CAS-46822-W2V2

Ombudsman's Determination

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

Outcome

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

Complaint summary

2. Mr R has complained that NHS BSA incorrectly decided, in June 2018, to decline his application for ill health early retirement benefits (**IHER**) from the Scheme.

Background information, including submissions from the parties

3. The Scheme is governed by the NHS Pension Scheme Regulations 1995 (as amended) (**the Scheme Regulations**).

4. As relevant, Regulation E2A, Early Retirement pension (ill-health)', states that:

> "…A member to whom this regulation applies who retires from pensionable employment before normal benefit age shall be entitled to a pension under this regulation if:
>
> (a) the member has at least 2 years' qualifying service or qualifies for a pension under regulation E1; and
>
> (b) the member's employment is terminated because of physical or mental infirmity as a result of which the member is:
>
> (i) permanently incapable of efficiently discharging the duties of that employment (the tier 1 condition), or
>
> (ii) permanently incapable of regular employment of like duration* (the tier 2 condition) in addition to meeting the tier 1 condition."

*"like duration" means a regular employment for similar hours to his/her NHS job.

5. Regulation E1 provides:

> "A member who retires from pensionable employment on or after attaining age 60 shall be entitled to a pension under this regulation."

6. If a member satisfies the tier one condition, he/she is entitled to the retirement benefits that he/she has earned to date in the Scheme without actuarial reduction for early payment. If a member also meets the tier two condition, then his/her accrued benefits are enhanced by two thirds of his/her prospective membership up to normal benefit age of 60.

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

8. Mr R was previously employed by the NHS as a full time healthcare assistant.

9. Mr R left NHS employment in February 2018 and applied for IHER benefits from the Scheme using form AW33E. At the time, he had been diagnosed as suffering from: (a) a right knee injury, (b) a ruptured quadriceps tendon, and (c) right ankle pain.

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

11. In its letter dated 5 June 2018, Medigold informed Mr R that his application for IHER benefits had been declined. The letter said:

> "The SMA has advised that:
>
> "This is an initial application for ill health retirement benefits under the Scheme.
>
> My understanding is that I am required to provide advice as to whether the member was likely to have met the pension scheme conditions at the time the member left employment on 7 February 2018.
>
> Permanent incapacity is assessed by reference to the normal benefit age of 60 years…
>
> The medical evidence considered:
>
> - The referral documents;
> - Report from Dr I Griffiths, consultant occupational physician, dated 26 February 2018;
> - Reports from Mr V Sharma, locum consultant in orthopaedics, dated 13 April 2018 and 24 May 2018;
> - The applicant's statement dated 15 January 2018.

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

Having considered the application and evidence there is, in my opinion, reasonable medical evidence that, 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.

I understand Mr R has been continuously absent from work…since July 2017 following an injury to the right knee sustained in June 2017. Dr Griffiths …indicates that Mr R underwent surgery 2 weeks after the injury to the right knee, for a ruptured quadriceps tendon. However, he continues to experience right knee pain and swelling. There is also right ankle pain with MRI scan in January 2018 showing a possible chipped talus bone. Dr Griffiths indicates that knee and ankle pain persist, though small improvements have occurred between Autumn 2017 and February 2018…Mr R was taking painkilling medication for knee and ankle pain and has undergone a course of physiotherapy.

Dr Griffiths was not aware of the reason Mr R had not recovered following knee surgery in June 2017 and is uncertain in relation to the exact diagnosis for the right ankle pain. Mr R has not been able to return to his substantive post…on account of the prolonged periods of walking and standing required.

Mr Sharma…in the report dated 13 April 2018, confirms that Mr R suffered a quadriceps rupture of the right knee, which was repaired in July 2017. As regards the foot and ankle, no injury was identified in the foot. The MRI scan of the ankle confirmed a small lesion of the talus. In relation to the talus injury, treatment involved a form of splint. Mr Sharma's opinion is such that it is very unlikely that Mr R will require surgical intervention for the ankle condition.

Mr Sharma indicates that Mr R's knee recovery is on schedule and feels that over the next 2-3 months, he should regain a full range of movement within the knee. Quadriceps rupture repair does cause initial knee stiffness which is likely to recover after 12-15 months of rehabilitation. Mr R is expected to regain full function around the knee. As regards the ankle function, Mr Sharma is hopeful that following treatment, the ankle function should also be more or less normal.

