The Pensions Ombudsman

Ombudsman's Determination

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

Outcome

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

Complaint summary

2. Miss P's complaint concerns NHS BSA's decision not to award her an early payment of deferred benefits (**EPDB**) on the grounds of ill health.

Background information, including submissions from the parties

3. Miss P worked for the NHS as a Mental Health Community Nurse. On 13 April 2015, she applied for an ill health pension from active status. However, her application was declined on the basis that with further treatments, on the balance of probabilities, Miss P "could become well enough" to return to work before her pension age of 60.

4. In June 2015, Miss P's employment ended, and she became a deferred member of the Scheme.

5. In January 2018, Miss P applied for an EPDB due to the physical and psychological implications of ongoing treatment for a pituitary tumour. In her submissions, Miss P said she was limited with her tasks due to the increased size of the tumour. Miss P was aged 52 at the time of her application. She also provided medical reports from her doctors, relevant sections of which can be found in the Appendix.

6. At the time of Miss P's application, Regulation L1(3)(b) of the Scheme's Regulations 1995 (SI1995/300), (**the Regulations**) provided:

> "The member shall be entitled to receive the pension and retirement lump sum before age 60 if—

> …the Secretary of State is satisfied that the member is suffering from mental or physical infirmity that makes him permanently incapable of engaging in regular employment of like duration,…"

7. On 21 March 2018, the first instance decision maker Medigold Health, the Scheme's Medical Adviser (**SMA**), made a decision that refused Miss P's application. The SMA referred to the opinion of its Medical Adviser (**MA**) who said permanent incapacity had not been established and said:

> "If Miss P's symptoms are the consequence of an increase in size of her residual pituitary tumour, then additional treatment to reduce the size of that residual tumour is available and would, in the first instance, most likely take the form of some form of radiotherapy. Miss P would be likely to benefit from such treatment. It is reasonable to consider that such treatment would reduce the size of the residual tumour and alleviate any incapacity arising from the tumour size...the benefits of treatment would be realised relatively quickly (by which I mean the timescale would be measurable in weeks or months) and would therefore be realised before Miss P reaches pension age as this is not until 2025."

8. On 10 May 2018, Miss P appealed by invoking the Scheme's two-stage Internal Dispute Resolution Procedure (**IDRP**). In her submissions, she said in summary:-

   - The symptoms she had suffered included: chronic headaches, hypertension, gastro-intestinal disturbances, impaired immune system, chronic fatigue and increased ocular pressure of her left eye.
   - She had been deemed incapable of undertaking regular full-time employment continuously by the DWP.
   - Any clinical intervention to date had neither cured nor eased her daily symptomatic presentation.
   - Ongoing treatment had no clear prognosis and she remained under her Neurosurgeon's team and other specialists.
   - She had permanently lost central vision in her left eye and had fluctuating vascular pressure to both eyes that caused the nature of her headaches to increase and intensify.
   - Her role was a high-risk profession due to exposure to violence and aggression, and she was unable and unwilling to place herself in this environment.
   - An MRI scan in September 2017 showed her tumour had increased in size. The doctors were unable to give a medical reason as to why her tumour had grown. Therefore, her treatment plan was long term, often repetitive with no clinical conclusion and no clear prognosis.

- She was still awaiting radiotherapy, the success of which was not known. Her retirement was due at age 55 under the 1995 Section of the Scheme, having already served 30 years within the NHS at the time of diagnosis, in 2014.

9. On 4 June 2018, the SMA wrote to Miss P acknowledging her appeal and said that it felt that it was necessary to obtain further information regarding her condition. It therefore had written to her Consultant Endocrinologist, Dr Kahal.

10. On 6 July and 7 September 2018, NHS BSA wrote to Miss P saying that it was not currently in a position to send her a stage one IDRP response as her case had been returned to the SMA for reconsideration, and the SMA was awaiting further medical evidence from Dr Kahal.

