CAS-54442-D4Z8

Ombudsman's Determination

Applicant	Ms R
Scheme	NHS Pension Scheme (the **Scheme**)
Respondent	NHS Pensions

Outcome

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

Complaint summary

2. Ms R's complaint is that she has been declined ill health retirement from the date her NHS employment ended.

Background information, including submissions from the parties

3. The sequence of events is not in dispute, so I have only set out the salient points. I acknowledge there were other exchanges of information between all the parties.

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. 'Permanently' means to Normal Pension Age (**NPA**) in accordance with section 10 of the Public Service Pensions Act 2013. Ms R's NPA is 67.

6. In late July/early August 2019 Ms R submitted an application for ill health retirement (form **AW33E**). Part C was completed by Dr Millar (GP). Summaries of and extracts from the medical evidence relating to Ms R's case are provided in Appendix 2.

7. In August 2019, at a Capability Meeting, it was decided that Ms R would not be able to return to her NHS role with support or adaptations and that suitable redeployment was not an option. Ms R's employment was ended on the grounds of capability due to ill health on 23 August 2019.

8. First instance decisions on applications for ill health retirement are made by the Scheme's medical adviser, Medigold Health **(Medigold)**, under delegated authority. Medigold wrote to Ms R, on 17 October 2019, saying it had been unable to accept her application. It quoted from its medical adviser (**MA**) (see Appendix 2), who had advised that Ms R was not permanently incapable of discharging the duties of her NHS employment; that is the Tier 1 condition was not met.

9. Ms R invoked the Scheme's two-stage internal dispute resolution procedure (**IDRP**). In a statement dated 13 December 2019, Ms R said:-

    9.1 The MA's report did not reference the minutes of a Capability Hearing and the resultant outcome letter that she had submitted, which led her to believe their supportive contents had not been considered.

    9.2 The report said that no response had been received from Dr Crellin (Consultant Oncologist). But in her AW33E application she had advised that Dr Crellin had retired. This lack of attention suggested her application had not been properly considered.

    9.3 The MA said only evidence available at the date her employment ended had been considered, but then referred to later communications from Dr Millar and Mr Graja. She found this contradictory and confusing.

    9.4 The MA noted Dr Millar's comments of a high risk of recurrence within 10 years and the future risk of metastatic spread and likely continued psychological symptoms over the period to normal retirement age. But then disregarded or overlooked this when drawing his conclusions on her prognosis and eligibility for ill health retirement.

    9.5 The MA noted that she had declined chemotherapy. This was because her father unexpectedly died from the treatment's side effects. Her decision was not taken lightly.

    9.6 The MA referenced Mr Graja's comment that she was concerned that return to her former NHS employment may not be possible in the foreseeable future. The MA had interpreted 'foreseeable future' to mean a number of months. But the Cambridge Dictionary (on-line) suggested it meant "as far into the future as you can imagine or plan for". This was more accurate and relevant to her case. Furthermore, she did not believe she would have been dismissed on the grounds of ill health if it had been felt that she could have achieved a full recovery and fitness to work in a "number of months".

9.7 The MA quoted Dr Millar as stating there had been no specific intervention for the psychological impact of the cancer diagnosis and the osteoporosis diagnosis and no measures had been taken to address her lack of confidence and motivation. But she had listed the specific interventions she had sought and engaged with, and lifestyle changes she had made in Part B of the AW33E form. To this she would add her attendance in October 2019 at a half-day seminar on bone health (at a branch of the Osteoporosis Society) and a residential course at the Penny Brohn Centre.

9.8 Attempts to address her loss of confidence in her NHS role were documented in the minutes of the Capability Hearing and in the outcome letter. This was a difficult and stressful role.

9.9 Her motivation was good and was primarily focused on self-education and managing her health. Her motivation to return to work was compromised. The consequence of the diagnoses and the side effects of prescribed medications meant she was no longer capable of doing her NHS job and for several years the job had been the most considerable source of stress in her life and links between stress and the progression of cancer were well evidenced[1].

9.10 While she was working privately as a therapist, it was not, and never would be, regular employment of like duration to her NHS role.

9.11 The MA noted that she had declined counselling. As a qualified mental health nurse for more than 30 years and a psychological therapist for 10 years, she had a very good understanding of issues relating to psychological health and wellbeing and her friendship group was largely comprised of mental health professionals, including counsellors. She was not sure how seeing a counsellor could help. However, since then she had been added to the waiting list for counselling.

