CAS-40514-J0R2

# Ombudsman's Determination

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| Applicant | Mrs R |
| Scheme | NHS Pension Scheme 2015 (the **2015 Scheme**) |
| Respondent | NHS Pensions |

## Outcome

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

## Complaint summary

2. Mrs R has complained that her application for an ill health retirement pension has not been considered in a proper manner.

## Background information, including submissions from the parties

### Background

3. Mrs R was originally a member of the 1995 Section of the NHS Pension Scheme (the **1995 Section**). She transitioned to the 2015 Scheme in December 2017.

4. The relevant regulations are The National Health Service Pension Scheme Regulations 2015 (SI2015/94) (as amended) (the **2015 Regulations**). Extracts from the 2015 Regulations are provided in Appendix 1. On retirement from active service, the 2015 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 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.

5. Mrs R was diagnosed with breast cancer in 2016. She completed chemotherapy in May 2017 and radiotherapy in July 2017. Mrs R's employment was terminated, on 31 January 2018, on the grounds of ill health.

6. Mrs R submitted an application for ill health retirement (form **AW33E**). Part C was completed by her employer's occupational health (**OH**) doctor in December 2017.

Summaries of and extracts from the medical evidence relating to Mrs R's case are provided in Appendix 2.

7. First instance decisions on applications for ill health retirement are made by the Scheme's medical advisers, **Medigold**, under delegated authority. Medigold wrote to Mrs R, on 1 March 2018, saying it had been unable to accept her application. It quoted from its medical adviser (**MA**) (see Appendix 2), who had advised that Mrs R was not permanently incapable of discharging the duties of her NHS employment; that is, the Tier 1 condition was not met.

8. Mrs R queried the way in which she had been assessed for permanent incapacity. In particular, she queried the normal pension age (**NPA**) by reference to which her case had been assessed. NHS Pensions responded by saying Mrs R would have had the right to retire from age 55 if she had remained in the 1995 Section of the Scheme because she had Special Class Status (**SCS**). It quoted Regulations E1 and E2 from the National Health Service Pension Scheme Regulations 1995 (SI1995/300) (as amended) (the **1995 Regulations**). It also said, to be considered permanently incapable of their NHS duties, a member was assessed to age 60. NHS Pensions said this was because the member had the option to retire at age 55. It explained that Mrs R had transitioned to the 2015 Scheme on 1 December 2017 and, because her application had been received after this date, her NPA was 67. NHS Pensions referred Mrs R to the Scheme's two-stage internal dispute resolution (**IDR**) procedure.

9. Mrs R submitted an IDR appeal. She raised the following points:-

- Her benefits in the 1995 Section should be treated separately and calculated in accordance with the 1995 Regulations. Similarly, her benefits in the 2015 Scheme should be treated separately and calculated in accordance with the 2015 Regulations. The retirement age of 55 was not described as an option under the 1995 Section. However, members did have the option to retire at 50 with reduced benefits.

- The NPA of 67 should only be used in relation to her benefits in the 2015 Scheme. Her NPA for the 1995 Section was 55 because of her SCS.

- There appeared to be a misunderstanding that the 1995 Regulations were superseded by the 2015 Regulations and the member's NPA changed when the Tapered Protection period ended. This was incorrect.

- The AW33E defined Tier 1 as "permanently incapable of carrying out the duties of your own job". The response to her application had referred to "physical or mental infirmity which gives rise to the permanent incapacity for the efficient discharge of the duties of NHS employment". This was an inaccurate and generic reference which was not defined in the NHS Scheme documentation.

- The Scheme's MA did not appear to have considered her over-demanding role, which had now been split into two full-time posts with more support staff.

- A letter from her consultant, Professor Chan, had been interpreted out of context. Her survival chances were only an estimate and only if she continued with endocrine therapy for 10 years. This would continue for 4½ years past her NPA of 55. She had severe side effects from the treatment but her only choice, in order to reduce the risk of her cancer recurring, was to continue with some form of endocrine treatment and endure the side effects. Professor Chan had acknowledged the demands of her post and the limitations whilst she received treatment.

- The report by the OH doctor was factually incorrect. It played down her cancer and ongoing treatment and concentrated on work-related stress. Whilst this was a contributing factor, it was not the reason she could not return to work.

- A letter from her GP failed to describe her treatment and symptoms in depth. During this time, she was seeing other healthcare professionals and her GP was not fully informed. She enclosed another letter from her GP dated 17 September 2018. She also enclosed a report relating to her application for Employment and Support Allowance (**ESA**).

- She did not see how she could return to her current post or a similar role within the NHS. She did not believe that there was any requirement within the Regulations for her to accept a lower skilled position if she was deemed fit for work.

10. NHS Pensions issued a stage one IDR decision on 22 January 2019. It declined Mrs R's appeal on the grounds that she was not permanently incapable of carrying out her duties as a Sister. NHS Pensions quoted from its MA (see Appendix 2).

11. On 25 January 2019, NHS Pensions responded further to Mrs R's concerns about the applicable NPA and assessment process. Among other things, NHS Pensions explained that Mrs R's 1995 Section benefits had been linked and had not yet been deferred. It said the benefits would become deferred when Mrs R incurred a break in NHS employment of more than 12 months. NHS Pensions referred to Mrs R's concerns about NMC[1] registration. It said it could not consider the qualification required to gain employment in Mrs R's role or the need for NMC registration. It said it could only consider Mrs R's duties and her ability to carry out those duties in the period between her last day of employment and her normal pension age.

12. The Royal College of Nursing (**RCN**) submitted a further appeal on Mrs R's behalf on 16 July 2019. Its submission is summarised below:-

    - It enclosed a letter from Mrs R's GP dated 9 July 2019, and a job description for a Sister/Charge Nurse.

    - NHS Pensions had failed to consider Mrs R's job description adequately or at all. The Scheme's MA had assumed that, after the conclusion of her treatment,

Mrs R could simply return to the full-time contractual role. S/he had failed to take into account:

- having 24 hours responsibility for managing staff and budgets;
- working 36 hours per week;
- undertaking regular direct clinical care;
- being involved in regular inspections to identify clinical and non-clinical risks; and
- the ability to work in unpleasant working conditions, including wearing a lead apron and appropriate PPE, and coping with potentially violent and threatening situations.

- There had been no assessment of the suitability of Mrs R working in interventional radiology in view of:
  - the potential link between the nature of her role and the development of breast cancer;
  - the likelihood of future relapse and/or exacerbation of her condition upon return to that working environment; particularly on a full-time basis;
  - the emotional and psychological impact of having to support and treat patients with breast cancer; and
  - the complex nature of the role, which was different to a general band 7 role; for example, the requirement to balance the needs of different patients and specialities.

- NHS Pensions and Medigold appeared to have focused on Mrs R's Tamoxifen treatment in isolation. She would remain a cancer sufferer and would automatically be regarded as a disabled person as defined in Section 6, the Equality Act 2010; by virtue of paragraph 6, Schedule 1. It was imperative that NHS Pensions considered the impact of Mrs R's disability on the nature of her role. Otherwise, its decision could amount to an unfavourable treatment because of something arising in consequence of her disability under Section 15, the Equality Act 2010. Alternatively, it could amount to indirect discrimination under Section 19, the Equality Act 2010.

