CAS-75001-F6C3

Ombudsman's Determination

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

Outcome

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

Complaint summary

2. Miss N has complained that NHS BSA incorrectly decided in June 2020 to award her Tier 1 instead of Tier 2 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, provides 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 his/her 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

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

[2] "permanently" means the period until Normal Pension Age (**NPA**). In Miss N's case, her NPA is 67 years.

[3] "like duration" means, in summary, a regular employment for similar hours to the member's NHS job (see Regulation 90(5) of the Regulations).

payment. If a member also meets the Tier 2 condition, then his/her accrued benefits are enhanced by 50% of his/her prospective membership up to NPA.

6. Tier 2 benefits are payable only if a member is accepted as permanently incapable of doing not only his/her NHS job but also any regular employment of like duration to his/her NHS job.

7. Miss N was previously employed by the NHS as a full-time urgent care assistant.

8. In March 2020, Miss N applied for IHER from the Scheme using form AW33E prior to leaving NHS employment. At the time, she had been diagnosed as suffering from cervical spondylosis, degenerative disc disease and associated conditions.

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. An application for IHER benefits is considered at the member's date of severance. However, if the Scheme member has not yet left NHS employment, the assessment is made as at the date of consideration.

11. In its letter dated 4 June 2020, Medigold informed Miss N that her application for IHER benefits had been accepted. 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.
> - Medical report on form AW33E by Dr Karen Jones, Occupational Health (**OH**) physician, dated 30 April 2020.
>
> 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 current incapacity is likely to be permanent.
>
> In the report of 30 April 2020, Dr Karen Jones stated:
>
> > "Cervical spondylosis diagnosed 6 February 2019, degenerative disc disease, large posterior disc prolapse C5/C6 (elsewhere in the report it

states the disc prolapse was at the level of C6/7). Restricted movement and pain affecting neck and arms. Nerve pain affecting right arm and lifting above shoulder height. She has been advised by her orthopaedic surgeon to avoid heavy lifting, twisting, getting into awkward positions with her neck. She reports difficulty with daily tasks – she requires help with shopping, washing, ironing and cleaning. She has difficulty washing her hair and has been sleeping on a sofa. She is most comfortable when sitting with her head upright/straight and when walking. She was referred to physiotherapy and undertook advised exercises during 2019 before being discharged. She has been advised to continue with medication (naproxen, codeine, paracetamol and amitriptyline at night for pain management). She has been advised to continue with exercises. Consideration was given to a nerve root block (injection) but this was declined having been advised of a small risk of stroke associated with the procedure. Surgery was not considered an appropriate treatment option. Her symptoms may well improve with continued medication and exercise. The degenerative disc disease will not improve but progression and further deterioration may be limited by alternative duties at work. She has been advised to avoid heavy lifting, twisting and getting into awkward positions of her neck. This will directly impact on her ability to fulfil her duty – urgent care within the Welsh Ambulance Service. Consideration may be given to redeployment in an administrative/office based role with a DSE assessment (display screen equipment) to ensure a suitable workstation is provided. I consider it likely that her functional abilities may improve before her NPA, she has not completed all treatment options. I consider redeployment a suitable option as her symptoms may improve before her NPA."

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.

The evidence indicates, on balance, that sufficient spontaneous improvement to render the applicant clinically capable of returning to her normal NHS role within the period to her normal benefit age, is not likely.

Dr Jones advises that Miss N's symptoms may well improve with continued medication and exercise but the degenerative disc disease will not improve…No reasonable treatment/remedial measures remain that might lead to improvement in her degenerative disc disease and allow her to return to her normal NHS job. Further treatment is therefore not likely to alter the permanence of her incapacity for her normal NHS role.

Dr Jones advises that her symptoms may well improve with continued medication and exercise. Further deterioration may be limited by alternative duties at work and consideration may be given to redeployment in an

> administrative/office based role. Reasonable treatment/remedial measures would likely include continued medication, appropriate exercise, physiotherapy and reconsideration of a nerve root block (injection). In my opinion, on the balance of probability, further treatment is likely to alter her incapacity for regular employment of like duration to her full time NHS role.
>
> In my opinion, the member does have physical or mental infirmity as a result of which the member is currently incapable of efficiently discharging the duties of their employment. This incapacity is likely to be permanent. The tier 1 condition is likely to be met for the reasons given above.
>
> …There is insufficient uncertainty regarding relevant functional prognosis and so Miss N may not request reassessment of the tier 2 condition in accordance with the regulations."

