the MA's remit is not to add to the weight of medical evidence but to objectively assess the evidence presented in support of any application or subsequent dispute. It was open, however, to the MA to request further medical evidence should the need arise.

69. So it is for the MA to exercise their professional judgement in deciding whether they: (a) needed to see Mrs N, and (b) obtain further medical evidence from her various treating doctors, occupational health, or her former employer before providing their advice to NHS BSA.

70. In Mrs N's case, the MA decided that it already had sufficient evidence to form their medical opinion and obtaining further information would not significantly add to their understanding of Mrs N's medical conditions.

71. That the MA was able to advise NHS BSA based on the available evidence did not consequently mean that it had failed to properly assess Ms N's IHER application.

72. Furthermore, it is, for NHS BSA to decide, within the bounds of reasonableness, the weight which is attached to any of the medical evidence. It is open to NHS BSA to prefer evidence from its own MAs unless there is a cogent reason why it should or should not do so without seeking clarification. By way of example, this might include such things as an error or omission of a fact or a misunderstanding of the relevant rules by the MA, neither of which I consider has occurred in this case.

73. As the adjudicator set out, the decision to give little or no weight to any of the evidence is not the same as failing to consider it. NHS BSA listed the medical evidence which its MAs considered in the two IDRP decision letters. It is clear that the medical evidence submitted by Dr Williamson and the specialists supporting Mrs N's application, along with the document detailing Mrs N's tasks during her employment, including photographs, was provided to the MAs for consideration.

74. Both IDRP decision letters also said that NHS BSA, together with the MA, had taken into account all the available evidence when carrying out a comprehensive review of Mrs N's application and there is no evidence to suggest that was not the case.

75. It is consequently clear that NHS BSA had given most weight to the MA's opinion that, at the time of leaving employment, Mrs N's condition did not, on the balance of probabilities, permanently prevent her from efficiently discharging the duties of her NHS employment before her normal benefit age of 67.

76. Needless to say, the decision made by NHS BSA would appear unfair to Mrs N. However, NHS BSA has a duty to pay benefits in accordance with the Scheme Regulations.

77. I find that NHS BSA did give proper consideration to Mrs N's IHER application by assessing all the relevant medical evidence available at the time and it had acted in accordance with the Scheme Regulations and the above principles.

78. While I sympathise with Mrs N's circumstances, the evidence does not support a finding of maladministration by NHS BSA in coming to the decision it did, and so I do not uphold Mrs N's complaint.

Dominic Harris

Pensions Ombudsman
30 May 2023

Appendix One

The National Health Service Pension Scheme Regulations 2015

At the time Mrs N's NHS employment ended, Regulation 90 provided:

"Entitlement to ill-health pension

(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 is qualified for retirement benefits and 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 claims 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 Two

Relevant excerpts from the Stage One IDRP decision letter dated 3 October 2018

"In my role as Dispute Officer I have undertaken, together with the SMA, a very full and thorough review of your application, taking into account all the available evidence…

The Medical Adviser has commented:

"My understanding is that I am required to provide advice as to whether the member was likely to have met the tier 1 condition at the time the member left employment on 3 April 2018 and, if so, to also advise on whether the member also met the tier 2 condition…

Medical Evidence

I have considered the documents submitted in respect of this first stage IDR review, specifically:

- The referral documents;
- Report from nurse endoscopist Machan dated 27 July 2018;
- Reports from Mr Kalyan, consultant spinal surgeon, dated 28 October and 11 May 2018;
- Report from colorectal specialist nurse Browne dated 10 May 2018;
- Hospital discharge summaries dated 5 April 2017 and 14 February 2018;
- Report from Dr Abbas, consultant radiologist, dated 5 October 2016;
- Two letters from Mrs N, both dated 6 August 2018;
- List of Medication

I have also considered the documents submitted in respect of the original application, specifically:

- The referral documents submitted with the original application;
- Report from GP, Dr Williamson, dated 1 March 2018;
- Report from Dr Raju, consultant radiologist, dated 24 April 2018;
- Reports from Mr Kalyan, consultant spinal surgeon, dated 7 November 2016, 17 March 2017 and 13 April 2018;
- Report from Mr Courtney, specialist registrar in colorectal surgery, dated 28 February 2018;
- Reports from Colonel Stewart, consultant orthopaedic surgeon, dated 16 June 2017, 2 October 2017 and 7 February 2018;
- Report from Dr Vagadia, consultant rheumatologist, dated 4 March 2017.