9.12 She agreed with the MA that when her NHS employment was terminated she “lacked resilience to the demands of her NHS role”.

9.13 She was permanently incapable of fulfilling her NHS role, or any other role of like duration. This was due to a combination of the psychological impact of the two diagnoses, and more so, living with the side effects of the treatment for these conditions. Namely: fatigue, poor sleep, chest/breast pain, headaches, breathlessness, back/hip/knee/ankle pain and stiffness, gastrointestinal sensitivities, blurred vision, hot flushes, irritability, depression and forgetfulness. Treatment was to continue for a minimum of five years and was likely to extend to 10 years. Additionally, there was a high risk of developing secondary cancer within that 10-year timeframe and therefore needing to go through debilitating treatment again. The side effects of

[1] Ms R referenced Dr Still’s letter of 11 December 2019.

Letrozole was the negative impact this had on bone health and the likelihood of fracturing, especially the spine.

9.14 For the sake of clarity, she slept badly every night and woke feeling tired and aching all over. Generally, she felt unwell and had headaches most days. She was fatigued every day. She took exercise every morning to prevent lymphoedema, to help with aches and pains, to promote bone and muscle strength and cardiac health. She ate healthily and practised mindfulness daily.

9.15 Optimising her health, now and for the future, was entirely incompatible with her former NHS role or any role of like duration.

10. Ms R submitted with her stage one appeal statement: an open letter from Dr Still (GP/Assoc Doctor at Penny Brohn UK) dated 11 December 2019; an article on 'Improving Access to Psychological Therapies (IAPT)'; a paper on 'Predictors of emotional exhaustion, disengagement and burnout amongst IAPT practitioners'; an article on 'stress and depression among psychological therapies staff'; and a paper on burnout in IAPT staff and package information on the prescribed medication she was taking.

11. NHS Pensions issued a stage one IDRP decision on 23 January 2020. It declined Ms R's appeal on the grounds that she was not permanently incapable of carrying out her duties as a High Intensity Therapist. NHS Pensions quoted from its MA (see Appendix 2).

12. Ms R submitted a stage two IDRP appeal in February 2020. Ms R said:-

12.1 Disproportionate weight had been given to Dr Millar's unsubstantiated statement in his report of 10 October 2019, that there was no evidence to support her assertion that she could not be employed in her current or any other regular employment. This was in stark contrast with Dr Millar's comments in Part C of the AW33E, where he stated there was a "High risk of recurrence within ten years!" and that she was "Unable to deal with the pressure of work and various demands including administrative and technical. She feels constantly stressed, conflicted and incompetent". He also stated that she was "Unfit for work" and listed her symptoms and side effects.

12.2 No consideration had been given to her personal response to the challenges she had faced and continued to face and losses she had experienced and continued to experience.

12.3 Her response, in her stage one IDRP appeal, to Mr Graja's incidental reference to her private work in his report of 19 July 2019 appeared to have been completely disregarded.

12.4 She was a single mother without an alternative source of income if she had

not found a way to work within her capabilities (which compared to her NHS role was much reduced) she would have lost her home.

12.5 She was devastated that she was no longer capable of fulfilling the role she had studied and worked hard for and gained a huge amount of satisfaction from. She did not choose to get the diagnoses at age 52. It happened to her. The causes were multifactorial (including stress) and she had to find a way to live with it, and to manage her conditions as well as she could with the reduced capacity that came with them.

12.6 The MA's report at stage one IDRP provided advice based on the conclusion that she was "incapable of undertaking her normal NHS role because of impaired psychological health following being diagnosed with breast cancer" and "no particular treatment for the breast cancer was required other than ongoing manipulation treatment…". This completely overlooked the physical issues that result from the treatment for breast cancer and their impact on osteoporosis, which she had described in her stage one IDRP appeal and gave no credibility to the well evidenced side effects of the medications she had provided and were readily available in medical literature.

12.7 The MA's comment, "I have no evidence that the osteoporosis itself was giving rise to incapacity for employment", similarly showed a lack of understanding that presentations become difficult to unpick when there are several different conditions and medications involved. The comment, "There was no evidence that the treatment for breast cancer had adversely affected her ability to work", beggared belief.