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

13. Miss N left NHS employment on 7 August 2020.

14. At both stages of the IDRP, NHS BSA informed Miss N that her complaint was not upheld because it agreed with the medical advice given by its MAs that she did not satisfy the Tier 2 condition at the time she left NHS employment.

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

16. The MAs recommended that Miss N should be given an opportunity to seek a further review of her claim against the Tier 2 condition once within three years from 24 August 2020, the date of her award notification letter.

17. Relevant paragraphs from the Stage One and Stage Two IDRP decision letters dated 29 September 2020 and 8 December 2020, including the opinions expressed by the MAs, are set out in Appendix Two.

18. Miss N did not request a reassessment of her claim by the deadline of 24 August 2023.

19. Following the complaint being referred to The Pensions Ombudsman (**TPO**), Miss N and NHS BSA made further submissions that have been summarised in paragraphs 20 to 30 below.

Miss N's position

20. Her health is getting worse and there is no cure for her medical condition.

21. Both her GP and the Consultant Orthopaedic Spinal Surgeon consider that she is unfit for any work.

22. She is concerned that NHS BSA has preferred medical advice from the OH physician over that from her GP and the Consultant Orthopaedic Spinal Surgeon who have medically assessed her.

23. She says that:

> "I feel NHS [BSA] have not fully understood my condition and the life changing symptoms. I have daily medication side effects which make sustaining regular employment impossible. I am unable to work and could never earn the wage I did.
>
> I have undergone physiotherapy rehabilitation, several medications, CBT therapy, all to no avail.
>
> My spinal surgeon has pointed out my pain is long term, NHS [BSA]do not understand root blocks have no impact on cervical spondylosis."

24. She receives both Personal Independent Payments (**PIP**) and Universal Credit from the Department for Work and Pensions (**DWP**).

25. She constantly worries about her financial future.

26. Her symptoms have not "stabilised or resolved". Her mental health has worsened and she is "now under the community psychiatric team".

27. She also says that:

> "Cervical pain doesn't correspond to the degree of damage and arthritis, some people with extensive damage have no pain and some people with less damage can have significantly more pain."

NHS BSA's position

28. NHS BSA refutes any allegation of maladministration on its part. It has correctly considered Miss 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.

29. It does not consider that Miss N meets the Tier 2 condition for IHER. In its opinion, she will be capable of regular employment of like duration to her NHS job before she attains NPA.

30. 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 Miss 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.

Adjudicator's Opinion

31. Miss 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 set out in paragraphs 32 to 55 below.

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

33. 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.

34. 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.

35. 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.

36. The PO cannot overturn the decision just because he might have acted differently.

37. Under regulation 90 of the Scheme Regulations, Tier 1 IHER benefits were available to Miss N if NHS BSA, acting on medical advice, decided 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.

38. So, for Miss 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.

39. If NHS BSA considered that Miss N was, more likely than not, also permanently incapable of regular employment of "like duration" to her NHS role, she would be entitled to Tier 2 IHER benefits.

40. The initial decision was made by Medigold in June 2020, under delegated authority from the Secretary of State who was the decision maker under the Scheme Regulations.

41. On reviewing the evidence, the Adjudicator was satisfied that Medigold's decision, to accept Miss 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 4 June 2020. Medigold had to weigh the evidence and take a decision based on the balance of probabilities.

42. At the time Medigold considered her IHER application, Miss N had been diagnosed as suffering from cervical spondylosis, degenerative disc disease and associated

conditions. Its MA was required to consider whether Miss 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 NPA of 67 years.

43. In Miss N's case, the MA said:-

- No reasonable treatment/remedial measures remained that might lead to improvement in Miss N's degenerative disc disease and allow her to return to her normal NHS job at some point before her NPA of 67.