I note that some of the medical reports post-date Mrs N's last day of service. Changes in Mrs N's health after she left employment are not relevant to the determination of whether Mrs N satisfied the pension scheme definitions as of her last day of service. I have therefore not taken the subsequent course of Mrs N's illness into account. I have, however, taken into consideration those elements of the reports that relate to, or provide insight into, Mrs N's circumstances at the time she left employment.

I note Mrs N's comments regarding her financial circumstances. While I sympathise with her difficulties, I cannot take her financial circumstances into account when considering this application.

Cases are considered on an individual basis and decisions are made on the balance of probabilities…

I consider that the relevant medical evidence indicates that, on the balance of probabilities, at the time of leaving employment, the applicant did not meet the tier 1 condition of permanent incapacity for the efficient discharge of the duties of the NHS employment. The tier 2 condition was therefore not met.

The rationale for this is as follows:

Having considered the application and evidence there is, in my opinion, reasonable medical evidence that, at the time of leaving employment, the member had a physical or mental infirmity as a result of which the member was incapable of efficiently discharging the duties of their employment. The key issue in relation to the application is whether the member's incapacity was likely to have been permanent.

The medical evidence is that, at the time she left employment, Mrs N was unfit for work. Mrs N's incapacity was primarily the result of her musculoskeletal conditions, specifically, fibromyalgia, bilateral shoulder impingement and degenerative changes in her cervical and lumbar spine giving rise to some nerve compression in the neck, low back pain and sciatica. Mrs N also had some gastrointestinal symptoms. The combined impact of these conditions was such that, at the time she left employment, Mrs N was unfit for work.

The key consideration is whether, at the time she left employment, Mrs N's incapacity was likely to have been permanent. When considering if a medical condition would be likely to give rise to permanent incapacity I would first consider whether, in the absence of future treatment, the incapacity would be likely to be permanent and, if so, then go on to consider whether future treatment would be likely to alter this.

I note that Mrs N worked as a sterile services technician, a role that involved the cleaning, disinfection and sterilisation of surgical instruments.

The natural history of fibromyalgia is that it is a chronic relapsing condition. It is therefore likely that, with the passage of time, the impact of Mrs N's fibromyalgia would have been expected to lessen, though it remains likely that she will have further episodes where she experiences significant symptoms from this condition. The natural history of shoulder impingement syndrome is that it can improve spontaneously. The natural history of degenerative change in the cervical spine with nerve compression is that even though the degenerative changes do not resolve, the majority of individuals do experience an improvement in their symptoms over time, though the timescale over which this improvement comes about is long (in the region of 10-15 years). The natural history of sciatic pain is that it tends to improve over time as the disc that is pressing on the nerves causing the symptoms gradually resorbs and gets smaller, with the result that the pressure on the nerve is released. Back pain from degenerative changes does tend to improve over

time. Although the degenerative changes do not resolve, as the degenerative changes progress this leads to a stiffening of the spine. The consequence of this is that pain declines, though the range of movement in the back decreases. It seems unlikely that Mrs N's gastrointestinal symptoms will spontaneously resolve, though whether, in isolation, they would prevent her from working is not clear.

In summary, the natural history of Mrs N's musculoskeletal conditions is such that improvement can be expected with the passage of time. However, given the impact of these conditions at the time she left employment, I think it was questionable whether the amount of improvement that would have reasonably been expected to occur spontaneously would have been sufficient to have enabled Mrs N to return to her normal role.

At the time Mrs N left employment, further treatment options were available for her various problems.

