PO-15760

Ombudsman's Determination

Applicant	Dr R
Scheme	NHS Pension Scheme (**the Scheme**)
Respondent	NHS Business Services Authority (**NHS BSA**)

Outcome

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

2. My reasons for reaching this decision are explained in more detail below.

Complaint summary

3. Dr R's complaint concerns NHS BSA's decision not to accept his application for ill health early retirement (**IHER**) benefits.

Background information, including submissions from the parties

4. On 30 October 1997, Fitzwilliam Hospital sent Dr R a letter in relation to an MRI scan that was carried out. This said the scan showed a "small generalised disc bulge" but that measures could be taken to improve his condition.

5. In 1998, the problem persisted; Dr R's General Practitioner (**GP**) noted that Dr R was unable to sit without discomfort. He arranged for Dr R to see the Consultant again.

6. In March 1999, it was identified that Dr R had a bilateral adeno viral conjunctivitis, a condition affecting his eyes.

7. Between 2000 and 2013, Dr R attended sessions with a registered osteopath for the issues he was experiencing with his back.

8. In June 2001, in a letter to the Cambridgeshire Advisory Committee, Dr R's Consultant Orthopaedic and Spinal surgeon explained that Dr R had been experiencing "low back pain and left Sciatica for a few years." He had last seen Dr R on 21 December 2000, when he was given another epidural injection.

9. In June 2006, Dr R attended a medical appointment in relation to his Functional Dysphonia; treatment was arranged.

10. Between February 2013 and June 2014, Dr R attended physiotherapy sessions.

11. In May 2013, Dr R attended an outpatient appointment in relation to symptoms of, "lower back pain, perineal discomfort, frequency, urgency and nocturia 0-1 every night." It was also identified that Dr R had chronic prostatitis.

12. On 28 August 2015, Capita carried out a workplace Needs Assessment for the back and neck issues Dr R was experiencing. Several adjustments were implemented.

13. In January 2016, the Cambridge and Peterborough NHS Foundation Trust sent Dr R a letter saying "left limb 7-8mm longer with bilateral rearfoot varus. Overpronation occurring as compensation…" Dr R explains that his left leg is slightly longer than his right leg, which contributes to the pain he has been suffering.

14. In March 2016, Dr R was seen in a Rheumatology clinic by the consultant Dr Gunasekara. The letter which followed said that Dr R had a 25 year history of back pain, which had gradually worsened in the last three years. It was noted that Dr R had been to an Osteopath and had acupuncture and physiotherapy, but none of these treatments had significantly helped. The other major symptom recorded was fatigue, along with anxiety and depression. The main diagnosis headed at the beginning of the letter was that of Fibromyalgia.

15. I also understand that from March 2016, Dr R was continually absent from work.

16. In July 2016, Dr R attended another appointment with Dr Gunasekara, where his blood test results and MRI scan findings were reviewed. Various methods of treatment were discussed, including perseverance with graded exercises, relaxation and sleep hygiene techniques, and medication.

17. In July 2016, Dr R completed an IHER application form. Part C of this was respectively completed by Dr R's GP and Dr Gunasekara. In the section, which asked for details of all diagnosed medical conditions, the following was listed by Dr R's GP: Fibromyalgia, Asthma, Hypertension, Prostatitis and symptoms of anxiety and depression.

18. In response to a question about the likely future course of Dr R's health and function, with normal therapeutic intervention over the period to normal pension or benefit age, Dr R's GP answered: "difficult to comment."

19. In the identical NHS BSA form completed by Dr Gunasekara, the final sentence in his response to the above question was:

    > "With fibromyalgia & osteoarthritis co-existing it is unlikely [Dr R] will be completely pain free in the future."

20. Also on this form, In response to a question regarding the likelihood of improvement in functional abilities before Normal Pension Age, Dr Gunasekara said:

> "As detailed before, the likelihood of improvement in his fibromyalgia and osteoarthritis are fair – however, he is unlikely to make a complete recovery from his pain."

21. On 15 August 2016, NHS BSA wrote to Dr R saying that it was unable to accept his IHER application. The rationale of the Scheme's medical adviser has been quoted in part below:

> "[Dr R] has a long history of low back pain and neck pain. More recently he has developed symptoms of chronic widespread pain and fatigue, this has been diagnosed as Fibromyalgia…[Dr R] also has symptoms of anxiety and depression, these symptoms are likely to improve with psychological treatment and medication in the longer term.
>
> He also has a long history of neck and back pain due to osteoarthritis and has attended physiotherapy and an osteopath for treatment…
>
> Dr Gunasekara has suggested a number of different medications to trial that are helpful in reducing symptoms of pain due to Fibromyalgia.
>
> It is accepted that [Dr R] is currently unfit to work as a GP and is likely to remain so for the foreseeable future, however with continuing treatment, graded exercise, cognitive behavioural therapy and the medication that has been advised by Dr Gunasekara, and the passage of time a return to fitness for his normal NHS employment can be anticipated within the next twenty years."