12.8 The MA expressed the subjective opinion that her psychological health was likely to improve with time. If it was not for the constant maintaining factors (physical symptoms/side effects) she would agree.

12.9 The ongoing physical issues (bad sleep nightly, waking tired and aching all over and most days feeling generally unwell and having headaches) impacted, in short, her capacity for work. This was all experienced within the context of the high probability of recurrence of the breast cancer and the degenerative nature of osteoporosis being escalated by treatment for the cancer.

12.10 The MA's comments that she had not had, "the benefit of a psychiatric assessment" or "treatment programme under the supervision of a psychological therapist, nor any medication to help alleviate her psychological distress", showed a complete disregard for her expertise as a senior clinician and a lack of understanding of the use of antidepressants. For those prescribed Letrozole, antidepressants were at worst high risk and at best their effectiveness was poorly evidenced.

12.11 A lack of attention had been given to Dr Still's letter, who she believed to be the best qualified to comment on the physical and psychological impact of cancer and its management, being a practising specialist in cancer care and integrative medicine, and the only one who had taken time to fully understand her experiences.

12.12 She had the clearest understanding of her capabilities and limitations as she had the daily burden of living with them. Adherence to treatment for cancer offered no guarantees and created incapacitating side effects in the present and the promise of longer-term osteoporotic degeneration. This combined made working in her NHS role, or any other role of like duration, impossible in the present and in the future.

13. NHS Pensions issued a stage two IDRP decision on 16 June 2020. It declined Ms 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).

Ms R's position

14. Ms R disagrees with NHS Pensions' conclusion that she did not meet the conditions for a Tier 1 ill health retirement pension when her NHS employment ended on 23 August 2019. She says her health difficulties are ongoing.

NHS Pensions' position

15. NHS Pensions submits:-

- It has declined Ms R's application for ill health retirement benefits on the grounds that it is considered that she is not permanently incapable of efficiently discharging the duties of her NHS employment. The Tier 1 condition has therefore not been met.

- This decision has been maintained throughout the application and IDR process.

- 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.

- It submits that it has properly considered Ms R's application, taking into account and weighing all relevant evidence and nothing irrelevant. It has taken advice from the Scheme's MAs, considered and accepted that advice and as a result, arrived at a decision that it believes is not perverse**.**

- In considering Ms R's application, the MA's recommendations and rationales are founded on the correct interpretation of the appropriate Scheme regulations; take into account relevant evidence and information and are not perverse, that is one which no reasonable body of decision makers could have reached in the circumstances on the facts.

- In matters medical, decisions are seldom black or white. A range of opinions may be given from various sources, all of which must be considered and weighed. However, the fact that Ms R does not agree with the conclusions drawn and the weight attached to various pieces of evidence does not mean that any conclusion is necessarily flawed.

Adjudicator's Opinion

16. Ms 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 set out in paragraphs 17 to 40 below.

17. In Ms R's case, the relevant regulations were the 2015 Regulations; in particular, regulation 90. This provided that Ms R would be entitled to the 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 Ms R was considered permanently incapable of efficiently discharging the duties of her NHS employment. Under the 2015 Regulations, permanently meant likely to last until Ms R attained her prospective NPA, which was 67. The Tier 2 conditions included the requirement that Ms R was considered permanently incapable of regular employment of like duration to her NHS employment. In Ms R's case this was regular employment of at least 22.5 hours per week. The regular employment did not have to be comparable to her NHS employment.

18. 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.

19. The decision must be made without the benefit of hindsight and, therefore, the way in which the member's condition progressed after their NHS employment ceased was not relevant. 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.

20. 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 MA; provided, that there was no good reason why it should not do so. The Adjudicator said the kind of things he had in mind were errors or omissions of fact or a misunderstanding of the relevant regulations by the MA. 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

[2] Sampson v Hodgson [2008] All ER (D) 395 (Apr).

explanation if its own MA's opinion was at variance to that held by Ms R's own doctors, if one had not already been provided.

21. The MA noted that they were required to provide advice on whether Ms R was likely to have met the ill health pension conditions at the time her employment was terminated in August 2019. They set out the medical elements of the Tier 1 and Tier 2 conditions and noted that permanent incapacity was to be assessed to Ms R's NPA of 67 and noted Ms R's age (52) and that she was a part-time (22.5 hours per week) APT HI Practitioner/High Intensity Therapist.