With regard to Mrs N's fibromyalgia, there is no evidence that she had had the opportunity of participating in an exercise programme by the time she left employment, as recommended by the European League Against Rheumatism in their current guidelines for the treatment of fibromyalgia. There is strong evidence that aerobic exercise is associated with a decrease in pain and an improvement in physical function in individuals with fibromyalgia. Three distinct subsets of individuals with fibromyalgia have been identified. The prognoses of these groups are different. Based on the information provided with this referral I think it is likely that Mrs N would not fall into the category of individuals with fibromyalgia who have the most favourable prognosis. However, she does not exhibit any of the patient characteristics that are generally associated with a guarded prognosis. Statistically, the majority of individuals with fibromyalgia do not have long term disability.

With regard to Mrs N's shoulder problems, she had had injections into the shoulders in February 2018 and had been advised by Colonel Stewart to exercise in order to strengthen her shoulder muscles. At the time Mrs N left employment it was too early to assess how effective this treatment had been. However, I think it is reasonable to consider that Colonel Stewart would not have recommended this treatment unless he had expected Mrs N to benefit from it. The prognosis of Mrs N's shoulder condition is generally favourable. The literature indicates that between 60-90% of individuals become symptom free with non-surgical treatment. The outcome of surgery is favourable in those who fail to improve sufficiently with non-surgical therapy.

With regard to Mrs N's spinal problems and sciatica, at the time Mrs N left employment, further treatment was available as evidenced by Mr Kalyan's most recent report. I think that at the time Mrs N left employment, she would have been expected to benefit from this treatment. Further treatment was also available for her gastrointestinal symptoms, as evidenced by nurse specialist Browne's report.

At the time Mrs N left employment, further treatment was available for all of her medical problems. However, the key consideration is not the availability of future treatment; rather it is the likely benefit of that treatment, specifically whether the benefits of treatment would

have been expected to be sufficient to have enabled Mrs N to return to work and provide regular and efficient service in her normal role before she reached scheme pension age. Predicting the future course of an illness is not an exact science. There is an inherent element of uncertainty in any such prediction. The element of uncertainty in Mrs N's case is greater than in many other pension cases. In part this is because of the nature of her medical conditions and in part it is because of the need to predict the likely future course of those conditions over an extended period of time (in this case, some two decades).

I think that there is an element of balance in this case. However, I think that, on balance of probability, at the time Mrs N left employment, it was reasonable to have expected that, either with the passage of time or in response to future treatment, her symptoms would improve. I do not think it would have been unreasonable to have considered that this improvement would have been sufficient to remove the obstacles posed by those medical conditions to Mrs N working. Given that the timescale for such improvement would have been likely to be measurable in a timescale of months to a small number of years, and since, at the time Mrs N left employment she was over 20 years from reaching scheme pension age, I think that these improvements would have been expected to come about before Mrs N reached scheme pension age.

In my opinion, at the time of leaving employment, the member had a physical or mental infirmity as a result of which the member was incapable of efficiently discharging the duties of their employment. This incapacity was unlikely to have been permanent. The tier 1 condition was unlikely to have been met for the reasons given above.

I note that my advice is in agreement with that of the SMA who considered the original application.

My advice is at variance with that of Dr Williamson, who was clearly pessimistic about Mrs N's future employment prospects. I agree with Dr Williamson that Mrs N is likely to have ongoing symptoms, that her various medical conditions cannot be cured and that some of her medical problems are permanent. However, the permanence of the medical condition is not the primary consideration; rather it is the permanence of the incapacity arising from that medical condition. For the reasons I have explained above, I think that the impact of Mrs N's conditions is unlikely to remain at its current level for the next 20 years and that, in consequence, her current incapacity is unlikely to be permanent. Dr Williamson has not explained the reason for his opinion…

The Medical Adviser has also further commented following the review of your additional personal letter dated 28 August 2018:

"Mrs N's letter provides some additional background information relating to when her symptoms first began. It also provides new information in that she states that she saw an orthopaedic surgeon, Mr White, in 2016. We were not previously aware of this. However, it seems from her letter that Mr White attributed the symptoms Mrs N was experiencing to disease in her back and recommended that she saw a specialist in spinal problems. She subsequently saw a spinal surgeon, Mr Kaylan. We have several reports from Mr Kaylan that post-date Mrs N seeing Mr White. It is therefore unlikely that information from Mr

White would significantly add to our understanding of Mrs N's circumstances and so I think it is unnecessary for us to request a report from Mr White. Mrs N's letter adds little to what is already known. It provides further evidence of her ongoing incapacity. However, the key consideration is the permanence of Mrs N's incapacity. While improvement in Mrs N's health may take longer to come about than I anticipated when reviewing her case last month, I am still of the view that, at the time she left employment, the improvement was more likely to be sufficient to enable her to undertake her former role than not, and that the improvement would have been likely to be realised before she reached scheme pension age in 2038. It remains my view that the tier 1 and tier 2 conditions were unlikely to have been met at the time Mrs N left employment.