- Further treatment options were, however, available that would likely alter Miss N's incapacity for regular employment of like duration to her full-time NHS role.

- The options considered to be of benefit included continued medication, appropriate exercise, physiotherapy and reconsideration of a nerve root block injection.

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

- Miss N's degenerative disc disease permanently prevented her from efficiently discharging the duties of her NHS employment up to age 67. The Tier 1 condition was met.

- Her symptoms of pain and restricted movement might improve with continued medication and exercise. Such improvement would allow Miss N in the period to her NPA of 67, to return to alternative employments of a like duration. The Tier 2 condition was not met.

45. Miss 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 Miss N that her appeal had been unsuccessful because it accepted the view of its MA.

46. Miss N felt that more weight should have been given by NHS BSA to the medical views expressed by her GP and the Consultant Orthopaedic Spinal Surgeon who had medically examined her.

47. However, within the bounds of reasonableness, 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 Miss N's own doctors, if one had not already been provided.

48. NHS BSA listed the medical evidence which its MAs considered in its decision letters at both stages of the IDRP. The medical evidence submitted by Miss N's GP and the Consultant Orthopaedic Spinal Surgeon supporting Miss N's application were on these lists.

49. So the Adjudicator was satisfied that the MAs considered all the medical evidence that pertained to Miss N's conditions at the time her NHS employment ended. Furthermore, the Adjudicator noted that the MAs at both stages of the IDRP acknowledged that their views differed to that expressed by Miss N's GP, and they explained why this was.

50. A difference of opinion between doctors, in and of itself, was 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.

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

52. So, it was the Adjudicator's view that there was no reason why NHS BSA should not have accepted the advice it received from its MAs in reaching its decision in Miss N's case.

53. The fact that Miss N was still suffering from the same medical condition 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.

54. 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 Miss 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 34 above.

55. Miss N had provided evidence of her PIP and Universal Credit payments. Receipt of these benefits did not, however, mean that Miss N would automatically qualify for IHER benefits from the Scheme because the criteria used to determine whether or not she qualified for a PIP and Universal Credit are different and less stringent.

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

57. Miss N said that:-

- Her medical condition is degenerative and has worsened over the years.

- Mr Manoj Thomas, Consultant Orthopaedic Spinal Surgeon, stated in his letter dated 5 March 2020 that there was no surgical cure for cervical spondylosis.

- He also said that the pain caused by her condition could be managed with medication. However, in 2023, she suffered complications following a cholecystectomy and can no longer receive opioid pain treatment.

- She now has issues also with her back and continues to suffer from poor mental health.

- She has suffered from bowel issues during the past few years.

58. Miss N has also said that:

> "The information at the time showed my condition to be permanent, unfortunately due to long NHS waiting lists I have been unable to demonstrate my condition has worsened medically via MRI scans etc and I am not in a position to pay privately. A reassessment would have been ideal but the NHS waits made this impossible and something I should not be penalised for. In addition my worsened mental health also made it very stressful to deal with another reassessment and the stress of trying to prove how ill I was at the time of the initial assessment and my deterioration since."

59. I note the additional points raised by Miss N but agree with the Adjudicator's Opinion.

Ombudsman's decision

60. 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 Miss N should in fact receive a Tier 2 IHER 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.

61. 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

- the decision was supported by the available relevant evidence.

62. 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 Miss N's eligibility for Tier 2 IHER

benefits from the Scheme. I am primarily concerned with the decision making process.

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

64. Miss N feels that more weight should have been given by NHS BSA to the medical view expressed by Mr Manoj Thomas, Consultant Orthopaedic Spinal Surgeon.

65. However, within the bounds of reasonableness, the weight which is attached to any of the medical evidence is for NHS BSA to decide. It is open to NHS BSA to prefer evidence from its own advisers unless there is a cogent reason why it should, or should not do so without seeking clarification. For example, an error or omission of fact or a misunderstanding of the relevant rules by the MA.

66. 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 Mr Manoj Thomas' letter dated 5 March 2020 was provided to the MAs for consideration.

67. 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 Miss N's application and there is no evidence to suggest that was not the case.