- No consideration had been given to the likely reasonable adjustments which an employer would have to make in the event that Mrs R returned to her contractual role. The role was inherently unsuitable for her. The employer would have to consider: redeployment to another role; downgrading to a lower band role; reducing her hours and/or varying her working pattern. Any of these changes would mean that Mrs R would not [*sic*] fulfil the eligibility for Tier 1 ill health retirement.

- No consideration had been given to Mrs R's concern about the difficulty of retaining NMC registration. In addition to the training and development required, Mrs R would be required to submit a declaration of good health.

13. NHS Pensions issued a stage two IDR decision on 19 August 2019. It declined Mrs R's appeal and said it was accepting the recommendation of its MA. NHS Pensions quoted the advice it had received from its MA (see Appendix 2).

**Mrs R's position**

14. On Mrs R's behalf, the RCN submits:-

- NHS Pensions states that Mrs R's job description was included as part of the original referral to its medical advisers and was considered. However, specific elements of Mrs R's job description were not considered. These were outlined in her appeal dated 16 July 2019. They include: unpleasant working conditions, wearing a lead apron, coping with potentially violent and threatening situations. There is no evidence that these issues were considered by NHS Pensions or its medical advisers.

- NHS Pensions failed to provide evidence that the medical assessments took into account all aspects of Mrs R's job. It failed to address the points raised in her appeal dated 16 July 2019.

- Mrs R had referred to a potential link between the nature of her contractual role and her cancer. This was disregarded by NHS Pensions' medical advisers.

- NHS Pensions wrongly concluded that, by the time Mrs R left employment, there was no evidence that her cancer was, itself, giving rise to any incapacity. It failed to acknowledge that Mrs R was unable to perform her role because of the adverse effects of her treatment for cancer. An impairment cannot be separated from any related treatment for the condition or its symptoms (Section 6, Equality Act 2010).

- NHS Pensions failed to provide an adequate response in respect of the relevance of potential reasonable adjustments. It did not address the issue of Mrs R's contractual role not being suitable for her.

- Section 6.33 of the Equality and Human Rights Commission's (**EHRC**) Statutory Code of Practice identifies a number of common reasonable adjustments; such as, allocating duties to another worker, transfer to fill an existing vacancy, and altering the hours of work. If Mrs R were to be redeployed, she would no longer be performing her contractual role. This would mean that she should have been entitled to a Tier 1 ill health retirement. If her hours of work were reduced or her duties changed from those appearing in her job description, she would no longer be performing her full role.

- NHS Pensions claims that, “on the basis of medical evidence available at the time [Mrs R] left employment”, it was likely that she would be fit to return to her normal NHS role before her scheme pension age. It is not clear which medical evidence it relied on. The OH doctor who completed the AW33 form said it was difficult to predict how Mrs R’s symptoms would change between then and pension age. S/he referred to an employer’s obligation to consider reasonable adjustments. This is a factor which could reasonably affect the prospect of Mrs R returning to her contractual role.

- The OH adviser’s reference to statistical data relating to the rate of return to work one year after diagnosis was not relevant in Mrs R’s case. This was because she had been unable to return to work within 12 months of diagnosis or initial treatment.

- Professor Chan’s report of 31 January 2018 only dealt with the issue of Mrs R’s prognosis; that is, the five-year survival and risk of recurrence. It did not deal with her ability to return to her contractual role as a senior nurse in the radiology department in the long term. NHS Pensions’ medical adviser did not assess Mrs R. In any event, s/he gave her/his opinion after the date Mrs R’s employment was terminated and it should not have been relied on for that reason. This is the reason given by NHS Pensions for excluding many of the points raised by Mrs R’s GP.

- NHS Pensions has not recognised the requirement for Mrs R to retain her NMC registration. As she could not perform any clinical duties for a long period of time, she could not preserve her registration until such time as she is fit to return to work.

- NHS Pensions failed to give due consideration to the demanding nature of Mrs R’s contractual role. It is not sufficient for it simply to state that her job description was considered. It is not clear what, if any, investigation was undertaken by NHS Pensions to understand the nature of Mrs R’s role.

- There is a difference between returning to work in general, which could be in any nursing capacity or working pattern, and a return to Mrs R’s contractual role on a full time basis. No medical evidence was presented which clearly indicated that Mrs R was expected to make a full recovery and return to her contractual role in the long term.

15. Mrs R has explained that the role which she had been undertaking has since been converted into two roles. She has also said that she had not wanted to transfer to the 2015 Scheme and her intention had always been to retire at age 55.

**NHS Pensions’ position**

16. NHS Pensions submits:-

- It has properly considered Mrs R's application, taking into account and weighing all relevant evidence and nothing irrelevant. It has taken advice from appropriate sources; that is, its own medical advisers. It has considered and accepted this advice and, as a result, it has arrived at a decision which it believes not to be perverse.

- It does not accept that Mrs R satisfied the Tier 1 conditions for ill health retirement benefits. It considers that, before she reaches the Scheme pension age, she will be capable of the duties of her NHS employment as a Nurse Sister working 36 hours per week.

- Its medical advisers' recommendations and rationales are founded on the correct interpretation of the 2015 Regulations. They took relevant evidence and information into account. The advice is not perverse; that is, it is not advice which no reasonable body could have offered in the circumstances based on the available facts.

- Medical decisions are seldom black and white. A range of opinions may be given from various sources; all of which must be considered and weighed. However, the fact that Mrs R does not agree with the conclusions it has drawn or the weight it has attached to any of the evidence does not mean that its decision is flawed.

17. NHS Pensions has confirmed that a job description for Mrs R's role was provided for its MAs. It has provided a copy. The job description is for a Band 7 Sister/Charge Nurse in Interventional Radiology. The document provides a detailed description of the role requirements and includes a description of the working conditions. This states that the post holder must be able to:

> "work within unpleasant clinical working conditions (for example exposure to body fluids)
>
> concentrate in an intense and sometimes noisy environment
>
> cope with potentially violent and threatening situations
>
> fulfil Trust health and safety policies and procedures when performing risk associated procedures including dealing with hazardous substances
>
> be able to safely wear lead aprons and appropriate PPE"

18. NHS Pensions has explained that its MA was also provided with a copy of Mrs R's description of her role.

## Adjudicator's Opinion

19. Mrs R's complaint was considered by one of our Adjudicators who concluded that no further action was required by NHS Pensions. The Adjudicator's findings are summarised below:-

- Members' entitlements to benefits when taking early retirement due to ill health were determined by the scheme rules or regulations. The scheme rules or regulations determined the circumstances in which members were eligible for ill health benefits, the conditions which they must satisfy, and the way in which decisions about ill health benefits must be taken.