22. The MA then referenced the medical evidence and noted its content. In summary, the position was that Ms R had made a good recovery from surgery and post-operative radiotherapy and was on medication to reduce the risk of recurrence. While Ms R was experiencing side effects, including "various symptoms of tiredness and feeling generally unwell", these were not expected to be permanent as her treatment was due to end in 2023. Ms R's osteoporosis was receiving appropriate treatment and there was no indication that it caused incapacity for her NHS role or any regular employment of like duration.

23. The MA considered that, at the date of termination of Ms R's employment, she was incapable of her NHS role, but not permanently so, and she was capable of work of like duration. The latter view appeared to have been based on Mr Graja's brief statement that Ms R was on unpaid leave and working privately from home as a therapist.

24. The Adjudicator noted, in her stage one IDRP appeal, Ms R said her work as a private therapist, was not, and never would be, regular employment of like duration to her NHS role. Nonetheless, by not satisfying the medical element of the Tier 1 conditions, Ms R could not satisfy the conditions for Tier 2, as eligibility for Tier 2 required first meeting the Tier 1 conditions. So, the MA's opinion that Ms R was capable of regular work of like duration to her NHS role did not affect the outcome of the decision.

25. It appeared the main reason why Ms R did not feel that she could ever return to her NHS role, or regular employment of like duration, was psychological, rather than the physical effects of her cancer and/or treatment. Clearly, Ms R felt quite strongly that stress would have a major role in her remaining cancer free and wanted to avoid the stress of her NHS role.

26. The MA said, spontaneous overall improvement, sufficient to restore Ms R's capacity for her NHS job prior to her NPA was dependant on her own perceptions and motivations to improve. But since Ms R had decided against a return this was unlikely.

27. The MA then detailed what they considered likely reasonable treatment/remedial measures at the date of termination of Ms R's employment and gave their opinion that it was likely within the 15-year period to her NPA, given compliance with

reasonable treatment and remedial measures, that she would be capable of her NHS role.

28. The Adjudicator said, the MA's opinion did not appear to conflict with the medical evidence from Ms R's treating doctors. Nonetheless, a difference of medical opinion was not normally sufficient for me to say that NHS Pensions acceptance of its MA's opinion meant that its decision was not properly made.

29. Ms R noted the MA referenced Mr Graja's comment that he was concerned that a return to her former NHS employment may not be possible in the "foreseeable future". Ms R contested the MA's comment that foreseeable future "usually means a number of months". She said the Cambridge Dictionary's (on-line) suggestion, that it meant "as far into the future as you can Imagine or plan for", was more accurate and relevant to her case. Furthermore, it was unlikely that she would have been dismissed on the grounds of ill health if it had been felt that she could return to her NHS role in a number of months.

30. In the context of Ms R's case, the Adjudicator agreed that foreseeable future meant more than "a number of months". Nonetheless, the MA was correct to observe that "may not be possible" did not amount to unlikely and that "psychological disability and occupational medicine" did not appear to be Mr Graja's areas of specialism. Furthermore, at stage one IDRP the MA had referenced the case of Mr Cookson against Cabinet Office (Determination PO-142)[3] before giving their opinion that within the period to Ms R's NPA it was likely that she would be capable of her former NHS role. While each complaint was case specific, Mr Cookson had seven/eight years to his normal retirement age when he applied for ill health retirement. In comparison, Ms R had more than 15 years to her NPA when her NHS employment ended. In the round the Adjudicator did not consider that I was likely to remit Ms R's case back to NHS Pensions based on its MA's interpretation of "foreseeable future" in the context of Mr Graja's report of 19 July 2019.

31. Ms R said the MA noted Dr Millar's comments of a high risk of recurrence within 10 years and the future risk of metastatic spread and likely continued psychological symptoms over the period to normal retirement age. But then disregarded or overlooked this when drawing his conclusions on her prognosis and eligibility for ill health retirement.