11. On 3 October 2018, NHS BSA sent Miss P its stage one IDRP decision declining her appeal. It said in summary:-

    - It referred to the criteria under the Regulations which required a determination as to whether “there is a physical or mental infirmity which gives rise to permanent incapacity for regular employment of like duration (regard being had to the number of hours, half days and sessions).

    - Based on the relevant medical evidence, on the balance of probabilities, Miss P did not have a physical or mental infirmity which gave rise to permanent incapacity for regular employment of like duration.

    - Miss P’s incapacity was caused by a combination of current therapy and the effects of the residual tumour. The information from the consultant indicated that there were at least two further medications which could be tried to control the tumour. If these failed, there remained treatment by radiotherapy, a treatment which was usually very successful in controlling the tumour, at least for a period of time.

    - It had to be shown that Miss P was permanently incapable of any occupation and not just other occupations to which she might be suited by training or experience and, so it had to consider the simplest light physical/clerical type occupations.

    - Therefore, while it was accepted that Miss P had been very ill over the last year or two, further treatments remained to be tried and so it could not be said that permanence of incapacity had been established on the evidence presented.

    - Having considered all the comments made by the MA regarding her application (see the Appendix), it could see no reason to disagree with their conclusions. Therefore, it was of the opinion that Miss P was not entitled to EPDB on the grounds of ill health.

12. On 6 October 2018, Miss P appealed under stage two of the IDRP. In her submissions, she said in summary:-

- Despite surgery in 2014, her residual tumour remained. Monthly injections had worsened her physical health and lowered her daily quality of life.
- While she accepted her application in 2015 from active status was rejected, it was now three and a half years later.
- Due to an ongoing formal complaint against Dr Kahal, she did not want Dr Kahal to complete any reports. She was informed that Dr Kahal had left the NHS Trust and any reports would be completed by Consultant Endocrinologist, Dr Randeva.
- Neither the stage one decision-maker nor the SMA made reference to making further attempts to contact her medical team when Dr Kahal did not reply to the request to provide a report.
- There was no reference made to having received any correspondence from her medical team let alone Dr Randeva who was in charge of her clinical case.
- The medical information submitted at the initial application was completed by Dr Kahal and was highlighted as clinically incorrect, yet NHS BSA was able to make an informed decision pertaining to its “concluding advice”.
- She was not happy that it had taken NHS BSA five months to take its decision when it had already been in possession of her medical evidence submitted at the initial application.
- How was NHS BSA able to conclude that she could go back to work before age 60, when her Neurosurgeon team clearly was unable to give her any clear or definite prognosis or treatment plan given the complexity of her case?
- What expertise did NHS BSA/the MA have to be able to reach such definitive conclusions on outdated clinical data?

13. On 7 November 2018, NHS BSA replied to Miss P’s stage two IDRP appeal. It said in summary:-

- The MAs were all doctors qualified and trained on the specific requirements of the Scheme.
- The MA was not required to conduct a personal examination, neither were they duty bound to seek further medical evidence with regard to any case.
- Their remit was not to add to the weight of medical evidence but to objectively assess the evidence presented in support of any application.
- The MA wrote to Dr Kahal on 4 June 2018 for further information. This was chased on 19 June, 28 June and 5 July 2018.
- The report request was then referred to Dr Randeva for completion. This was chased on 16 July 2018, and the secretary confirmed that the report was still with

the doctor for completion. It was further chased on 31 July and 9 August 2018, however no report was received.

14. On 16 November 2018, Miss P wrote to NHS BSA saying that for unknown reasons, Dr Randeva had chosen not to even respond.

15. Between February and July 2019, there was further correspondence between Miss P and NHS BSA regarding her appeal. She provided further comments supporting her appeal, such as that she had raised a complaint about Dr Kahal as he was rude and incompetent and she referred to her condition having not improved.

16. On 7 August 2019, NHS BSA sent Miss P its stage two IDRP decision that referred to the advice of its MA, and said in summary:-

- It referred to the criteria under Regulation L1(3)(b) that required Miss P to be permanently incapable of any kind of employment of like duration because of illness or injury, not just her NHS employment.

- The ill health pension was for life and, once awarded, it could not be medically reviewed or withdrawn even if Miss P went on to make a full recovery.