22. The concluding opinion quoted from the medical adviser's report was:

> "It is my opinion that relevant medical evidence has been considered in this and, on the balance of probabilities, indicates:
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> That the applicant is not permanently incapable of the NHS employment, the NHS Pension Scheme condition for Tier 1 is not met and
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> That the applicant is not permanently incapable of regular employment of like duration, the NHS Pension Scheme condition for tier 2 is not met."

23. Dr R made a complaint to NHS BSA about his application being unsuccessful.

24. In September 2016, Dr R was registered as a person with a physical disability by Adult Social Services at Peterborough City Council.

25. On 21 September 2016, NHS BSA responded to the complaint under stage one of the Scheme's Internal Dispute Resolution Procedure (**IDRP**). A medical adviser reviewed the IHER application and endorsed the view that Dr R was not entitled to such benefits. The following points were made: -

    - Dr R had a long history of back pain. He had osteoarthritis of his neck and lower spine, with pain symptoms of a mechanical nature. The recommendations for

the treatment of this were: to encourage light, regular activity and controlled exercise.

- He had more recently been diagnosed with bilateral acetabular osteochondropathy and trochanteric bursitis, for which he had been directed for physiotherapy intervention.

- Fibromyalgia is a chronic condition but clinical guidelines indicated that the severity of the symptoms could be improved with Graded Exercise Therapy, Cognitive Behavioural Therapy and pain relief neuropathic medication.

- The associated symptoms of fatigue and cognitive dysfunction may be exacerbated by his low psychological status. Treatment in the form of psychoactive medication, together with psychotherapy, should help to resolve these.

- Dr R had "good prognostic factors for health improvement…availability of access further treatment interventions for Fibromyalgic symptom improvement, and availability of access to psychological therapies to help restore psychological well-being."

26. Dr R subsequently wrote to NHS BSA with information he said it had not considered.

27. On 20 October 2016, NHS BSA responded in a letter which it said replaced the original stage one IDRP decision of September 2016. It included the medical adviser's original opinion in the stage one decision, and said the adviser had further reviewed the case, although they felt most of the evidence submitted had been on file prior to the IDRP review. The medical adviser concluded that the opinion expressed in the original stage one decision still stood. NHS BSA also maintained the same position.

28. Dr R appealed this. On 17 November 2016, Dr R wrote to NHS BSA explaining that he had received copies of the medical information which had originally been considered by the initial medical adviser. He said: -

- There were 58 pages in total, which included several duplicates. Also, some pages were not at all clear.

- His own statement was missing from the pension form.

- Medical notes had not been obtained from his GP, therefore the medical adviser would not have known which medication had already been tried without success.

29. Dr R provided NHS BSA further information to consider as part of his stage two appeal under the IDRP, including letters from his High Intensity Therapist, prescriptions and a medical certificate.

30. On 19 January 2017, NHS BSA sent Dr R its stage two IDRP response, in which a different medical adviser assessed Dr R's application. They did not accept that Dr R's condition was likely to be permanent and NHS BSA found no reason to disagree with their findings.

Adjudicator's Opinion

31. Dr R'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 briefly below: -

- The opinion held by all of the medical advisers who assessed Dr R's application was that he did not satisfy the conditions for tier 1; each of whom asked the correct questions and applied the appropriate test.

- The factors which the medical advisers were required to consider were set out under regulation 90 of the NHS Pension Scheme Regulations 2015 (**the Regulations**). This included the member's mental and physical capacity, whether they had received appropriate medical treatment and the type of rehabilitation it would be reasonable for them to undergo.

- In the initial decision made by NHS BSA, the medical adviser referred to a long history of lower back and neck pain, anxiety, depression and osteoarthritis. He concluded that Dr R's depression and anxiety would improve with psychological treatment and medication in the longer term. In the revised stage one IDRP decision, Dr R's medical history was addressed in more detail, as well as there being some consideration of the recovery of Fibromyalgia alongside depression/anxiety.

- NHS BSA's stage two IDRP response noted a range of medical conditions which Dr R had been suffering from. Whilst the severity of Dr R's condition was acknowledged, various treatment options were suggested.

- In considering the factors outlined above, the medical adviser, in each respective decision, gave due regard to Dr R's mental and physical capacity, the treatment he had undergone, and the rehabilitation it would be reasonable for him to undergo.

- In response to Dr R's comment that his medical records were not requested for the first decision, the Adjudicator said that Dr R had submitted information at both stages of the IDRP which he said had been missed, including GP

prescriptions; and, Part C of the application was completed by Dr R's GP. The Adjudicator therefore felt that by stage two of the IDRP at the latest, the medical adviser had a good understanding of Dr R's overall state of health.