32. The Adjudicator said there was a difference between ignoring or overlooking medical evidence and attaching little weight to it. The MA clearly noted Dr Millar's comments. The MA agreed that at the time Ms R's NHS employment ended she was not capable of efficiently discharging her duties. But the MA considered it was likely that she would be capable of her NHS role before reaching her NPA given compliance with

[3] In the case, the then Deputy Pensions Ombudsman said:

"In my view the term "foreseeable future" is simply not the same as the actual period to normal retirement date, and so the distinction from "permanence" was a real one."

reasonable treatment and remedial measures. This position was maintained at stage one IDRP and stage two IDRP.

33. In respect of the initial decision, the Adjudicator found no reason why NHS Pensions should not have accepted the MA's rationale. The MA pointed to potential treatment which they felt would sufficiently improve Ms R's psychological wellbeing for her to return to her NHS role. At the time Ms R did not appear to have undertaken any psychological treatment. She had declined counselling, later, in her stage one appeal, Ms R advised that she had since been added to the waiting list for counselling, so the MA's suggestion was not unreasonable.

34. At stage one IDRP, the MA noted Ms R's comments about the actions she was taking to improve her psychological health and wellbeing. The MA said these were at an early stage, "in her therapeutic journey", and noted that Ms R had not had a psychiatric assessment or the benefit of a treatment programme or any medication to help alleviate her psychological distress.

35. In her stage two appeal, Ms R said she was unhappy and disappointed with the lack of attention given to Dr Still's letter, which she had submitted at stage one. Ms R said she strongly believed that Dr Still, a specialist in cancer care and integrative medicine, was best qualified to comment on the physical and psychological impact of cancer and its management.

36. In his open letter, Dr Still said he supported Ms R's application for ill health retirement benefits under the Scheme; specifically, Ms R's stance that she was unable to return to her NHS role or any other of like duration, as in addition to performance related difficulties, doing so would not be conducive to her recovery and may put her at a higher risk of recurrence of her cancer. Dr Still said there was adequate cause for Ms R to want to avoid working in stressful environments such as the NHS clinical environment and quoted extracts from a book on 'Anti-cancer living' for details for a link between chronic stress and cancer occurrence/recurrence.

37. But it was not clear that Dr Still was aware that for Tier 1 Ms R had to be deemed permanently incapable of her NHS role and for Tier 2 additionally permanently incapable of any regular employment of like duration.

38. Dr Still's letter did not particularly add much to previous submissions made by Ms R linking stress with immunological changes in women with breast cancer; and the quotations included in the letter were general rather than specific to Ms R's health at the time her NHS employment ended. While Dr Still was a specialist, he was not a psychiatrist. The Adjudicator acknowledged that neither was the MA, but they were experts in Occupational Health.

39. The Adjudicator said he realised that it would be disappointing for Ms R, but it was his opinion that her complaint could not be upheld.

40. Finally, the Adjudicator said, that if Ms R was not in receipt of her deferred pension, she may, if she so wished, apply for ill health retirement from deferred status. This would consider medical evidence pertaining to her current health.

41. Ms R did not accept the Adjudicator's Opinion and the complaint was passed to me to consider. Ms R provided her further comments which do not change the outcome. I agree with the Adjudicator's Opinion and note the additional points raised by Ms R.

Ms R's further comments

42. Ms R says she does not agree with the outcome. She says she is disappointed, devastated and feels terribly hurt and let down. Ms R asked the Adjudicator if he was aware that she now had stage four cancer?

43. The Adjudicator replied to Ms R that he was aware that her cancer had returned and that she was receiving treatment. But, as her complaint was about being declined ill health retirement at the date her NHS employment ended (in 2019), consideration could only be given to how NHS Pensions had reached its decision and whether it was properly made.

44. Ms R asked for information on applying for ill health retirement from deferred status. The Adjudicator provided Ms R with NHS Pensions' contact details and said NHS Pensions should be able to assist her.

Ombudsman's decision

45. While I really empathise with Ms R concerning her current state of health, the matter for me to decide is whether NHS Pensions properly considered her application for ill health retirement at the date her NHS employment ended.

46. I have considered the relevant evidence, including the medical evidence pertaining to Ms R's condition at the time her NHS employment ended, and for the same reasons as the Adjudicator (see paragraphs 17 to 38 above) I have found no reason why NHS Pensions should not have accepted its MA's opinion.