68. It is consequently clear that NHS BSA had given most weight to the MA's opinion that, at the time of leaving employment, Miss N's condition did not, on the balance of probabilities, permanently prevent her from regular employment before her NPA of 67.

69. I find that NHS BSA did give proper consideration to Miss 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.

70. I consider its decision not to award Miss N Tier 2 IHER benefits was not one that no reasonable body would make, and it was within the bounds of reasonableness.

71. The fact that Miss N is still suffering from the same medical condition does not impact upon the validity of the original decision. NHS BSA could only be expected to make its decision in June 2020 on the basis of the condition as it was understood at the time and to reconsider that decision in light of the medical prognosis available at each stage of the review process.

72. That Miss N's condition may not have followed the course anticipated at the time she left employment does not in itself provide evidence that the original decision made in June 2020 was incorrect.

73. While I sympathise with Miss N's circumstances, the evidence does not support a finding of maladministration by NHS BSA in coming to the decision it did.

74. I do not uphold Miss N's complaint.

Camilla Barry

Deputy Pensions Ombudsman
2 April 2025

Appendix One

The National Health Service Pension Scheme Regulations 2015

At the time Miss 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 NPA;

(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 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 29 September 2020

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

The MA…has commented:

My understanding is that I am required to provide advice as to whether the member is likely to meet the tier 2 condition and, if so, to also advise on whether the member also meets the HMRC severe ill-health test criteria.

Medical Evidence

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

- The referral documents;
- An undated letter from the applicant.
- A letter from the Department for Work and Pensions (**DWP**), dated 19/5/20;
- A report from Consultant Orthopaedic Spinal Surgeon, Mr Manoj Thomas, dated 12/2/20.
- A report from the GP, Dr Hughes, dated 7/9/20, commissioned by Medigold including:
- A report from Consultant Orthopaedic Spinal Surgeon, Mr Manoj Thomas, dated 5/3/20.

…

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

…

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, the applicant is permanently incapable of the NHS employment. The tier 1 condition is met. The applicant is not permanently incapable of regular employment of like duration. The tier 2 is not met.

The rationale for this is as follows:

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 regular employment of like duration. The key issue in

relation to the application is whether the member's current incapacity is likely to be permanent.

In considering whether 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.

In this case, 'permanent' means at least until normal NHS pension age of 67, which is currently 22 years and 3 months in the future.

Employer records indicate long-term absence from work from 10/2/17 to 3/2/19 and from 30/4/19 to date, due to musculo-skeletal / spinal problems.

It is noted that she has recently been awarded Personal Independence Payment (**PIP**), at the standard rates for daily living activities and mobility, from 4/2/20 until 29/4/23 (when it will be reviewed). Entitlement to PIP may change in the future, depending upon her functional capability assessment at that time.

Miss N states in her letter of appeal that her condition is "progressive". The medical evidence is that she has multi-level degenerative disease (spondylosis) in her cervical spine (neck), with a specific single disc prolapse evident on CT and MRI scanning. No surgical target has been identified in this regard and Mr Manoj Thomas has confirmed that there are no plans for spinal surgery. This is not a progressive condition.

On 22/1/20, Mr Manoj Thomas stated "continues to have problems with pain in the neck which radiates down the left arm…reviewed her MRI scan which shows disc degeneration at multiple levels, worse at C5/6 with a disc bulge at this level…most of the other levels mainly have disc dehydration…at C5/6 there is some foraminal narrowing with left C6 nerve irritation; no cord or nerve compression…treatment options are continuing conservative treatment with medication and physiotherapy and exercises…next treatment to consider would be a left C6 nerve root block…last option would be surgery".

Having reviewed the existing evidence, it was my opinion that something else was going on with this lady's health; hence a report was requested from her GP.

On 7/9/20, Dr Hughes confirmed she also has a long history of a chronic anxiety disorder, for which a single antidepressant medication (fluoxetine) at a relatively high dose of 40mg / day is prescribed. In my opinion, this mental health disorder is likely to be contributing to her overall level of functional disability, particularly in relation to her stated beliefs that her neck condition is likely to be progressive and that she will never improve (medically, this is not necessarily the case, with further treatment).