- Dr R had also said that his Fibromyalgia had been present for years but NHS BSA's assessment seemed to only factor in the year and a half before its decision. However, the formal diagnosis of this was in March 2016. The Adjudicator said that in any case, Dr R's "long history of back pain" was noted in the stage one IDRP decision; and did not find that NHS BSA had been remiss in focusing on the more recent symptoms which led to his leaving work, the eventual diagnosis and untried treatment options.

- Dr R had pointed to recent medical appointments where his mental health practitioner and rheumatologist respectively said that his condition was unlikely to improve. However, the Adjudicator said the only information which could be considered is that which was presented to NHS BSA at the time it reviewed the application.

- Dr R had made reference to Dr Gunasekara's suggestion that it was unlikely he would be completely pain free in the future. The Adjudicator said this statement could be distinguished from the specific question put forward by the Regulations concerning whether he was permanently incapable of efficiently discharging the duties of his employment.

- Dr R had felt that NHS BSA's suggestion that he would be able to return to work in the next few years was unrealistic, due to the retraining that would be required. NHS BSA was only required to answer the question of whether Dr R would return to a well enough condition to carry out the duties of his employment, which it did. Nonetheless, it did make reference to "Dr R's relatively young age" against a Normal Benefit Age of 67.

- Dr R had complained about the state of the file presented to the medical advisers prior to stage two of the IDRP, and presented new information. However, the prognosis provided by the respective medical advisers in each decision took into account the range of health conditions at hand and the key points from Dr R's specialist. Therefore, it did not appear that the presentation of information to NHS BSA had an impact on the overall decision.

- The medical adviser took into account Dr R's osteoarthritis, and said that this could be managed by regular activity and controlled exercise.

32. Dr R not accept the Adjudicator's Opinion and made the following comments: -

- Had his GP notes been requested, episodes of Keratitis would have been noted, which was a more serious condition than bilateral adenoviral conjunctivitis.

- The standing required due to the raised computer platform which had been implemented had brought on pain in his left hip.

- An MRI scan of his hip and its various surrounding problems had not been taken into account.

- Two podiatrists had now confirmed that the difference in the length of his legs would contribute to the worsening of his osteoarthritis.

- His rheumatologist had since confirmed that there was no further treatment left to try for Fibromyalgia. Furthermore, his mental health specialist considered it unlikely that he would be able to work as a GP in the future.

- He had tried exercise but this had been limited by fatigue and pain.

33. The Adjudicator responded to the above points, saying: -

- Episodes of Keratitis were not referenced in the information presented to the medial advisers, therefore NHS BSA had not been remiss in failing to address this.

- In its stage two IDRP response, the medical adviser noted the results of an MRI scan of Dr R's pelvis. Therefore, this was taken into account.

- Although Dr R's podiatrist, rheumatologist and mental health specialist had recently expressed the view that Dr R would not be able to return to work, it was the information available at the time of NHS BSA's assessment which must be considered.

- At the time when the application was being assessed, the potential impact of treatment using exercise had not been fully tried. Other recommendations were suggested too.

34. The complaint has been passed to me to consider. I agree with the Adjudicator's Opinion and I will therefore only respond to the key points made by Dr R for completeness.

Ombudsman's decision

35. In order to be eligible for tier 1 benefits, Dr R would need to satisfy the criteria set out in the Regulations, part of which involves being permanently incapable of efficiently discharging the duties of his employment. NHS BSA considered the matter on four separate occasions and was unable to conclude that this is the case.

36. My role is not to review the medical evidence and make a decision on the conclusions reached, but to review the decision making process.

37. Dr R has presented an array of health issues which he believes, when considered together, would lead to a conclusion that he would not be capable of returning to his employment. He has also placed emphasis on the fact that some of these conditions are chronic or recurrent, and says the conclusions of the medical advisers are flawed. However, I do not agree that the medical advisers, and consequently NHS BSA, have failed to appropriately consider the medical evidence. Dr R's rheumatologist had said that the likelihood of improvement was fair, and suggested several, at that stage, untried treatments.

38. Dr R is also concerned that omissions have been made by the medical advisers in assessing his overall state of health, and has pointed to specific points either being missed or not commented on in full. However, the overall summary of Dr R's condition, by the medical adviser and NHS BSA accords with the information available, therefore I am satisfied that Dr R's overall health has been taken into account. I do not deem that that there has been a breach of process in applying a greater focus on certain symptoms over others, in their respective medical opinions.

39. With regard to the more recent medical opinions put forward by the medical specialists he is a patient of currently. I am afraid this does not bear any relevance to my decision as I am limited to considering the evidence presented at the time of his application.

40. I appreciate that Dr R's view of his prognosis partly derives from his capacity as a medical professional. However, it is not within my remit to assess the relative merits of the medical adviser's view against his own. Instead, it is to evaluate whether the decision made by NHS BSA is supported by the evidence provided. I am satisfied that this is the case.

41. Therefore, I do not uphold Dr R's complaint.

Anthony Arter

Pensions Ombudsman
27 September 2017