47. I find that NHS Pensions' decision to decline Ms R ill health retirement was reached in the proper manner.

48. I do not uphold Ms R's complaint.

Anthony Arter

Pensions Ombudsman
19 July 2022

Appendix 1

The National Health Service Pension Scheme Regulations 2015

49. As at the date Ms 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."

50. 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

Mr Graja (Consultant Surgeon), 23 August 2018

51. Mr Graja thanked Dr Crellin (Consultant Clinical Oncologist) for seeing Ms R and noted that Ms R had made a good recovery from surgery for right breast cancer.

52. Mr Graja said in view of this the MDT had recommended radiotherapy and endocrine treatment. Ms R had also agreed an Oncotype DX test and depending on the result MDT would or would not recommend chemotherapy. Ms R was otherwise healthy and on no medication. Mammograms had been requested for the next five years.

Dr Crellin, 3 October 2018

53. In a report to Mr Graja, Dr Crellin said he noted the Oncotype DX score result and had discussed with Ms R the MDT's recommendations of adjuvant chemotherapy followed by radiotherapy and an aromatase inhibitor for five years. Concerned about the side effects and the financial implications of time off work to receive the treatment, Ms R had declined adjuvant chemotherapy but had agreed to a three-week course of radiotherapy. Dr Crellin said he had also prescribed Letrozole with A… for the next five years.

Dr Crellin, 9 January 2019

54. In a report to Ms R's GP, Dr Crellin said he had reviewed Ms R in outpatients today. Ms R had recovered from the side effects of completed radiotherapy treatment. Ms R had a slight discomfort in her right breast with minimal oedema. Clinically there were no signs of recurrence, and she was tolerating Letrozole very well.

55. Dr Crellin noted that her DEXA scan showed osteoporosis and she was on appropriate treatment for this.

56. Dr Crellin said annual mammograms had been requested for the next five years.

Form AW33E, July 2019

57. In Part B, Ms R said Dr Crellin had retired and she had been seen by various members of the Breast Team, including Mr Graja.

58. Ms R said in addition to NHS treatment she had attended local cancer information clinics, a six-week course provided by Breast Cancer Care, a residential course at the Penny Brohn Centre (and had another booked) and a training day with Stirling Moorey (Consultant Psychiatrist, head of psychotherapy for the SLaM Trust and author on psychological treatments for cancer patients).

59. Ms R said recent developments in psychoneuroimmunology had linked stress with immunological changes in women with breast cancer, and this was associated with poor survival rates. Ms R said leaving work was one of a number of changes she had made to proactively manage her physical health and psychological wellbeing. She had also made dietary changes, adhered to regular recommended exercise to prevent/treat lymphedema, walking, practising yoga and meditation.

60. In Part C, Dr Millar (GP) listed Ms R's medical conditions as breast cancer and osteoporosis. Dr Millar detailed the reported reason for Ms R's current incapacity as:

> "Profound psychological impact of cancer & osteoporosis diagnoses. Fatigue, irritability, distress, tearfulness (under pressure / random). Loss of confidence, loss of motivation, poor sleep, reduced organisation & time management."

and Ms R's reported symptoms and functional impairment as:

> "Fatigue, poor sleep, chest/breast pain, breathlessness, back/hip/knee/ankle pain & stiffness, gastrointestinal sensitivities, blurred vision (near), difficulty regulating body temperature (hot-flushes)".

61. Dr Millar provided details of Ms R's treatment to date: surgery (August 2018), radiotherapy (October/November 2018), endocrine treatment (August 2018) and lifestyle changes (diet, exercise, meditation and yoga).

62. Under "What is the likely future course of this member's health and function, with normal therapeutic intervention over the period to Normal Pension Age?", Dr Millar entered: "Risk of metastatic spread" and "Continue psychological symptoms".

63. Under "How does this member's diagnosed medical condition(s) impact on their capacity to carry out their NHS duties?", Dr Miller entered:
"Unable to deal with the pressure of work & various demands including administrative & technical. She feels constantly stressed, conflicted & incompetent."

64. Dr Millar said that Ms R was unfit for work and the likelihood of improvement in her functional abilities before her Normal Pension Age was "Not known".

65. Under 'Please summarise information you consider to be relevant to this member's long term incapacity for the duties of their NHS employment', Dr Millar entered:

> "This woman does not believe she is capable in her current role of working to a competent and reliable level".