- In Mrs R's case, the relevant regulations were the 2015 Regulations; in particular, Regulation 90. This provided that Mrs R would be entitled to immediate payment of a pension if she satisfied the Tier 1 conditions. If she also satisfied the Tier 2 conditions, she would be entitled to a Tier 2 addition. The Tier 1 conditions included the requirement that Mrs R was considered permanently incapable of efficiently discharging the duties of her NHS employment. Under the 2015 Regulations, permanently meant likely to last until Mrs R attained her prospective NPA, which was 67.

- Decisions as to entitlement to a pension under Regulation 90 were made by Medigold, in the first instance, and NHS Pensions, on appeal, under delegated authority from the Secretary of State, as Scheme Manager.

- The Ombudsman was primarily concerned with the way in which the decision as to Mrs R's entitlement under Regulation 90 had been reached. One of the specific obligations on decision-makers was to consider all the relevant evidence which was available to them and ignore any irrelevant matters. In Mrs R's case, it was argued that NHS Pensions and/or its MAs had failed to consider all the relevant evidence. Specifically:-

  - Neither NHS Pensions nor its MAs had considered the nature of Mrs R's NHS role.

    The RCN had submitted that there was a difference between returning to work in general, which could be in any nursing capacity or working pattern, and a return to Mrs R's contractual role on a full-time basis. The Adjudicator agreed that Regulation 90 called for an assessment of the member's incapacity by reference to the duties of her/his particular NHS role. In Mrs R's case, this meant assessing her capacity for the duties of a Band 7 Sister in Interventional Radiology; rather than, for example, a generic Band 7 role.

    The RCN had highlighted certain aspects of Mrs R's role in particular. These were: unpleasant working conditions; wearing a lead apron; and coping with potentially violent and threatening situations. The Adjudicator noted that these elements of the role were specifically referred to in the job

description which had been provided for the MAs. The RCN had suggested that it was not sufficient for NHS Pensions simply to say a job description had been provided. It suggested that NHS Pensions and/or it MAs should have undertaken further investigation to understand the nature of Mrs R's role. It was not clear what the RCN envisaged by way of investigation. In the Adjudicator's experience, it was common practice for a medical adviser simply to be provided with a job description for the role in question. Given that the job description in Mrs R's case was quite detailed and referred specifically to those elements which she and the RCN considered significant, the Adjudicator was of the opinion that NHS Pensions and its MAs had taken sufficient steps in this respect.

- NHS Pensions and/or its MAs had disregarded Mrs R's reference to a potential link between her job and her cancer.

  The Adjudicator acknowledged that this had not been referred to in the advice NHS Pensions received from its MAs. However, the advice was required to consider whether Mrs R's incapacity for her NHS role was likely to be permanent; that is, whether it was likely to last until her 67th birthday. For the purposes of determining eligibility under Regulation 90, causation was not a factor which either NHS Pensions or its medical advisers were required to consider.

- NHS Pensions had failed to take into account the fact that Mrs R had lost her NMC registration.

  The RCN and Mrs R had explained that she was unable to maintain her NMC registration because she was unable to undertake the required continuous professional development. The Adjudicator said she understood that Mrs R had been removed from the NMC register.

  NMC registration was a necessary part of Mrs R's NHS employment and she was unable to undertake her role without it. The Adjudicator considered it reasonable to say that Mrs R's ill health was the reason why she was unable to fulfil the requirements for continued registration. However, as with other aspects of Mrs R's case, the question was whether this situation was likely to be permanent; that is, whether it would continue until Mrs R reached age 67. The loss of registration, in and of itself, was not sufficient for Mrs R to satisfy the Tier 1 conditions. The Adjudicator said she understood it was possible for an individual to re-register by undertaking appropriate training.

- The RCN had also submitted that NHS Pensions and/or its MAs had taken irrelevant information into account. Specifically:-

  - The statistical data quoted by the OH doctor in the AW33E.

The OH doctor had quoted some statistics for survival rates in her AW33E report, which the RCN had suggested were not relevant in Mrs R's case because she had been unable to return to work within 12 months of diagnosis or initial treatment. However, there appeared to be no reference to these statistics in the MAs' advice and their opinions had been based on their interpretation of other evidence relating to Mrs R's case.

- NHS Pensions should not have relied on its MAs' reports because they post-date the cessation of Mrs R's employment.

  This might have been a misunderstanding of the references, in the MAs' reports, to not having taken certain information contained in medical reports which post-dated the cessation of Mrs R's employment into account. In order to receive a pension under Regulation 90, Mrs R had to satisfy the Tier 1 conditions as at the date her employment ceased. The decision had to be made without the benefit of hindsight and, therefore, the way in which the member's condition had actually progressed after employment ceased was not taken into account. However, this did not mean that a doctor could not express a view as to what might have been expected at the earlier date. Provided that the evidence which was considered related to the situation as at the date employment ceased, it was acceptable for medical advice to be given at a later date. NHS Pensions' MAs appeared to have been fully aware that they were required to advise as to the situation in January 2018.

- Mrs R and the RCN had raised other concerns about the approach taken by NHS Pensions in making its decision. They were concerned that Professor Chan's report had been taken out of context and, in particular, they pointed out that he had not addressed the question of Mrs R's ability to return to her contractual role.

- The Adjudicator agreed that Professor Chan had not expressed a view as to whether Mrs R would be capable of undertaking her NHS duties at any time before her 67th birthday. He had been asked about prognosis but his answer focussed on the risk of Mrs R's cancer recurring and the role of Tamoxifen.

- The Adjudicator agreed that it was important not to read anymore into Professor Chan's report than was actually there. For example, it would not have been appropriate to assume, because he did not say Mrs R would not be able to return to her NHS role before her NPA, that Professor Chan was of the view that she would be able to return to her role. Having reviewed the opinions provided by NHS Pensions' MAs, the Adjudicator was of the view that the references to Professor Chan's report were appropriate; inasmuch as they were factual and did not purport to read anything into his report which was not there.

- While NHS Pensions was required to consider all the relevant evidence, the weight which it attached to any of the evidence was for it to decide[2]. This included giving some of the evidence little or no weight. It was open to NHS Pensions to prefer the advice which it received from its own MAs; provided, that is, there was no good reason why it should not do so. The Adjudicator explained that the kind of things she 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 Pensions 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 R's own doctors; if one had not already been provided. The Adjudicator noted that the NHS Pensions' MAs had acknowledged that their views differed to that expressed by Mrs R's GP and they had explained why this was.

- It was the Adjudicator's view that there was no reason why NHS Pensions could not rely on the advice it received from its MAs in reaching its decision in Mrs R's case.

- The Adjudicator noted that the RCN had suggested that it was not clear which medical evidence NHS Pensions had relied on. It asserted that no medical evidence had been presented which clearly indicated that Mrs R was expected to make a full recovery and return to her contractual role in the long term. The Adjudicator disagreed on this point. The reports provided by NHS Pensions' MAs set out in some detail the medical evidence they had considered and NHS Pensions explained it was accepting the MAs' advice. That advice had dealt with the question of whether Mrs R could be expected to recover sufficiently to be capable of undertaking her former role before her NPA.

- The RCN had made reference to the Equality Act 2010. In particular, it had referred to Section 6 in the context of comments by NHS Pensions' MAs that Mrs R's cancer did not, itself, give rise to incapacity at the date her employment ceased. The RCN had asserted that an impairment could not be separated from any related treatment for the condition or its symptoms.