- The MA was required to provide their advice as to whether the criteria for EPDB were likely to have been met at the time of the original application on 26 January 2018.

- Having considered all the relevant evidence, it was its opinion, that at the time of Miss P's application, she had a physical or mental infirmity which gave rise to incapacity for regular employment of like duration. The key issue in relation to the application was whether her incapacity was likely to have been permanent.

- Miss P had a pituitary microadenoma compressing her optic chiasm in April 2014 for which she underwent a surgery on 17 April 2014. Evidence from March 2015 suggested that Miss P still had the active disease and it was difficult to predict the long term outcome.

- There was medical evidence at the time Miss P left employment that the medication was already producing biochemical improvement. In light of this and taking into account further possible treatments, these would have been more likely than not to alter the permanence of Miss P's incapacity.

- The MA wrote to Miss P's Consultant Endocrinologist, Dr Kahal, to request a report on 4 June 2018 but to date it had not had a reply. It had considered reports from Dr Kahal dated December 2017, which were dated prior to her application.

- Dr Kahal advised that Miss P's case would be discussed at the Multidisciplinary Team (**MDT**) as she was clinically and biochemically controlled. The decision of the MDT was to repeat the MRI scan in six months.

- As numerous attempts to obtain further information had been unsuccessful, the MA could only provide comments based on the medical evidence that had already been made available to them.

- The latest medical reports suggested good control of Miss P's condition, hence, on the balance of probability, her incapacity for regular employment of like duration to her former NHS role was not likely to be permanent. Having considered Miss P's case, it had no reason to disagree with its MA and therefore her application was declined.

17. In her submissions to TPO, Miss P said in summary:-

- NHS BSA had failed to follow its guidelines and policies when making its decision on her application for an EPDB.

- NHS BSA had demonstrated blatant disregard for her specialist doctors' medical opinions and in seeking further specialist opinion regarding her ongoing treatments.

- NHS BSA had failed to make reasonable attempts to access the relevant specialist in her care team.

- She had lost: her 30-year long career due to her deteriorating health condition, quality of life and trust in official organisations.

- She wanted justice to be served and the "gross and unprofessional practices" of NHS BSA to be highlighted.

Adjudicator's Opinion

18. Miss P'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 below:-

19. Member's 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 they must satisfy and the way in which decisions about ill health benefits must be taken.

20. Under Regulation L1(3)(b), to be eligible for an EPDB on the grounds of ill health, Miss P must be deemed permanently (that was to age 60) incapable of engaging in regular employment of like duration. The employment did not have to be the same as or similar to the kind of role which Miss P undertook in the NHS. The requirement was for it to be of like duration. In Miss P's case, this meant that it was regular full-time employment.

21. The first instance decision was made by the SMA under a delegated authority from NHS BSA. NHS BSA acted on behalf of the Secretary of State who was the decision maker under the Regulations. The Adjudicator was satisfied that the decision was made by the correct decision maker, so the decision could not be challenged on this basis.

22. One of the specific obligations on the decision maker was to consider all relevant evidence available to them and ignore all irrelevant information. However, the weight which was attached to any of the evidence was for NHS BSA, or the SMA in the first instance, to decide, including giving some of it little or no weight. It was open to it to prefer the advice of its own MAs unless there was a cogent reason why it should not, or should not do so without seeking clarification. This might include errors or omissions of fact on the part of the MA, or a misunderstanding of the relevant Regulations.

23. NHSA BSA needed to consider Miss P's EPDB application in line with the Regulations, review all the relevant medical evidence and properly explain its decision. The Adjudicator was of the opinion that NHS BSA did that. It was for NHS BSA, in consultation with its MA, to decide what weight (if any) to attach to the relevant evidence.

24. The MA was of the opinion that Miss P was not permanently incapacitated from regular employment of like duration because there was not enough evidence to support her permanent incapacity. He was of the view that Miss P would be likely to benefit from further treatments because such treatments would reduce the size of the residual tumour and alleviate any incapacity arising from the tumour's size. He further said that the benefits of treatment would be realised relatively quickly, within weeks or months and would therefore be realised before Miss P reached her normal pension age in 2025.