Mr Sharma, in the report dated 24 May 2018, indicates that at review at the end of March 2018, Mr R denied having any pain in the knee joint. There was no significant weakness of the quadriceps muscle and the quadriceps was clinically intact. Mr Sharma again indicates that Mr R is expected to make a nearly full recovery of knee function following the initial injury. The quadriceps

> tendon rupture is likely to recover to a virtually full extent in about 12-18 months' time.
>
> Mr R himself indicates that recovery following a surgery for rupture of quadriceps tendon has been very slow, even with intensive physiotherapy. He alludes to impairment in mobility, requiring the use of a walking stick to get around. He had not been able to walk on any uneven or slippery ground and has to go up and down steps very slowly, resting on occasions. Mr R indicates that he is still taking regular painkillers for pain in the right knee and ankle.
>
> On the basis of the medical evidence currently available, in my opinion, on the balance of probabilities, Mr R would not be considered permanently incapable of undertaking the duties of NHS employment. The medical evidence suggests that Mr R will make a full recovery in relation to the right knee and also is expected to regain good ankle function following treatment.
>
> 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. The incapacity was unlikely to have been permanent. The tier 1 condition was unlikely to have been met for the reasons given above...
>
> We have written to your Pensions Officer today informing them of this decision."

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

13. At Stage One of the IDRP in April 2019, NHS BSA informed Mr R that his complaint was not upheld because it agreed with the medical advice given by its SMA (**the Stage One Decision Letter**).

14. Relevant paragraphs from the Stage One Decision Letter, including the medical opinion expressed by the SMA, are set out in the Appendix.

15. In March 2020, Mr R requested that his complaint be considered at Stage Two of the IDRP.

16. On 23 April 2020, NHS BSA informed Mr R that his complaint could not be considered under Stage Two of the IDRP because it had not been made within six months of the date of the Stage One Decision Letter.

Mr R's position

17. In his view, the injury to his knee is permanent. He has had further scans and surgery on it. He is still receiving physiotherapy on his knee and taking painkillers regularly.

18. He now works part time at a private nursing home during the evenings. His injury and subsequent disability is making it difficult for him to carry out his duties despite reasonable adjustments having been made by his employer.

19. His former NHS job had involved restraining patients while on his knees. It was impossible for him to do this because of the injury to his knee. Furthermore, he could not complete the annual training, which was mandatory, because it included physical work on his knees. Consequently, he was unable to keep his knowledge updated in order to perform his role effectively.

20. The hospital, where he has been receiving treatment for his knee, is poor at sharing medical information with him and his GP. So he has limited medical evidence to prove that he has "poor leg function".

NHS BSA's position

21. It refutes any allegation of maladministration on the part of NHS BSA. NHS BSA has correctly considered Mr R'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 SMA.

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

23. 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 Mr R 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

24. Mr 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 in paragraphs 25 to 42 below.

25. Under regulation E2A of the Scheme Regulations, tier one IHER benefits were available to Mr R if NHS BSA, acting on medical advice, formed the opinion that his medical condition would prevent him from permanently[1] discharging the duties of his NHS employment efficiently. Its decision was made on the balance of probabilities.

26. Consequently, for Mr R to meet the criteria for tier one IHER benefits, he must be considered by NHS BSA to be permanently incapable of undertaking efficiently the duties of his NHS post until the normal benefit age of 60.

27. If NHS BSA considered that Mr R was, more likely than not, also incapable of regular employment of "like duration" to his NHS role, he would be entitled to tier two IHER

[1] "permanently" means the period until the normal benefit age of 60.

benefits. This was irrespective of whether employment of this nature was available to him.

28. However, it was not the role of the Pensions Ombudsman (**the PO**) to review the medical evidence and come to a decision of his own as to Mr R's eligibility for IHER benefits from the Scheme.

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

30. However, it was for NHS BSA (the SMA in the first instance) to decide the reasonable 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 medical advisers, unless there was a persuasive reason why it should not do so without first seeking clarification. For example, where there had been an error or omission, or where the medical adviser has misinterpreted the relevant regulations.