- Section 6, the Equality Act 2010, defined the protected characteristic 'disability' for the purposes of determining whether there had been discrimination (direct or indirect), harassment or victimisation; that is, prohibited conduct. In addition, the Adjudicator noted that Section 15 provided that discrimination could arise if a person (A) treated a disabled person (B) unfavourably because of something arising in consequence of B's disability. This would include the need to receive treatment.

- However, the Adjudicator said it was not clear that either Section 6 or Section 15 assisted in Mrs R's case. The MAs had said that Mrs R's cancer was not, itself, giving rise to incapacity at the time her employment ceased. They had

then considered the effect of Mrs R's treatment and had agreed that this was giving rise to an incapacity to undertake her NHS role. The RCN had not explained why it considered this to be less favourable treatment. Nor did the Adjudicator consider it accurate to say that NHS Pensions had failed to acknowledge that Mrs R was unable to perform her role because of the adverse effects of her treatment for cancer. This had been clearly acknowledged in the MAs' reports. The point of disagreement was whether this position was likely to be permanent; that is, likely to continue to Mrs R's NPA.

- The advice which NHS Pensions had received from its MAs was that Mrs R was experiencing severe side effects from Tamoxifen. The MAs had pointed out that Mrs R might be expected to continue with Tamoxifen for up to 10 years and, as a worst case scenario, might continue to experience the side effects. However, the MAs had pointed out that Mrs R's treatment was due to finish around eight years before she reached NPA and it was expected that the side effects would diminish at this point. It was for this reason that they were of the view that Mrs R's incapacity to undertake her NHS role could not be considered permanent.

- The RCN had also referred to Section 6.33 of the EHRC's Code of Practice. This identified a number of reasonable adjustments which employers could be expected to make, including redeployment. The RCN argued that, if Mrs R were to be redeployed, she would no longer be performing her contractual role. Mrs R had also explained that her former role had since been converted into two roles. If her employer had been able to make reasonable adjustments to enable her to remain in employment, including redeployment, Mrs R would not have satisfied the Tier 1 conditions. One of those conditions was that the member "has ceased to be employed in NHS employment".

- Finally, Mrs R had raised the question of her NPA. She had made the point that, under the regulations which applied to the 1995 Section, she had been able to retire at age 55 because of her SCS. Mrs R had explained that she did not wish to transfer to the 2015 Scheme and it had always been her intention to retire at age 55. The 1995 Regulations were amended[3] so that members were not able to continue to contribute to or accrue further pensionable service in the 1995 Section. The date on which a member transitioned to the 2015 Scheme depended upon their age in April 2012. Mrs R did not have the option to continue as an active member of the 1995 Section once she had reached her "eligibility cessation date" in December 2017.

- Once Mrs R had transitioned to the 2015 Scheme, her eligibility for an ill health retirement pension had to be determined under Regulations 90 and 91 of the 2015 Regulations. For the purposes of deciding whether she satisfied the Tier

1 conditions, “permanently” was defined as likely to last until Mrs R attained her “prospective normal pension age”, which was 67.

20. Mrs R did not accept the Adjudicator’s Opinion and the complaint was passed to me to consider. The RCN provided further comments on Mrs R’s behalf which do not change the outcome. I agree with the Adjudicator’s Opinion and I will, therefore, only respond to the main points made by the RCN on Mrs R’s behalf for completeness.

**The RCN’s further comments**

21. The RCN has submitted, on Mrs R’s behalf:-

- With regard to an investigation into Mrs R’s job description and working conditions, it is not unreasonable to expect NHS Pensions’ MA, who is an occupational health consultant, to comment on the specific concerns which were identified. For example, wearing a lead apron has not been considered at all. The job description does not specify the frequency or duration for which Mrs R was required to wear a lead apron whilst undertaking her role. It is not satisfactory simply to rely on a review of the job description and contend that this was sufficient because wearing a lead apron had been listed in the job description. No occupational health assessment was carried out to see what the impact of wearing a lead apron would be for someone who had suffered from breast cancer.

- Requiring a Band 7 Sister in Interventional Radiology to comply with the job description, including wearing a lead apron, is a “provision, criterion, or practice” which puts Mrs R, as a disabled person, at a substantial disadvantage, as defined in Section 20 [*sic*] of Equality Act 2010. NHS Pensions is not in a position to state that the specific elements of Mrs R’s job description would not place her at a substantial disadvantage, which would affect her ability, as a disabled person, to return to her contractual role on a full-time basis in the long term (which is not currently foreseeable), as and when she has completed her cancer-related treatment.

- The link between Mrs R’s breast cancer and the nature of her role is highly relevant. If working in an environment with higher exposure to radioactive material can cause a relapse of her cancer, this will prevent her from returning to her contractual role and will place her health at greater risk. Given the specific type of cancer, the issue should have been considered and NHS Pensions ought to have stated why little weight was attached to it. It trusts that neither NHS Pensions nor its MAs wish to potentially expose Mrs R to greater risk by suggesting that she could be fit to return to the radiology department when they have not considered the issue at all.

- Section 15 of the Equality Act 2010 deals with “unfavourable”, as opposed to less favourable, treatment and, therefore, there is no requirement for a comparator who is not disabled. As long as there is a connection between Mrs R’s disability and her medical treatment (or the incapacity caused by the

treatment), it is sufficient to show that she had a disability related treatment. Her application for ill health retirement was rejected at the time when she was undergoing a disability related treatment and/or suffering from complications caused by that treatment. NHS Pensions failed to consider that its unfavourable treatment was because of something arising in consequence of her disability.

- Redeployment can be a form of reasonable adjustment. If Mrs R is redeployed upon a potential return to work in the NHS, she will not be able to return to her contractual role. The fact that she would remain in some other form of NHS employment as a band 7 nurse is not relevant. Furthermore, the fact that Mrs R's role has been split and the effect of any future reasonable adjustment on her ability to perform the full-time contractual role, as existed in January 2018, are relevant.

## Ombudsman's decision

22. The question at the heart of Mrs R's case is whether she satisfied the conditions to receive a pension under Regulation 90 at the time her NHS employment ceased. If she did, she was entitled to an immediate pension; if she did not, she was not entitled to a pension.

23. It is not for me to answer that question; rather, my role is to consider the way in which NHS Pensions and/or its MAs sought to answer that question. Put simply, I need to consider whether NHS Pensions and/or its MAs applied the 2015 Regulations correctly and whether the decision reached was supported by sufficient appropriate evidence.

24. The RCN referred to Section 6 of the Equality Act 2010, in its submissions to NHS Pensions and to me. Section 6 sets out what is meant by the protected characteristic of "Disability". Paragraph 6, Schedule 1 provides that cancer is a disability for the purposes of the Equality Act 2010. The intention appears to have been to establish that NHS Pensions had discriminated against Mrs R in deciding that she was not entitled to a pension under Regulation 90.