25. NHS BSA was not expected to question the opinion of its MA per se, but it could be expected to review the evidence from a lay perspective and check that there were no errors or omissions of fact or misunderstanding of the relevant Regulations by the MA. It was then for NHS BSA to decide whether there were any such reasons why it should not have relied on the MA's advice. When it came to the MA's opinion, NHS BSA could be expected to check if there was any difference of opinion or inconsistency between its MA and any other medical professional. If there was, it should have sought an explanation from the MA.

26. Having reviewed the advice provided by the MA, the Adjudicator did not identify any errors or omissions of fact. In the Adjudicator's view, NHS BSA and its MAs correctly considered the question of whether Miss P was likely to be permanently incapable of performing regular employment of like duration to her previous NHS role, so there was no misunderstanding of the Regulations. In addition, the advice offered by the MA did not appear to be inconsistent with the medical evidence from Dr Kahal. The Adjudicator saw no reason why NHS BSA should not have accepted the advice from its MA.

27. Miss P contended that NHS BSA did not make reasonable attempts to contact her specialist Dr Kahal and later Dr Randeva for further medical opinions. The Adjudicator disagreed with Miss P in this regard. NHS BSA chased the request on several occasions through its SMA. NHS BSA could not be expected to do more than that. The Adjudicator was satisfied that NHS BSA made reasonable attempts between June and August 2018 to obtain further medical evidence from Miss P's treating physicians. It was not due to maladministration on the part of NHS BSA that the requested medical evidence was not provided to it for assessment. The evidence that was considered was reasonably contemporaneous with Miss P's application and appeal. For example, the latest report from Dr Kahal was dated 22 May 2018.

28. The Adjudicator was satisfied that NHS BSA gave proper consideration to Miss P's application at the date of her application, January 2018, by assessing all the relevant medical evidence available at that time. It sought more than one MA's report after Miss P submitted further medical evidence from her doctors in support of her application. The MAs' reports assessed Miss P's capacity and her likelihood of returning to an employment of like duration. In the Adjudicator's view, NHS BSA acted in accordance with the Regulations and there were no grounds to remit the matter back to NHS BSA.

29. The fact that Miss P was still suffering from the same condition did not impact upon the validity of the original decision as that was applying the benefit of hindsight. Regulation L1(3)(b) referred to a member's incapacity being permanent; not the member's condition. It was possible for a member to be diagnosed with a permanent medical condition but not to be permanently incapacitated (as defined) by that condition. NHS BSA could only be expected to make its decision in January 2018 on the basis of the condition as it was understood at the time and to reconsider that decision in light of the medical prognosis available at each stage of the review process. It was unfortunate that Miss P's specialists did not respond to NHS BSA's request for further opinions.

30. However, the Adjudicator said Miss P might submit a fresh application for an EPDB on the grounds of ill health. This would consider her current health and recent medical evidence.

31. Miss P did not accept the Adjudicator's Opinion and in response, she provided further comments. In summary she said:-

- The MAs were not clinically competent to carry out the assessments and reviews of her case. It has now been eight years since she first applied in 2015. "Not one aspect of the 'balance of probabilities' criteria that they all stated [she] was assessed under has proven to be valid."

- Not one doctor stated that she would be cured regarding her brain tumour. She disagrees with the MAs' opinion that her tumour and physical health would improve sufficiently for her to return to her NHS role, or any other employment. Her tumour has grown since post operative intervention in 2015.

- She has not worked since 2015. The Job Centre, her GP and the Department for Work & Pensions (**DWP**) still consider her unfit for work.
- Only her old occupational health department and Neurosurgeon had the knowledge to predict a valid prognosis regarding her brain tumour.
- Miss P provided medical evidence post dating her application in 2018, supporting her case. She also provided letters from DWP showing her Personal Independence Payment was still payable to her as she is unfit for work.
- Miss P referred to the application from active status from 2015. She said the Early resolution Team at TPO had told her the decision making process regarding that application was flawed.