31. If the PO found that the decision-making process was flawed, or that the decision reached by NHS BSA was not supported by the evidence, the case could be remitted to NHS BSA to reconsider. The PO could not overturn the decision just because he might have acted differently.

32. The initial decision was made by the SMA in June 2018, under delegated authority from the Secretary of State who was the decision maker under the Scheme Regulations. On reviewing the evidence, the Adjudicator was satisfied that the SMA's decision, to decline Mr R's IHER application, was taken after it had considered the medical evidence provided with the application, which it listed in its letter dated 5 June 2018. The SMA had to weigh the evidence and take a decision based on the balance of probabilities.

33. Mr R suffered from a right knee injury, a ruptured quadriceps tendon and right ankle pain. However, in his reports dated 13 April 2018 and 24 May 2018, Mr Sharma, locum consultant in orthopaedics, said that:-

- Mr R should regain a full range of movement within the knee over the next two to three months.

- The quadriceps tendon rupture was likely to fully recover in about 12 to 18 months.

- After treatment, Mr R's ankle function should also be more or less normal.

34. The role of the SMA was to consider the available medical evidence and offer an opinion as to the likely future course of the member's medical condition.

35. In Mr R's case, based on the evidence presented, in particular the reports from Mr Sharma, the SMA concluded on the balance of probabilities that:-

    - Mr R would make a full recovery to his right knee and was expected to regain good ankle function following treatment. This would allow him to return to his NHS role in the period to his normal benefit age of 60.

      Mr R's condition did not permanently prevent him from efficiently discharging the duties of his NHS employment up to age 60. Consequently, the tier one condition for IHER had not been met.

36. Mr R was dissatisfied with the outcome of his IHER application and appealed under Stage One of the IDRP. NHS BSA informed Mr R that his appeal had been unsuccessful because it accepted the view of its SMA.

37. When faced with a divergence of medical opinions on the prognosis of Mr R's condition as detailed in the Stage One Decision Letter, it was reasonable for NHS BSA to prefer one medical view over the other. Moreover, it was entitled to give more weight to its own SMA's opinion.

38. The only requirement was that NHS BSA made its decision based on the information available to it at the time. However, there was nothing wrong with NHS BSA taking into account recent medical evidence, when reviewing its decision, provided it was relevant to Mr R's condition at the time the original decision was made. However, caution needed to be exercised when revisiting earlier decisions based on contemporary evidence.

39. In the Adjudicator's view, NHS BSA took an appropriate course of action in this case. It looked at Mr N's application again after obtaining a further medical opinion from its SMA.

40. The Adjudicator was satisfied that NHS BSA gave proper consideration to Mr R's application at the time by assessing all the relevant medical evidence available and that it acted in accordance with the Scheme Regulations and the principles outlined in paragraph 29 above. In the Adjudicator's view, its decision not to award Mr R tier one IHER benefits from the Scheme was supported by the available evidence and within the bounds of reasonableness.

41. The fact that Mr R was still suffering from the same medical condition did not mean that the original decision was not valid. NHS BSA could only be expected to make its decision based on the medical evidence available at the time Mr R left NHS employment. It could only be expected to reconsider that decision in light of evidence on medical prognosis available at each stage of the review process.

42. Needless to say, the decision made by NHS BSA would appear unfair to Mr R. However, NHS BSA had a duty to pay benefits in accordance with the Scheme Regulations. In the Adjudicator's view, it had acted consistently with those Regulations in this case.

43. Mr R did not accept the Adjudicator's Opinion and the complaint was passed to me to consider. Mr R provided his further comments which do not change the outcome.

44. Mr R said that:-

- He worked for the NHS in a role that qualified for "Nursing Officer Status" in the Scheme.

- He could consequently have retired at age 55 and received a normal retirement pension from the Scheme.

- After carrying out a medical assessment of him, Ms C Tonks, Clinical Specialist OT Rheumatology, concluded in her occupational therapy report dated 18 December 2018 that:-

    1. It was unlikely that he could return to his previous role and the fact that he has lost this job "bears witness to this".

    2. Any employment he undertook would be severely limited by "his reduced mobility, pain and fatigue."

45. I note the additional points raised by Mr R but I agree with the Adjudicator's Opinion.

Ombudsman's decision

46. 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.

47. 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 Mr R's eligibility for IHER benefits from the Scheme. I am primarily concerned with the decision making process.