25. For the purposes of establishing direct or indirect disability discrimination under the Equality Act 2010, a comparator is required. There must be no material difference between the circumstances relating to the claimant and the comparator. The comparator might be non-disabled or have a different disability to Mrs R. The RCN has not explained in what way it considers Mrs R was treated less favourably than an appropriate comparator or, indeed, who that comparator might be. I accept that an individual with cancer is disabled for the purposes of the Equality Act 2010. However, being disabled, in and of itself, does not automatically qualify Mrs R for a pension under Regulation 90.

26. Section 15 of the Equality Act 2010 sets out what is meant by "Discrimination **arising from** disability" (emphasis added). Section 15(1) provides that a person (A)

discriminates against a disabled person (B) if A treats B unfavourably because of something arising in consequence of B's disability. A comparator is not required for discrimination *arising from* disability. Unfavourable treatment is not, itself, defined in the Act. The Courts have, however, provided some guidance[4]. The test for unfavourable treatment asks two questions:-

- What was the relevant treatment?
- Was it unfavourable to the claimant?

27. It is not entirely clear from the RCN's submission what it considers to be the relevant treatment which it wishes to argue was unfavourable to Mrs R. A decision that a person does not satisfy the Tier 1 or 2 conditions for a pension under Regulation 90 is not, in and of itself, unfavourable treatment arising in consequence of the person's disability. It is the end product of applying the eligibility conditions to the facts of the case. To find otherwise would, in effect, remove the requirement to satisfy the Tier 1 or 2 conditions in order to receive a pension under Regulation 90 for any disabled member. The unfavourable treatment must, therefore, lie in the way in which the decision is reached.

28. The RCN argues that, if there is a connection between Mrs R's disability and her medical treatment or incapacity caused by that treatment, this is sufficient to show that she had a "disability related treatment". It argues that Mrs R's application for ill health retirement was rejected at the time when she was undergoing a disability related treatment and/or suffering from complications caused by that treatment. It argues that NHS Pensions failed to consider that its unfavourable treatment was because of something arising in consequence of Mrs R's disability. Again, the RCN has not said what it considered the unfavourable treatment to be. The only thing which might be said to be unfavourable to Mrs R would appear to be the decision that she did not satisfy the Tier 1 or 2 conditions. I do not find that this constitutes "unfavourable treatment" as envisaged by the Equality Act 2010.

29. The RCN has referred to wearing a lead apron as being a "provision, criterion, or practice" (**PCP**) which puts Mrs R, as a disabled person, at a substantial disadvantage. It is referring to the duty to make reasonable adjustments, which does extend to occupational pension schemes[5]. However, whilst the requirement to wear a lead apron could amount to a PCP, the duty to make reasonable adjustments for this would be for Mrs R's employer to address. It is not something which NHS Pensions was required to address in reaching its decision under Regulation 90. It is not a PCP in relation to the 2015 Scheme or the administration of the 2015 Scheme.

30. Instead of trying to approach Mrs R's case from a disability discrimination point of view, it would be more appropriate to consider whether her eligibility under Regulation

90 has been properly considered. I have explained, in paragraph 23 above, what this entails.

31. NHS Pensions takes advice from its own MAs and it is entitled to rely on the advice it receives unless there is a good reason why it should not; for example, an error or omission of fact or a misunderstanding of the relevant regulation. It is for NHS Pensions to decide what weight it gives to any of the available evidence, including giving some of it little or no weight. It is, however, required to consider all relevant evidence and not to take account of anything irrelevant.

32. The RCN has suggested that simply providing the MAs with a copy of Mrs R's job description was not going far enough. It argues that NHS Pensions failed to consider the frequency and duration for which Mrs R was required to wear a lead apron. It suggests that an occupational health assessment should have been carried out to ascertain what the impact of wearing a lead apron would be for someone who had suffered from breast cancer.

33. NHS Pensions could be expected to take appropriate steps to ensure both it and its MAs understood the nature of the role against which Mrs R was being assessed. I am not persuaded that this could not be achieved by considering her job description. This is quite a detailed document. I do, however, acknowledge that, although it does refer to the need to wear a lead apron, it does not detail frequency or duration. It does state that Mrs R was required to undertake "regular" direct clinical care in addition to her managerial duties; again, without specifying what percentage of her time this involved. Nevertheless, the job description did provide both NHS Pensions and its MAs with ample information about Mrs R's role. I note also that Mrs R was given the opportunity to submit her own statement, which would have allowed her to expand on the job description if she had thought it necessary.

34. Both the RCN and Mrs R have made the point that, since her employment ceased, her role has been divided into two. I take it they consider this an indication that the role she had been undertaking was too much for one person. That might well be the case, and I make no finding on this point, but the subsequent rearrangement of duties is not relevant to Mrs R's eligibility under Regulation 90. NHS Pensions was required to make its decision by reference to her role as it stood in January 2018.

35. Equally, speculation as to the position if Mrs R was to be redeployed on a return to the NHS does not assist her case. The question for NHS Pensions and its MAs was whether Mrs R was permanently incapable of efficiently discharging the duties of her NHS employment as it stood in January 2018. I am satisfied that this is the question addressed by NHS Pensions and its MAs. There was no misunderstanding as to what was required by Regulation 90.

36. The advice which NHS Pensions received was that Mrs R's incapacity to discharge the duties of her NHS role was unlikely to be permanent. This was on the basis that the principal reason for her current incapacity was the side effects she was experiencing from taking Tamoxifen. Briefly, the MAs acknowledged that Mrs R was

experiencing significant side effects and was currently unfit for her NHS role. However, they noted that her course of Tamoxifen was due to last for 10 years and she had 18 years to go to her normal pension age. In the absence of any incapacity arising directly from Mrs R's cancer, the MAs concluded that her incapacity resulting from the side effects of Tamoxifen could not be considered permanent for the purposes of Regulation 90. This position is not incompatible with the evidence from Professor Chan. It is contrary to the view expressed by Mrs R's GP, but he had not addressed the position once her course of Tamoxifen had come to an end.

37. I note that the RCN has suggested there might be a link between Mrs R's breast cancer and the nature of her role. It argues that, if working in an environment with a higher exposure to radioactive material could cause a return of her cancer, it would prevent her from returning to her contractual role and would place her health at greater risk. The RCN suggests that, given the specific type of cancer, this issue should have been considered and NHS Pensions ought to have stated why little weight was attached to it.

38. The RCN has offered no evidence of there being such a link in Mrs R's case and there is no discussion of such a link in the supporting medical evidence. Ionising radiation is considered a risk factor in the development of breast cancer, but this is in the context of receiving medical treatment such as x-rays, CT scans and radiotherapy to the chest area at a young age and the risk is considered to be slight. It is not appropriate for the RCN to speculate on the existence of a link between Mrs R's cancer and her NHS role in the absence of any evidence for such a link in her case. In the context of future employment, Mrs R's employer would have a duty to provide a safe working environment for her; as it would for any other employees.

39. I acknowledge that Mrs R has had to deal with an extremely distressing medical condition and the side effects of treatment for that condition. However, I do not find that there are grounds for me to uphold her complaint.