Degeneration and dehydration of intervertebral discs on CT or MRI scanning are very common findings on imaging, with a well-recognised extremely poor correlation between the presence / absence and severity of symptoms and functional restrictions. Whilst the degenerative process may continue in the intervertebral discs, there was no evidence of

specific nerve compression or entrapment (necessitating decompression surgery) and no evidence that such compression or entrapment might occur in the future.

In his letter of 7/9/20, Dr Hughes describes her as having an “inoperable prolapsed cervical disc” – the fact that it is inoperable indicates that surgery is not clinically appropriate because it is not severe enough to warrant it (in the absence of nerve or spinal cord compression). Dr Hughes re-iterated the advice from Mr Manoj Thomas that “she has been advised to do no lifting or bending or twisting to avoid the nerve root pain”. Whilst such activities would be incompatible with her NHS role (hence tier 1 entitlement was accepted), such activities would not necessarily be required in other forms of regular full-time employment, particularly once all reasonable and appropriate treatments had been provided (see below).

The medical evidence is that she is currently unfit for any kind of regular full-time employment due to chronic neck and arm pain and the psychological consequences thereof. The chronic pain has clearly also affected her underlying mental health condition.

The natural history of both these conditions, particularly when present together, is one of persistence. Spontaneous recovery is not likely. That is, in the absence of future treatment, her incapacity for any kind of regular full-time employment would be more likely than not (on balance of probability) to continue beyond her 67th birthday, despite this being 22.25 years in the future, and therefore be considered ‘permanent’.

Future treatment is, however, considered likely, at this stage, to alter the permanence of her incapacity for any regular full-time employment.

Such physical treatment might comprise:

- Referral to, assessment and treatment by a consultant in pain management.

- Cervical spine nerve blocks, as outlined by Mr Manoj Thomas.

- Attendance at a holistic pain management rehabilitation programme (including pain education, a review of medications, physical therapy / rehab and psychological pain interventions, such as CBT or cognitive behavioural therapy).

Such mental health treatment might comprise:

- Antidepressant / anxiolytic medications, at appropriate therapeutic doses, including several different types of drug and / or in combination.

- Mood stabilising drugs.

- Low-dose anti-psychotic drugs for particular issues relating to agitated anxiety or severe insomnia.

- Referral to, assessment and treatment by the community mental health team.

- Referral to, assessment and treatment by a consultant psychiatrist.

- Specialist psychological therapies.

On balance of probability, it is considered more likely than not that such treatments would enable sufficient and sustained, physical and mental, symptomatic and functional recovery, during the next 22 years and 3 months until her normal pension age of 67, for her to be able to resume some kind of supported regular full-time employment, at some point during this time.

Thus, permanent incapacity for regular employment of like duration is not supported by the medical evidence and the medical criteria for the tier 2 condition are not satisfied, on balance of probability.

It is noted that my opinion differs from that of Dr Hughes, GP, in this regard. Dr Hughes has justified his opinion thus “most employment these days results in sitting opposite a VDU unavoidable hyper-flection of the neck, this gives her extremely unpleasant pain which can take hours to fade”. Dr Hughes’ opinion takes no account of reasonable adjustments in this regard, which might include, for example, voice-activated software and readback, which would enable her to use a computer in an entirely different way and therefore not require the seated position with hyper-flexion of the neck that is reported to result in significant and distracting pain. There are also other light physical forms of employment that do not require the use of a VDU, which Dr Hughes has not considered.

In my opinion, the member does have physical or mental infirmity, as a result of which the member is currently incapable of regular employment of like duration. This incapacity is unlikely to be permanent. The tier 2 condition is unlikely to be met for the reasons given above.

Tier 1 entitlement has previously been established, on the basis of her neck problems causing permanent incapacity for the role of an Ambulance Care Assistant (due to this job role’s specific physical requirements).

Her longer-term prognosis with further treatments (as outlined above) is, in my opinion, sufficiently uncertain as to allow one re-assessment of the tier 2 condition, at a date of the applicant’s choosing, in accordance with the Regulations…”

Relevant excerpts from the Stage Two IDRP decision letter dated 8 December 2020

“NHS Pensions takes advice on medical matters from professionally qualified, experienced and specially trained OH 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 including the latest information you kindly provided.