32. Miss P's complaint was passed to me to consider. I have noted Miss P's further comments but I find that they do not change the outcome. I agree with the Adjudicator's Opinion.

Ombudsman's decision

33. It is clear from Miss P's submissions that she is still experiencing significant issues with her health. However, the decision not to award her EPDB on the grounds of ill health under the Regulations must be considered by reference to her health at the time she submitted her application in January 2018. In particular, the decision must be considered by reference to the likelihood of her engaging in regular employment of like duration before normal pension age which was expected at that time. It is not a question of applying hindsight. It is for this reason that the latest medical reports or letters from DWP by Miss P do not assist me in determining her complaint.

34. In order for her to qualify for an ill health pension under Regulation L1(3)(b), the expectation in 2018, must have been that Miss P would be deemed permanently incapable of engaging in regular employment of like duration. This meant any regular full-time employment. Permanently meant likely, on the balance of probabilities, to last at least until Miss P's prospective normal pension age of 60.

35. The MAs who reviewed Miss P's case concluded that she did not meet the criteria for an EPDB. The advice did not appear to be inconsistent with the medical evidence from Miss P's specialist, Dr Kahal. I find no reason why NHS BSA should not have accepted the advice from the MAs.

36. I am aware that Miss P does not agree with the conclusions reached by the MAs. It is not my role to review the medical opinions provided by the MAs. My concern is with the decision making process and my interest in the MAs' reports extends to determining whether or not there was any reason why NHS BSA should not have relied on them in reaching a decision.

37. This would include errors or omissions of fact, irrelevant matters taken into account or a misinterpretation of the relevant regulations. The MAs' suggestions concerning

treatment or their views on the likely outcome of treatment would not normally be something I would expect NHS BSA to query. If, for example, there was an obvious disparity between the MAs' views and those of the member's treating physicians, I would expect this to be explained to NHS BSA and to Miss P. However, I have seen no such obvious disparity in Miss P's case.

38. I note Miss P has provided letters from DWP as evidence to show she has been deemed unfit for work. However, these cannot be considered in relation to her complaint as the criteria when assessing welfare benefits are different to the ones under the Scheme. In particular, the DWP does not require an assessment as to the likelihood of any incapacity lasting until normal pension age.

39. In summary, I find that there was no reason why NHS BSA should not have relied on the advice it received from the MAs in reaching its decision. Its decision is supported by that advice and is compliant with the Regulations. The fact that Miss P's recovery since has not been as positive as might have been expected in 2018, does not undermine NHS BSA's decision.

40. Miss P referred to her application from active status in 2015. This aspect of her complaint has been dealt by TPO separately under PO-29576.

41. Miss P may wish to consider submitting a fresh application for an EPDB by providing medical evidence reflecting her current health condition.

42. I do not uphold Miss P's complaint.

Anthony Arter

Pensions Ombudsman
30 June 2022

Appendix

Summary of the Medical evidence

43. In his report dated 6 June 2017, Clinical Lecturer, Dr Kahal said:

> "Our agreed management plan:
>
> 1. I am going to refer her back to the Eye Clinic.
>
> 2. I am going to refer her to the Urologists.
>
> 3. Visual field tests.
>
> 4. 9 am cortisol, HbA1c and plasma osmolality.
>
> 5. Repeat MRI scan around October 2017.
>
> 6. We will see her again following her MRI scan, in around six months' time from now.
>
> 7. We will consider repeating the colonoscopy next year.
>
> 8. She will have repeat hormonal profile before her next clinic appointment."

44. In his report dated 9 June 2017, Dr Kahal said:

> "Today, you mentioned again that knowing the size of the residual pituitary tumour is very important to you. I have emailed the Consultant Radiologist to kindly provide us with the exact size of your residual tumour on your latest MRI scan. When this is reported I will let you know."

45. In his report dated 4 December 2017, Dr Kahal said:

> "We are going to discuss [Miss P's] case in our pituitary MDT to decide on the best step forward which may include either repeat imaging to assess progress, as she is clinically and biochemically well controlled, or to offer her radiotherapy. We will see her again in around three to four months time."