**Anthony Arter**
Pensions Ombudsman

19 May 2020

# Appendix 1

## The National Health Service Pension Scheme Regulations 2015

40. As at the date Mrs R's employment was terminated, 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 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.

…

(5) In paragraph (3)(b), **"regular employment of like duration"** means -

(a) …;

(b) in any other case, where prior to ceasing NHS employment, M was employed -

(i) on a whole-time basis, regular employment on a whole-time basis;

(ii) on a part-time basis, regular employment on a part-time basis, regard being had to the number of hours, half days and sessions M worked in the employment.

(6) A pension under this regulation is payable for life: but see regulations 95 and 96."

41. Regulation 91 provided:

"**Member's incapacity**

(1) For the purpose of determining whether a member (M) is permanently incapable of discharging the duties of M's employment efficiently, the scheme manager must -

(a) have regard to the factors in paragraph (2), no one of which is to be decisive; and

(b) disregard M's personal preference for or against engaging in the employment.

(2) The factors mentioned in paragraph (1)(a) are -

(a) whether M has received appropriate medical treatment in respect of the infirmity;

(b) M's mental capacity;

(c) M's physical capacity;

(d) the type and period of rehabilitation it would be reasonable for M to undergo in respect of the infirmity, regardless of whether M has undergone the rehabilitation; and

(e) any other matter the scheme manager thinks appropriate.

(3) For the purpose of determining whether M is permanently incapable of engaging in regular employment of like duration as mentioned in paragraph (3)(b) of regulation 90, the scheme manager must -

(a) have regard to the factors in paragraph (4), no one of which is to be decisive; and

(b) disregard the factors in paragraph (5).

(4) The factors mentioned in paragraph (3)(a) are -

(a) whether M has received appropriate medical treatment in respect of the infirmity;

(b) such reasonable employment as M would be capable of engaging in if due regard is given to -

(i) M's mental capacity;

(ii) M's physical capacity;

(iii) M's previous training; and

(iv) M's previous practical, professional and vocational experience,

irrespective of whether or not such employment is available to M.

(c) the type and period of rehabilitation it would be reasonable for M to undergo in respect of the infirmity, regardless of whether M has undergone the rehabilitation, having regard to -

(i) M's mental capacity; and

(ii) M's physical capacity;

(d) the type and period of training it would be reasonable for M to undergo in respect of the infirmity, regardless of whether M has undergone the training, having regard to -

(i) M's mental capacity;

(ii) M's physical capacity;

(iii) M's previous training; and

(iv) M's previous practical, professional and vocational experience; and

(e) any other matter the scheme manager thinks appropriate.

(5) The factors mentioned in paragraph (3)(b) are -

(a) M's personal preference for or against engaging in any particular employment; and

(b) the geographical location of M.

(6) In this regulation -

**“appropriate medical treatment”** means such medical treatment as it would be normal to receive in respect of the infirmity, but does not include any treatment that the scheme manager considers -

(a) that it would be reasonable for M to refuse;

(b) would provide no benefit to restoring M's capacity for -

(i) discharging the duties of M's employment efficiently for the purposes of paragraph (2)(c) of regulation 90 before M reaches prospective normal pension age; or

(ii) engaging in regular employment of like duration for the purposes of paragraph (3)(b) of that regulation before M reaches prospective normal pension age; or;

(c) that, through no fault on the part of M, it is not possible for M to receive before M reaches prospective normal pension age.

**“permanently”** means until M attains M's prospective normal pension age; and

**“regular employment of like duration”** has the same meaning as in regulation 90.”

# Appendix 2

## Medical evidence

### Mrs R's GP, 1 December 2017

42. In a letter to the employer's OH doctor, Mrs R's GP said she was currently undergoing treatment for breast cancer and anxiety. He listed Mrs R's medication and said she had undergone chemotherapy and radiotherapy. He said he was not aware of any side effect which Mrs R was experiencing.

### Form AW33, 19 December 2017

43. In Part C, the OH doctor listed Mrs R's medical conditions as breast cancer and work-related stress anxiety and provided details of her treatment. She then described Mrs R's symptoms and functional limitations. She said Mrs R related the symptoms to the side effects of her cancer treatment and the decline in her mental health to work-related stress. The OH doctor said Mrs R's cancer had been treated via combined chemotherapy, surgery and radiotherapy. She said Mrs R was currently undergoing chemotherapy which was expected to last until 2027. The OH doctor said Mrs R was currently on Herceptin (every three weeks for one year) and Tamoxifen (daily for 10 years).

44. In answer to the question: "What is the likely future course of this member's health and function, with normal therapeutic intervention over the period to normal pension or benefit age?", the OH doctor said:-

- Mrs R's breast cancer was a Stage 1B cancer and the five-year relative survival for Stage 1 breast cancer was 99%. She provided a link to the Cancer Research UK website.
- Almost 78% of women diagnosed with breast cancer in England and Wales survive for ten years or more. Around nine in ten women in England diagnosed between the ages of 40 and 69 survive for five years or more compared with seven in ten for women diagnosed at age 80 or over. She provided another link to the Cancer Research UK website.
- There was a 59% rate of return to work one year after diagnosis or treatment. The same study had shown 35% of participants reported being absent from work longer than one year. She provided a link to an article.
- She had identified the following negative prognostic factors in Mrs R's case: pain; anxiety; fatigue; cognitive symptoms; hot flashes [*sic*]; stress associated with specific job; flexibility of work schedule; high-demand job; potential environmental hazards; lack of perceived support from colleagues and employer; decreased desire to keep job; decreased self-efficacy; not financially dependent upon working; treatments.

- Mrs R had expressed the view that she would not be able to return to her role. She had expressed the view that her work (ionising radiation and stress) had contributed to the development of her cancer.

- As far as she was aware, Mrs R's work-related stress had not been discussed with her employer and was likely to remain an obstacle.

45. The OH doctor said:

> "[Mrs R] has not attempted to return to work since her diagnosis of breast cancer in October 2016 given that she did not feel able to in the context of her symptoms.
>
> In my opinion she is currently unfit for work as a Band 6 [*sic*] nurse in Interventional Radiology, given that she described to me symptoms that limit her ability to carry out everyday activities (fatigue, poor concentration, memory problems, being tearful and irritable). Furthermore, she would be in direct and indirect contact with patients treated for breast cancer and this would be likely to trigger her psychological symptoms.
>
> She explained to me that she is making steps to improve her physical and mental health (physical exercise …, socially engaging with friends, complying with treatment including CBT offered by her GP).
>
> It is difficult to predict how her symptoms would change between now and pension age her symptoms and psychological well-being might improve when she has left her perceived stressful work environment. For statistical data regarding return to work following the diagnosis of breast cancer, please see above. Overall more people return to work 12 months after the diagnosis of breast cancer than those who do not return …"

46. The OH doctor said Mrs R was still experiencing side effects from her cancer treatment which limited her ability to carry out everyday activities. She said Mrs R would remain on Tamoxifen for 10 years. She said the side effects which Mrs R was experiencing might last throughout her treatment but it was difficult to quantify the risk for this.