48. NHS BSA was required to assess Mr R's IHER application in accordance with the Scheme Regulations, and to do so in consultation with the SMA.

49. Mr R feels that more weight should have been given by NHS BSA to the medical view expressed by Ms Tonks, Clinical Specialist OT Rheumatology, who examined him.

50. 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 medical adviser.

51. The decision to give little or no weight to any of the evidence is not the same as failing to consider it. In the Stage One Decision Letter, Ms Tonks' report dated 18 December 2018 was listed in the medical evidence considered by the SMA. This letter also said that NHS BSA, together with the SMA, had taken into account all the available evidence when carrying out a comprehensive review of Mr R's application.

52. It is consequently clear that NHS BSA had given most weight to the SMA's opinion that, at the time of leaving employment, Mr R's condition did not, on the balance of probabilities, permanently prevent him from efficiently discharging the duties of his NHS employment before his normal benefit age of 60.

53. Mr R also says that he would have been able to retire at age 55 and receive a normal retirement pension from the Scheme. However, regulation E2A stipulates that, for the purpose of assessing IHER benefits, his normal benefit age is 60 and NHS BSA must act in accordance with the Scheme Regulations.

54. I consequently find that NHS BSA did give proper consideration to Mr R'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.

55. As the evidence does not support a finding of maladministration by NHS BSA in coming to the decision, I do not uphold Mr R's complaint.

Dominic Harris
Pensions Ombudsman

7 February 2023

Appendix

Relevant excerpts from the Stage One Decision

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

The medical adviser has commented:

My understanding is that I am required to provide advice as to whether the member was likely to have met the tier 1 condition at the time the member left employment on 7/2/18 and, if so, to also advise on whether the member also met the tier 2 condition.

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

- …
- A report from Occupational Therapist, C Tonks, dated 18/12/18
- …

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…

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

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.

It should be noted that, in this particular case, ‘permanent’ means at least until Mr R’s normal NHS pension age of 60, some 8 years and 10 months in the future, as of his last day of NHS employment on 7/2/18.

Some of the medical evidence post-dates the member’s last day of service. Changes in the member’s health after he left employment are not relevant to the determination of whether he satisfied the pension scheme definitions as of his last day of service. I have therefore not taken the subsequent course of his illness into account. I have, however, taken into consideration those elements of the reports that relate to, or provide insight into, his circumstances at the time he left employment.

In other words, medical evidence that post-dates 7/2/18 can only be considered for the purposes of this IDR1 appeal if it indicates either:

- valid information that could have been known as of that date but which was not available to the SMA.

- or, symptoms and clinical signs that were present at that time but which were subsequently given a formal diagnosis and prognosis. This latter point relates to much of the evidence submitted that post-dates 7/2/18.

Relevant quotations from the medical evidence are as follows:

The GP stated “also sustained an osteochondral fracture of the medial aspect of the talar dome but this wasn’t detected until March 2018 associated with possible partial rupture of the anterior talofibular ligament…has been left with persistent pain in both his hip and ankle / foot with marked instability especially around the ankle…is having regular physio…knee is slowly increasing though his foot and ankle are not improving at present…due to see his orthopaedic specialist in the month or two to discuss whether surgery is also required there”.

On 24/5/18, Mr Sharma stated “as regards his ankle he underwent an MRI scan which showed an osteochondral lesion on the dome of the talus…he had been referred to Mr Bodo…initially treatment started with a sugar tong splint…as of 7th February 2018 further rehabilitation of his knee was being planned…he was due to be seen by Mr Bodo in the near future regarding his ankle…I would have expected him to have made a nearly full recovery of his knee function following the initial injury…the quadriceps tendon rupture is likely to recover to a virtually full extent in about 12–18 months’ time…Mr Bodo…will be forwarding his views on Mr R’s foot and ankle injury”.

On 12/12/17, Mr Yunus stated “right foot that keeps swelling up…has point tenderness …over the 5th metatarsal base cuboid metatarsal joint…I have arranged an MRI scan of the right foot”.

On 15/1/18, Mr Shahid stated “an MRI scan had been arranged which is absolutely normal and is reported as to have no obvious abnormality…clinically he is still tender at the base of the 5th metatarsal and to extent on the ATFL…the foot still has mild swelling…he cannot do a single heel raise stance”. (Interpretation – ATFL is the anterior talofibular ligament).