66. Under 'Please summarise information you consider to be relevant to this member's long term incapacity for any regular employment', Dr Millar entered:

> "This woman does not believe she can be reliably employed due to inability to cope with deadlines & pressure to achieve outcomes".

Mr Gaja, 19 July 2019

67. In a report to Ms R's GP Practice (which was also sent to Occupational Health), Mr Graja said Ms R had attended the Breast Clinic today. Ms R was not aware of any new symptoms in her breasts but reported discomfort in the treated right breast. An examination confirmed mild post-radiotherapy breast lymphoedema, but no palpable abnormalities. Ms R's left breast was normal.

68. Mr Graja said Ms R also discussed her work situation. Since surgery, she had not returned to her job as she found it too stressful. She had contacted Occupational

Health about this, and he understood an application for Ill Health retirement was in process.

69. Mr Graja said Ms R had always struggled with the diagnosis of cancer and unfortunately this had not resolved over the year since then. Ms R had tried to return to work earlier in the year but had found her job too stressful and was unable to cope with this. She was currently on unpaid leave and working privately at home as a therapist.

70. Mr Graja said Ms R was reporting various symptoms of tiredness and feeling generally unwell. Mr Graja added:

> "She had treatment with curative intention and we hope that her breast cancer will never return. She had treatment with surgery, radiotherapy and remains on endocrine treatment with L… She decided against having chemotherapy due to personal concerns as her father died from chemotherapy complications.
>
> [Ms R] Had support from the Breast Care Nurses throughout the diagnosis and treatment. She attended the Moving Forward meeting and was referred to Macmillan Advocacy for financial advice. I believe she has been offered counselling, but was not keen on this. She is in fact a professional CBT therapist herself and therefore felt that this would not be for her. If she now seeks this type of support I am more than happy to make arrangements.

Dr Millar (GP), 10 October 2019

71. In a report to Occupational Health, Dr Millar said Ms R was unfit for work due to "Profound psychological impact of cancer and osteoporosis. Symptoms include fatigue, irritability, distress".

72. Dr Millar said Ms R's active medical problems were:-

- Right-sided breast cancer. Ms R had completed a course of radiotherapy and was taking an anti-oestrogen (Latrozole) which should be continued for the foreseeable future. Regular follow up would be arranged. No further treatment was anticipated. Chemotherapy had been recommended but was declined. Life expectancy was greater than 12 months. Unfortunately, there was a high risk of recurrence within 10 years based on the histological diagnosis.

- Osteoporosis. Dr Millar said this was diagnosed in 2018 and treatment included a bisphosphonate tablet ibandronate acid and calcium and vitamin D supplements. This was a 5-7 year management plan and the prognosis was increased fracture risk.

73. On the psychological impact of the cancer diagnosis and osteoporosis diagnosis, Dr Millar said:

> "There has been no specific intervention for this in the form of referral for specialist opinion or therapy. There is no note in the medical record of any measures [being] taken to address her loss of confidence and poor motivation. There is no evidence

> to what extent her symptoms affect her abilities of daily living and there is no evidence to support her assertion that she cannot be reliably employed either in her current role or any regular employment."

Medigold, 17 October 2019

74. In his report, Medigold's MA set out the medical element of the Tier 1 and Tier 2 conditions and noted that permanent incapacity was to be assessed to age 67, Ms R's age (52) and that she was a part-time (22.5 hours per week) APT HI Practitioner/High Intensity Therapist.

75. The MA listed the evidence they had considered as:

- referral documents;
- job description and person specification;
- form AW33E, Part C completed by Dr Millar (GP);
- report from Dr Millar to Medigold dated 10 October 2019;
- reports from Mr Graja (Consultant Breast Surgeon) dated 23 August 2018 and 19 July 2019;
- reports from Dr Crellin (Consultant Clinical Oncologist) dated 3 October 2018 and 9 January 2019; and
- multidisciplinary breast cancer meeting notes dated 23 August and 13 September 2018.