**Professor Chan, 31 January 2018**

47. In a letter to the employer's OH doctor, Professor Chan set out Mrs R's cancer treatment. He mentioned that Tamoxifen had to be discontinued due to side effects, including insomnia, hot flushes and depressive psychosis. In response to a question about prognosis, Professor Chan said there was a 10% risk of recurrence over the next ten years. He said this could be reduced further with Tamoxifen for a duration of at least five years and up to ten years. He noted that Tamoxifen had been discontinued in Mrs R's case because of severe side effects. In response to a question concerning whether it was his expectation that the side effects would decrease, increase or remain the same, Professor Chan said:

> "[Mrs R's] side effects from Tamoxifen were certainly severe enough for her to discontinue the medication. This is partially related to the stress of her work. I feel that unless she finds a suitable way of working, she would not be able to cope with the side effects of Tamoxifen. We know from past experience that at least 25% of patients on adjuvant endocrine therapy treatment are not able to tolerate the medication due to these side effects. [Mrs R] feels that she needs to give herself the optimal chance of achieving the 10 years of Tamoxifen treatment to attain 25% risk reduction of recurrence from her breast cancer. I do feel that this is a perfectly rational and reasonable decision."

**Medigold, March 2018**

48. Medigold's MA began by setting out the medical elements of the Tier 1 and Tier 2 conditions and noting that permanent incapacity was to be assessed by reference to age 67. S/he noted that Mrs R was a part-time (36 hours per week) sister. The MA listed the evidence s/he had considered. This consisted of the three reports summarised above and a statement from Mrs R.

49. The MA said the evidence indicated that Mrs R was currently incapable of efficiently discharging the duties of her NHS employment, as a sister in the interventional radiology theatres, but this was not likely to be permanent. S/he referred to Professor Chan's report and noted that Tamoxifen had been discontinued because of side effects. S/he noted that Professor Chan had said that Mrs R had had an excellent response to chemotherapy and that the risk of her cancer recurring in the next 10 years was around 10%. The MA noted Professor Chan's comment that the side effects of Tamoxifen had been severe enough for Mrs R to discontinue it and this was partly related to the stress of her work.

50. The MA referred to the GP's report and noted that he was not aware of the side effects which Mrs R had experienced.

51. The MA then referred to the OH doctor's report in the AW33E. S/he noted the OH doctor's comments concerning work-related stress. S/he noted that Mrs R had undertaken physiotherapy, mindfulness meditation and regular counselling sessions, and that she was about to start a course of cognitive behavioural therapy. The MA said Mrs R's role involved 36 hours over five days, plus occasional on-call sessions. S/he noted that, in her statement, Mrs R had alluded to an increase in stress and anxiety levels. The MA concluded:

> "The current medical evidence suggests that [Mrs R] has current incapacity for her substantive post. However, I note that there would be a further 19 years until her normal pension age and the consultant oncologist alludes to a favourable prognosis for her breast cancer. It would be expected that the residual symptoms following the treatment for the breast cancer would improve over time and certainly before her normal pension age, thus facilitating a return to work to her substantive post. It would be expected that further treatment for the anxiety symptoms, in the form of cognitive behaviour

> therapy and adjustment to anti-depressant and anxiolytic medication will help to mitigate symptoms, particularly fatigue and impairment in memory and concentration. In relation to the unresolved issues from perceived cumulative work stress, this would involve dialogue with the employer to discuss the provision of additional support and adjustments in the workplace. A stress risk assessment could also have been undertaken. My understanding is that there are alternative options available for endocrine therapy treatment."

**Mrs R's GP, 14 March 2018**

52. In an open letter, Mrs R's GP explained the treatment she had received for her breast cancer. He said she had started on Tamoxifen but this had caused side effects; notably low mood and aches and pains. The GP said Mrs R was taking other medication and had received counselling. He explained that Mrs R's intolerable menopausal symptoms had gone away when she stopped Tamoxifen but returned when she tried restarting on a very low dose. The GP said Mrs R was continuing with Tamoxifen and was waiting to be seen at a menopause clinic. He concluded:

> "Given these intolerable symptoms and the effects of the treatment regime she has been through, she does not feel able to return to work. She also worries that if she was to return to work, her registration will have lapsed by then as she won't have done her 450 hours of practice, not kept up with her studies for revalidation, due to her illness and the side effects of her treatment."

**Employment and Support Allowance Report, May 2018**

53. Mrs R has submitted copies of a report completed by a registered nurse in connection with her claim for ESA in May 2018. The report was completed following an assessment and Mrs R was found to meet the criteria for "Limited Capability for Work and Work Related Activity".

**Mrs R's GP, 17 September 2018**

54. Mrs R's GP said he was writing in support of her appeal against the decision to refuse her application for ill health retirement. He set out details of her treatment for breast cancer and the side effects, including ocular hypertension, reduced visual acuity, fatigue, "brain fog", and menopausal symptoms. The GP said Mrs R's job was very stressful and made extreme demands on her mentally and physically. He enclosed a job description. He explained that Mrs R was in receipt of Employment Support Allowance. The GP said Mrs R had been removed from the NMC register and, to re-register, she would be required to undertake a return to nursing course, including participation in clinical work and academic study. He concluded:

> "Although the oncologists have given a general favourable prognosis for her breast cancer, you should be aware that they were unable to use their Predict software for her illness because of the neo-adjuvant chemotherapy and grade 3 multifocal breast cancer. This means the estimate of prognosis should not be considered too accurate or relied upon too greatly.

> It is my opinion that [Mrs R] fits the criteria for Tier 1 ill health retirement, as she will never be able to return to her current job, Sister-In-Interventional Radiology, or any other Band 7 position.
>
> As she has been assessed for ESA and has been awarded the higher rate until May 2019, she may also fit the criteria for tier 2 ill health retirement.
>
> I feel that although her breast cancer treatment is complete, apart from continuing her tamoxifen until 2027, and the prognosis, although an estimate is generally favourable, she has been left with a large number of disabling symptoms and sequalae which will mean that she will never be capable of returning to her band 7 role."

**NHS Pensions' MA at IDR Stage One**

55. The MA quoted in NHS Pensions' stage one IDR response noted that s/he was instructed to consider Mrs R's case under the 2015 Regulations. The MA set out the Tier 1 and Tier 2 conditions as before and noted that Mrs R's normal benefit age was 67. S/he noted that Mrs R was a part-time (36 hours) Sister. The MA then listed the documents s/he had considered and said a number of the documents post-dated Mrs R's last day of service. S/he said changes in Mrs R's health after she left employment were not relevant to determining whether she satisfied the Scheme definitions as of her last day of service. The MA said s/he had not, therefore, taken the subsequent course of Mrs R's illness into account. S/he said s/he had taken account of elements of the documents which related to or provided insight into Mrs R's circumstances at the time she left employment.

56. The MA said s/he considered that the medical evidence indicated that, on the balance of probabilities, Mrs R did not satisfy the Tier 1 condition of permanent incapacity for the efficient discharge of her NHS duties. S/he said there was reasonable medical evidence that, at the time of leaving employment, Mrs R had a physical or mental infirmity as a result of which she was incapable of efficiently discharging the duties of her employment. The MA said the key issue was whether Mrs R's incapacity was likely to have been permanent.