On 26/2/18, Mr Hagroo stated “suffers from chronic pain in his right foot…MRI scan which has shown an osteochondral fracture of the medial aspect of the talar dome but this is tiny…good range of pain free movements in the ankle…he says that sometimes on walking he is a little bit uncomfortable and I have put him in an ankle stirrup and he has more support up to 80–90% and was symptomatically better and left the clinic happy in walking and weight bearing”.

On 21/5/18, Mr Bodo stated “right ankle sprain injury with suspected partial ATFL rupture…looking at the MRI scan carefully I did not identify any other abnormalities other than a thinning of the ATFL suggesting a possible partial rupture behind his symptoms …the patient reveals he did not get any physiotherapy addressed to the ankle, only to his knee which the latter has well recovered, demonstrated full extension and flexion up to 120 degrees of the right knee…I think it is time to start physiotherapy for the ankle and we

have fitted him into another ankle brace which he can use for comfort and can wean off once the symptoms have started improving…certainly from now onwards, physiotherapy would be the best option for his ankle problem".

On 25/7/18, S. Hilbourne stated "he is still really struggling with pain in his ankle and as a consequence he feels his function is continuing to decrease…he finds any weight bearing exercises too challenging because of the on-going weakness in his right knee, which continues to give way when walking". On 18/12/18, she also stated "he does not appear to be progressing with treatment and his function is still limited".

The key consideration in this case is whether or not incapacity for the NHS employment was likely to persist at least until the appellant's 60th birthday, as of his last day of NHS employment on 7/2/18.

The medical evidence provided indicates that, on balance of probability, this was unlikely.

Specialist opinion was sought at the initial assessment (report Mr Sharma, 24/5/18), which anticipated a good outcome from treatment and a good long-term functional prognosis for his knee injury and surgical tendon repair. Mr Sharma did, however, recognise that he would take 12–18 months to recovery fully. This time period is not yet expired and the recovery of the knee condition has been hampered by the persistence of the ankle problem in the same leg. This could not have been reasonably predicted as of 7/2/18.

There is some discrepancy surrounding the MRI scan of the right foot, undertaken in late 2017/early 2018, as it was initially reported as normal but latterly found to show a very small bony injury to the dome of the talus (part of the ankle joint itself). The clinical significance of such a fracture is questionable and is considered very unlikely to be the cause for his ongoing symptoms and functional disability.

The residual ankle problem would therefore appear to be an injury (with or without a partial rupture – only the GP refers to it in this manner) of the ATFL (anterior talofibular ligament). As of 7/2/18, this had not been diagnosed, although it is accepted that the symptoms were present and had not yet been diagnosed.

However, more than 3 months after he left NHS employment, Mr Bodo stated that "physiotherapy would be the best option for his ankle problem", indicating that no further surgical interventions were likely to be required.

As of 7/2/18 and in the absence of future treatment, the ATFL partial rupture and symptoms of a chronic sprain to the right ankle (thereby causing impaired mobility) are considered more likely than not, on balance of probability, to have led to incapacity for the NHS employment beyond age 60.

The knee condition was likely to have sufficiently recovered, within 12–18 months from May 2018, to as to cause minimal impairment and, therefore, no major effects upon fitness for work.

However, as of 7/2/18, the ATFL injury had not been diagnosed. It is accepted that this was diagnosed later but Mr Bodo is clear that he anticipated good resolution with physiotherapy, as of May 2018 (some 3 months after he left NHS employment).

Therefore, as of 7/2/18, further treatment was considered likely to return Mr R to sufficient functional capacity overall, whereby he would be likely to become medically fit to resume the duties required of his NHS employment, at some point prior to his 60th birthday.

Thus, as of 7/2/18, permanent incapacity for the NHS employment was not supported by the medical evidence and the medical criteria for the Tier 1 condition were not satisfied.

That Mr R has not recovered as anticipated and continues to have chronic right lower limb pain and impaired mobility is not in doubt. However, the medical evidence remains consistent with sufficient recovery during the next 7 years and 8 months until his 60th birthday, such that he will be likely to become capable of the NHS employment at some point during this time.

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