Having very carefully considered all comments of the medical adviser I can see no reason to disagree with their conclusion. I therefore endorse the view that you are not entitled to ill health retirement benefits from the NHS Pension Scheme."

Relevant excerpts from the Stage Two IDRP decision letter dated 11 June 2019

"NHS Pensions takes advice on medical matters from professionally qualified, experienced and specially trained occupational health doctors who also have access to expert resource where necessary.

I have undertaken a very full and thorough review of your application taking into account all the available evidence...

The medical adviser considering your case has recommended that you do not satisfy the tier 1 conditions laid down in Regulation 90 of the Scheme Regulations for payment of IHR benefits and I have accepted that recommendation.

In reaching the recommendation the medical adviser provided the following comments:-

"I have considered the documents submitted in respect of this second stage IDR review, specifically:

- The referral documents;
- Letter from Mrs N dated 22 March 2019…Included with the letter are the following documents:
    - Letter from Dr K Williamson, GP, dated 1 March 2018 (letter submitted with original application);
    - Letter from Dr K Williamson. GP, dated 16 November 2017;
    - Letter from Dr L Russell, GP, dated 17 October 2018 (this letter post-dated Mrs N's last day of service);
    - Referral letter summary from Dr K Williamson, GP, dated 13 April 2017;
    - Proctogram report dated 19 October 2018 (post-dates last day of service)
    - Referral letter to occupational therapy dated 26 April 2017 from Dr K Williamson, GP;

- Document detailing description of Mrs N's tasks during her employment including photographs;
- Personal Independence Payment mandatory reconsideration notice dated 16 December 2018 (post-dates last day of service);
- Letter regarding claim for Employment and Support Allowance dated 26 February 2019 (post-dates last day of service);
- Letter regarding supplier of continence products dated 7 September 2018 from continence specialist nurse (post-dates last day of service).

I have also considered the documents submitted in respect of the first stage IDR review and the original application, specifically:

- The referral documents submitted with the first stage IDR review and the original application;
- Report from nurse endoscopist Machan dated 27 July 2018;
- Reports from Mr Kalyan, consultant spinal surgeon, dated 28 October and 11 May 2018;
- Report from colorectal specialist nurse Browne dated 10 May 2018;
- Hospital discharge summaries dated 5 April 2017 and 14 February 2018;
- Report from Dr Abbas, consultant radiologist, dated 5 October 2016;
- Two letters from Mrs N, both dated 6 August 2018;
- List of Medication;
- Letter from Dr Williamson, GP, dated 1 March 2018 (resubmitted with second stage IDR review as above);
- Report from Dr Raju, consultant radiologist, dated 24 April 2018;
- Letter from Mr Kalyan, consultant spinal surgeon, dated 7 November 2016, 17 March 2017 and 13 April 2018;
- Letter from Mr Courtney, registrar in colorectal surgery, dated 28 February 2018;
- Letters from Colonel Stewart, consultant orthopaedic surgeon, dated 16 June 2017, 2 October 2017 and 7 February 2018;
- Report from Dr Vagadia, consultant rheumatologist, dated 4 March 2017.

Changes in Mrs N's health since she left employment are not relevant to whether she satisfied the pension scheme definitions as of her last day of service. Where the post-dated documents provide information taken into consideration those elements of the reports that relate to, or provide insight into Mrs N's condition at the time she left employment, I have taken such information into consideration.

Cases are considered on an individual basis and decisions are made on the balance of probabilities. I consider that the relevant medical evidence indicates that, on the balance of probabilities, at the time of leaving employment, the applicant did not meet the tier 1 condition of permanent incapacity for the efficient discharge of the duties of the NHS employment. The tier 2 condition was therefore not met.