46. In his report dated 11 December 2017, Dr Kahal said:

> "[Miss P's] MRI scan image from 30th September 2017 were reviewed and there is an increase in the size of the residual pituitary tumour compared to her previous MRI scan from 2015. As she is clinically and biomechanically stable, the team suggests repeating the MRI scan in six months' time which I have arranged."

47. In his report dated 22 May 2018, Dr Kahal said:

> "I have the result of your MRI scan of the pituitary which was performed on the 7th April 2018. The scan showed that the residual pituitary adenoma has not changed in size compared to your last MRI scan from September 2017. The

MRI scan from September 2017 mentioned that the tumour measures 9mm in maximum diameter compared to 5.6mm on the scan performed in September 2016."

48. Stage one IDRP advice from the SMA

In its stage one IDRP decision letter, NHS BSA quoted the advice it had received from the SMA. The SMA said:

"… there is, in my opinion, reasonable medical evidence that, at the time of the original application, the member had a physical or mental infirmity which gave rise to incapacity for regular employment of like duration. The key issue … is whether the member's incapacity was likely to have been permanent.

For permanence of incapacity … to be decided it has to be shown that all reasonably available treatment options have been given adequate trial and found to be ineffective, and in this case further treatment options remain.

On the evidence presented it would appear that the applicant's incapacity is caused by a combination of current therapy and the effects of the residual tumour and the information from the consultant indicates that there are at least two further medications which can be tried to control the tumour and that, if these fail, there remains treatment by radiotherapy, a treatment which is usually very successful in controlling the tumour, at least for a period of time.

As far as [a] deferred benefits claim is concerned, it has to be shown that the applicant is permanently incapable of any occupation and not just other occupations to which the applicant may be suited by training or experience and so we have to consider the most simple light physical/clerical type occupations.

Therefore, whilst it is accepted that the applicant has been very ill over the last year or two, further treatments remain to be tried and so it cannot be said that permanence of incapacity has been established on the evidence presented …"

49. Stage two IDRP advice from the SMA

In its stage two decision letter, NHS BSA quoted the advice it had received from the SMA. The SMA said:

"Consideration of this application requires a determination of whether there is a physical or mental infirmity which gives rise to permanent incapacity for regular employment of like duration … Permanent incapacity is assessed by reference to the normal benefit age of 60 years.

Having considered the application and evidence there is, in my opinion, reasonable medical evidence that, at the time of the original application, the member had a physical or mental infirmity which gave rise to incapacity for

> regular employment of like duration. The key issue … is whether the member's incapacity was likely to have been permanent.

The SMA then outlined the history of Miss P's condition and referred to reports, in 2015, from a consultant neurosurgeon and an occupational health doctor. The SMA said it was accepted that, at the time she left employment, Miss P was incapacitated and the key question was whether the incapacity was likely to have been permanent. They said it had been accepted that, without treatment, it was likely that Miss P's incapacity would have been permanent. The SMA went on to say:

> "However, treatment options remained including continuing with medication to supress abnormal levels of hormones and possibly radiotherapy (if hormone suppressing medication proved inadequate). There was medical evidence at the time she left employment that the medication was already producing biochemical improvement. In light of this and taking into account further possible treatments, in my opinion, on the balance of probability, further treatment would have been more likely than not to alter the permanence of [Miss P's] incapacity.
>
> We wrote to Dr Hassan Kahal … on 4 June 2018, but unfortunately we did not receive a reply. Letters from Dr Kahal, dated 7 December 2017 and 21 December 2017 (prior to the date of [Miss P's] original application for early payment of deferred benefit) advised that her case would be discussed at the MDT as she was clinically and biochemically well controlled. The decision of the MDT was to repeat the MRI scan in six months. As the latest specialist medical information we have suggests good control of [Miss P's] condition, on the balance of probability, [Miss P's] incapacity for regular employment of like duration to her former full time NHS role is not likely to be permanent."