57. The MA provided her/his rationale for her/his opinion. This is summarised below:-

- Mrs R's incapacity was due to the combined effect of the consequences of breast cancer and impaired mental health.
- She had been diagnosed with breast cancer in late 2016. Chemotherapy had been completed in May 2017. Radiotherapy was completed in July 2017. The intention had been that Mrs R would continue with Tamoxifen for 10 years.
- At the time she left employment, Mrs R was experiencing symptoms which were probably a side effect of the chemotherapy and radiotherapy. These symptoms commonly followed such treatment and generally resolved with time; often within six months or so. On occasion it could take longer but it was

unlikely that they would have been expected to continue until Mrs R reached the Scheme pension age, which lay some 18 years in the future.

- At the time Mrs R left employment, she had been experiencing significant side effects from Tamoxifen. These were of such severity that she had stopped treatment. It appeared that Mrs R had restarted Tamoxifen on a lower dose but still experienced side effects. Not unreasonably, Mrs R wished to persevere with Tamoxifen because this would reduce the risk of her cancer recurring. It was not possible to accurately predict the extent of the risk reduction. Professor Chan had indicated that, even without Tamoxifen, the risk of recurrence in the following ten years was around 10%.

- When considering whether a medical condition was likely to give rise to permanent incapacity, the MA said s/he first considered if the incapacity was likely to be permanent in the absence of future treatment. If so, s/he then considered if future treatment was likely to alter this.

- At the time Mrs R left employment, there was no evidence that the breast cancer was, itself, giving rise to any incapacity. Mrs R's incapacity arose from the side effects of her treatment. If she had stopped taking Tamoxifen, it was likely that the side effects of her treatment would have resolved over time. The expected timescale for this would have been a period of months or a small number of years. Mrs R was 18 years away from her Scheme pension age. Therefore, in the absence of future treatment, her incapacity was unlikely to have been permanent.

- Mrs R wished to continue with Tamoxifen. The MA said s/he had not been able to identify any research to indicate whether her symptoms were likely to abate if she did continue. In a worst case scenario, the side effects would have been expected to decline once treatment ended. At the time she left employment, Mrs R was 18 years away from reaching her pension age and the Tamoxifen treatment was scheduled to continue for 10 years. It was possible that, if the side effects remained intrusive, Mrs R's view on the relative benefits of the treatment may have altered and/or she may have elected to change to another treatment option; for example, an aromatase inhibitor which had been suggested to her.

- Mrs R's impaired mental health appeared to be linked to her perception of her work circumstances. She had experienced difficulties in 2012 but improved with antidepressants and counselling and was able to return to work. She was experiencing further difficulties prior to her diagnosis of breast cancer. There was no indication that Mrs R's mental health had been a cause of sickness absence in recent years.

- There was no evidence that Mrs R's employer had taken any action to address her concerns. It would not be unreasonable to consider that Mrs R's mental health had been further adversely affected by her diagnosis of breast cancer.

There was no evidence that Mrs R had, by the time she left employment, received any treatment for her impaired mental health. In December 2017, she was awaiting cognitive behavioural therapy.

- The workplace was not a static environment; over time people moved on, working practices changed, and policies and procedures evolved. It was unlikely that the circumstances which Mrs R perceived as stressful in late 2016 would have continued unchanged for the best part of 20 years.

- Whilst Mrs R's mental health might not have been expected to spontaneously improve, at the time she left employment, treatment would have been thought likely to improve her mental health sufficiently to remove it as an obstacle to her working. The timescale for improvement would have been measured in months or a small number of years.

- The MA noted that her/his opinion was at variance to that expressed by Mrs R's GP. S/he noted that the GP's opinion had been given several months after Mrs R had left employment. S/he said s/he did not infer from the GP's report that this would have been his opinion in February 2018.

**Mrs R's GP, 9 July 2019**

58. The contents of the GP's July 2019 letter were the same as for his September 2018 letter (see paragraph 54 above).

**NHS Pensions' MA at IDR Stage Two**

59. The MA quoted in NHS Pensions' IDR stage two decision said s/he understood s/he was required to advise whether Mrs R was likely to have met the Tier 1 and Tier 2 conditions on 9 February 2018. The MA set out the Tier 1 and Tier 2 conditions and listed the documents s/he had considered. These included the appeal document submitted by the RCN, the GP's July 2019 letter and a job description for a sister/charge nurse at Mrs R's employing NHS Trust. They also included all the documents previously submitted.

60. The MA expressed the view that the medical evidence indicated that Mrs R did not meet the Tier 1 conditions at the time of leaving her employment. The MA's rationale is summarised below:-

- It had been accepted that, at the time she left employment, Mrs R was unfit for regular employment in any capacity for 36 hours per week. This was due to the combined effect of the consequences of her breast cancer and her impaired mental health.

- The key question was whether, on the basis of the information available at the time she left employment, her incapacity was likely to be permanent.

- Mrs R had been treated with Tamoxifen but had experienced significant side effects, even on a lower dose. She wanted to persevere with Tamoxifen to

reduce the risk of her breast cancer recurring. Even if the side effects had persisted, the Tamoxifen would have been stopped after 10 years. This would be eight years before Mrs R reached the Scheme pension age. The side effects of Tamoxifen would not, therefore, have led to permanent incapacity.

- It would have been expected that Mrs R's mental health would improve with treatment and if her employer addressed the situation at work. At the time Mrs R left her employment, this improvement would have been expected before she reached the Scheme pension age.

- In response to the points raised by the RCN, the MA said:

  Mrs R's job description had been included with her original referral documents. Both previous MAs' reports indicated that the referral documents had been considered.

  The MAs' assessments would have taken into account all aspects of Mrs R's job.

  S/he acknowledged that Mrs R would automatically be considered disabled for the purposes of the Equality Act 2010. However, at the time she left employment, there was no evidence that the breast cancer, itself, was giving rise to any incapacity. Long term incapacity could have arisen from the side effects of Tamoxifen, but only for the 10 years' treatment.

  Professor Chan had indicated that Mrs R had had an excellent response to chemotherapy and that the risk of recurrence over the next 10 years was around 10%. It was more likely than not that Mrs R would not suffer a recurrence and would, therefore, be fit to return to work.

  Should reasonable adjustments have been required to enable Mrs R to return to work, it would be expected that her NHS employer would have fulfilled its legal obligations to make these. Given that it was likely that Mrs R would be fit to return to her NHS role before her pension age, there would have been no necessity for redeployment.

  Given that Mrs R's incapacity was not thought to be permanent, there was no reason why she should not have been able to fulfil the requirements for NMC registration. Nor was there any reason why she should not have been able to submit a good health declaration. The requirement for continued registration was an inherent part of Mrs R's role and had been considered.

  Mrs R's GP had expressed the view that she would never be able to return to her NHS role or any other band 7 role. However, he not offered any explanation for his opinion and the opinion was not expressed in terms of the Scheme criteria. In particular, the GP had not referred to the fact that Mrs R was some 18 years away from her Scheme pension age.