Having considered the application and the evidence there is, in my opinion, reasonable medical evidence that, at the time of leaving employment, the member had a physical or

mental infirmity as a result of which the member was incapable of efficiently discharging the duties of their employment. The key issue in relation to the application is whether the member's incapacity was likely to have been permanent.

The rationale for this is as follows

At the time she left employment on 3 April 2018 the evidence was that she was unfit for work. The key issue in relation to the application is whether the member's incapacity was likely to have been permanent. When considering if a medical condition would be likely to give rise to permanent incapacity I would first consider whether, in the absence of future treatment, the incapacity would be likely to be permanent and, if so, then go on to consider whether future treatment would be likely to alter this.

Mrs N raises several points in her letter of appeal dated 22 March 2019 and I will consider these individually.

The letter from Dr K Williamson dated 1 March 2018

Dr Williamson refers to the diagnosis of fibromyalgia and advises that this is a condition which has no cure and will remain life-long but that Mrs N will continue to undergo treatment. Dr Williamson expresses the opinion that Mrs N is unable to work and she will continue to be unable to work going forwards. However, Dr Williamson does not explain on what basis the opinion that she will be unable to work going forwards is made and why Mrs N's incapacity is likely to remain at the level that it would prevent her from working for the next 20 years.

Bowel issues

The letter from Dr Russell of 17 October 2018 confirms a diagnosis of obstructive defecation, atonic rectum, anterior rectocele, perineal dissent and rectal intussusception. The protogram of 19 October 2018 indicates appearances are in keeping with anismus but no enteocele and none of the previously documented findings were demonstrated. The letter of 5 March 2018 from Michael Courtney, specialist registrar in colorectal surgery says that Mrs N reports a long history of obstructive defecation type symptoms and complains of incomplete evacuation and constant feeling of tenesmus. The bowel symptoms appear to have developed in 2013/2014 but did not prevent Mrs N from working. Information from in Dr Russell's letter of 17 October 2018 indicated deterioration in Mrs N's bowel disorder since she left employment cannot be taken into account. The only medical evidence pertaining to this condition provided with the original application was the letter of 5 March 2018 from Mr Courtney which does not indicate severe or debilitating bowel symptoms at the time.

Spinal neck, arm and shoulder issues

Mrs N has been under the care of Colonel M Stewart consultant orthopaedic surgeon. The latest letter from Colonel Stewart dated 12 February 2018 document the discussion with Mrs N about rotator cuff syndrome/impingement and how to break the vicious cycle of pain, weakness and recurrent pain and recurrent weakness. Mrs N was advised on a

diligent daily home exercise programme building on the instruction she had received to strengthen her rotator cuff when in physiotherapy. It was reasonable to expect at the time Mrs N left employment that Mrs N would benefit from this exercise programme.

Fibromyalgia

Mrs N saw Dr Vagadia, consultant rheumatologist, with regards widespread aches and pains in neck, shoulders, mid-thoracic area, hips, knees and low back pain with associated fatigue in March 2017 and Dr Williamson confirms that Mrs N has been struggling for many years with chronic pain. Dr Vagadia however reports that Mrs N said that for the last year or so (prior to March 2017) she has been having quite different widespread aches and pains. All of this information suggests Mrs N may have fibromyalgia for some years but symptoms did not previously prevent her from working. This is in keeping with the chronic relapsing nature of fibromyalgia. It follows that it is likely that her current level of symptoms will improve and reduce to former levels which did not previously prevent her from working. Mrs N may also benefit from treatment through a specialist fibromyalgia syndrome / chronic fatigue syndrome centre including therapy with occupational therapists and physiotherapy.

At the time she left employment Mrs N was over 20 years from her scheme pension age of 67. In my opinion, on the balance of probabilities, it is likely that she would have benefitted from further treatment and from remission in her fibromyalgia syndrome before she reached scheme pension age.

In my opinion, at the time of leaving employment, the member had a physical or mental infirmity as a result of which the member was incapable of efficiently discharging the duties of their employment. This incapacity was unlikely to have been permanent. The tier 1 condition was unlikely to have been met for the reasons given above.

…”