The MA considering your case has recommended that you do not satisfy the Tier 2 conditions laid down in Regulation 90 of the Scheme Regulations for payment of Tier 2 IHR benefits and I have accepted that recommendation.

In reaching the recommendation the MA…provided the following comments:

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

- The referral documents:
- Applicant’s statement dated 15 October 2020;
- Letters and reports from Mr Manoj Thomas, consultant orthopaedic spinal surgeon, dated 12 February 2020, 5 March 2020 and 11 May 2020 (I note that these letters have been seen by the previous medical advisor)

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

…

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 was permanent incapable of the NHS employment. The tier 1 condition was met. The applicant was not permanently incapable of regular employment of like duration. The tier 2 condition was 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.

On reviewing the series of letters and reports from Mr Manoj Thomas, consultant orthopaedic spinal surgeon I note that Miss N consulted in August 2019. Mr Manoj Thomas describes her history of sudden onset of neck pain whilst carrying out patient handling. She was also experiencing right arm pain. Examination revealed no sensory or motor reduced function but severe radicular pain when sitting or lifting her arm indicating irritation of a nerve. Previous CT scan had shown a C5/6 disc prolapse and Mr Manoj Thomas recommended an MRI scan. Reporting from the clinic attendance in January 2020, the MRI scan showed disc degeneration at multiple levels again worse at C5/6 with left C6 nerve irritation but no spinal cord or other nerve compression. The surgeon explained that the appropriate treatment was with medication and physiotherapy (and exercise) with a lesser consideration of a nerve root block at C6. Other potential options would be an approach to the bulging disc from the front of the neck together with stabilisation but this would have even more risks than doing the injection and Miss N chose not to go for surgical intervention. My interpretation of Mr Manoj Thomas’ wording of the report is that he felt that conservative, non-interventional treatments were more appropriate. She was discharged from follow up. The subsequent reports of 12 February 2020, 5 March 2020 and 11 May 2020 were not as a result of further care episodes but reiterating the previous advice. In February 2020 Mr Manoj Thomas advises that “the cervical spondylosis is not something that will completely heal and she is likely to have some discomfort in the long term”. In March 2020 he reiterates the advice for physiotherapy and exercise but that there is no surgical cure and in May 2020 again he

reiterates the trial of physiotherapy and exercise over 6 months to see if this helps and if it were to do so to continue doing the exercise component in the long term. He highlights that the radicular pain had eased when seen in January which was therefore the contraindication to doing a nerve root block or surgery. It was in the May report that he identified that she could have longstanding neck pain which may be helped to some extent and that ongoing management could prevent exacerbation and that from an occupational functional perspective that she should avoid heaving lifting, sudden twisting and putting her head in awkward positions.

Dr Hughes' report of September 2020 identifies that she remains unfit due to her neck pain. He reiterates the advice provided by the orthopaedic spinal surgeon. The GP identifies that she has suffered from anxiety in the past and is on an antidepressant medication. No further detail is provided about the nature of this anxiety. Miss N however clarifies that she has had anxiety since her early 20s and has received CBT and counselling through the Ambulance Service. She also identifies that she has had severe endometriosis in her late 20s and 30s and at age 38 had a hysterectomy after which she has been pain free. She states that her anxiety has had no impact on clouding her judgement.

Dr Hughes is of the opinion that she will not "recover sufficiently to rehabilitate back into any kind of regular full time employment in the next 22 years and 5 months until her 67th birthday. The reason for this is that most employment these days results in sitting opposite a VDU unavoidable hyper flexion of the neck".

The OH physician's report identifies the cervical spondylosis, the restricted movement in pain in her neck and arms and restriction of movement of the right arm. This affects her activities of daily living including washing, shopping, ironing and cleaning. The occupational physician's opinion is that it is likely that in the future her symptoms will respond to her treatment but that it will not be possible for her to undertake active and manual handling roles. Dr Jones states that "I consider redeployment a suitable option as her symptoms may improve before her NPA".

Miss N has identified the assessment of function within her PIP assessment. This states that she is to receive over the next 3 years the standard rates for mobility and living.

This evidence indicates that Miss N has multilevel spondylosis or wear and tear type degeneration of the spine in her neck with drying out and degeneration of a number of the discs in between the vertebrae and one in particular, C5/6 bulging. Of note she has no spinal cord compression and no nerve root compression and therefore there was no clinical indication for surgical correction. Neither her GP nor the occupational physician indicate that her anxiety is a cause for her inability to work. I note the orthopaedic spinal surgeon's comments on prognosis being that the presence of spondylosis is permanent and that the pain and function within her neck can be helped with physiotherapy and exercises.

I note the GP's prognosis that she will never work in full time employment again. I note the OH physician's prognosis that redeployment is a suitable option as her symptoms may improve before her NPA.

My understanding of cervical spondylosis is that there can be evidence of wear and tear changes from our 20s onwards when looked for in MRI scans. The proportion of the population that has identifiable wear and tear changes increases so that by the end of the 60s approximately 90% of people will have evidence of wear and tear on an MRI scan. There is a high rate of asymptomatic changes and the tissue changes that can be seen within the discs, cartilage and the bones of the spine do not correlate well with pain that people experience unless there is spinal cord of nerve compression. There is an increased presentation of pain in the neck from the 30s onwards peaking from the 40s until 60s. After the age of 60 the new presentations of neck pain reduce despite the increasing presence of spondylosis on scans. The natural history of symptoms for people that do have a presentation associated with spondylitic changes on the MRI is that pain and loss of function is greatest at onset, stabilises in initial years and follows a steadily improving course as the acute degenerative changes within the spine become fibrotic and have less impact. The long term effect is that people do tend to have permanent reduced function in their neck and permanent ache towards levels of pain.

Where necessary it is appropriate for either the specialist or the GP to refer to a specialist pain clinic where a multidisciplinary team of a consultant anaesthetist and pain consultant, physiotherapist and psychological therapist would address all facets of pain control. At present this would appear not to be indicated but could be considered if Miss N does not follow the natural stabilisation and improvement path described above.

As stated at the beginning of my advice, I agree with the previous MA's recommendations that the tier 1 condition is met. My consideration is therefore whether the evidence together with my understanding of the natural history of the long term effects of cervical spondylosis will prevent a return to alternative full time employment. I give weight to the orthopaedic spinal surgeon's evidence as he will be experienced in the treatment of cervical spondylosis. I give greater weight to the OH physician's prognosis rather than that of the GP as the OH physician will have greater specialist knowledge and experience of providing advice to employers and the range of reasonable adjustments that can be implemented by employers to facilitate working.

Taking into account all of these considerations there remains the probability that before her 67th birthday, Miss N will be able to return to alternative employments of a like duration.

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 likely to have been permanent. The tier 1 condition was likely to have been met for the reasons given above.

I acknowledge Miss N's concerns about the degree of long term impact of her condition and indeed Dr Hughes' professional concerns and no doubt experience of patients who

have not been able to return to full time employment. Should Miss N therefore be one of the minority for whom a degree of recovery or indeed worsening of the condition occurs, it would be appropriate to afford her the opportunity to seek a reassessment of the Tier 2 conditions once within 3 years or up to normal benefit age, whichever is sooner…"

Having very carefully considered the comments of the MA I can see no reason to disagree with his conclusion….

You will note from the MA's comments that you may seek a further review of your claim against the Tier 2 conditions once within 3 years from the date of the award notification letter. The date of your award notification letter was 24 August 2020; you therefore have until 24 August 2023 to request a reassessment of the Tier 2 conditions.

Any request for reassessment must relate to the physical or mental infirmity that qualifies you for your Tier 1 pension. In order to take up the opportunity to have your claim reassessed you will need to provide fresh supporting medical evidence to demonstrate that you are permanently incapable of regular employment of like duration to your former NHS job.

I should point out that were Tier 2 entitlement established as a result of a reassessment, the Tier 2 benefits become payable from the date on which the Tier 2 decision is reached, they are not backdated to the date from which the Tier 1 benefits were paid…"