76. The MA noted that a current report had been requested from Dr Crellin but no response had been received.

77. The MA continued:

> "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.
>
> NHS BSA indicates that employment was terminated on 06/08/2019 and so only evidence that could have been made available on that date has been taken into account.
>
> Sickness record shows continuous absence from 10/06/19, prior absence from 10/10/18 to 31/03/19 and otherwise reasonable attendance.
>
> The employer states that, during phased return periods, that were not patient facing, the applicant was unable to manage therapeutic or administrative work.
>
> Job description and person specification indicate that her role is to provide high intensity psychological interventions to clients of the IAPT service and to supervise staff in the service. This role requires advanced communication and

relationship building, computer literacy, teaching and liaison, ability to work under pressure, self-reflection and likely good emotional resilience.

The applicant states:

Recent developments in the field of psychoimmunology link stress with immunological changes in women with breast cancer and this is associated with poorer survival rates. She has made a number of lifestyle changes in order to proactively manage her physical health and psychological wellbeing, since receiving her cancer diagnosis, including leaving work. she has attended local cancer information clinics, a 6 week course provided by Breast Cancer Care, a residential course (with another booked) and a training day with…, Consultant Psychiatrist, head of psychotherapy at a research Trust and published author on the subject of psychological treatments for cancer patients.

Dr Millar states:

In July 2018, the applicant was diagnosed with grade 3, invasive ductal carcinoma and high-grade ductal carcinoma in situ right breast (with high risk of recurrence within 10 years) and she has osteoporosis (diagnosed in November 2018). She had wide local excision and sentinel node biopsy surgery in August 2018 and radiotherapy in October/November 2018. She has had Letrozole endocrine treatment since August 2018 and she takes Adcal and Ibandronic acid. She has made lifestyle changes to diet, exercise, medication and Yoga. Current incapacity is due to profound psychological impact of these diagnoses. She has fatigue, irritability, distress, tearfulness, loss of confidence, loss of motivation, poor sleep and reduced organisation and time management. She also has poor sleep [sic], chest/breast pain, breathlessness, back, hip, knee and ankle pain and stiffness, gastrointestinal sensitivities, blurred near vision and hot flushes. There is future risk of metastatic spread and likely continued psychological symptoms over the period to normal pension age. She is unable to deal with the pressures of work, including administrative and technical. She feels constantly stressed, conflicted and incompetent. She is unfit to work. She does not believe she is capable of working competently and reliably in her NHS role or in any employment due to her inability to cope with deadlines and pressure to achieve outcomes.

On 03/10/18, Dr Crellin stated that the applicant had declined chemotherapy, ‘despite our recommendations’, but agree to post-operative radiotherapy for her right breast cancer (node negative). She agreed to taking Letrozole for 5 years. On 09/01/19, Dr Crellin stated that the applicant had recovered from the effects of radiotherapy treatment and just had slight right breast discomfort with minimal oedema. There were no signs of recurrence clinically and she was tolerating Letrozole well. DEXA scan showed osteoporosis and she had been commenced on appropriate treatment for this.

On 19/07/19, Mr Graja wrote that the applicant had normal mammograms in May 2019 and she has no new breast symptoms. She has mild post-radiotherapy breast oedema but no other abnormalities. She reported she was not able to return to her previous job as she found it too stressful and she contacted Occupational Health. She is one year since her surgery, she has always struggled with her cancer diagnosis and this has not resolved. She is currently on unpaid leave and working privately at home as a therapist. She is reporting various symptoms of tiredness and feeling generally unwell. She has been treated with curative intention and we hope that the breast cancer will never return. She had support from Breast Care Nurses throughout diagnosis and treatment, she attended the Moving Forward meeting and was referred to Macmillan Advocacy for financial advice. 'I believe she was offered counselling but was not keen on this.' She is a professional CBT therapist herself and felt this would not be for her. If she seeks this type of support, I am more than happy to make the arrangements. 'I am concerned that her return to her previous job may not be possible for the foreseeable future.'

This time scale is not quantified and usually means a number of months, concern that 'may not be possible', does not amount to unlikely and psychological disability and occupational medicine do not appear to be Mr Graja's areas of specialism.

On 10/10/19, Dr Millar wrote: [Ms R] was unfit for work on 06/08/19 because of profound psychological impact of cancer and osteoporosis. Symptoms include fatigue, irritability and distress. There has been no specific intervention for the psychological impact of cancer diagnosis and osteoporosis diagnosis and no record of any measures taken to address her loss of confidence and poor motivation. There is no evidence to what extent her symptoms affect her abilities of daily living and there is no evidence to support her assertion that she cannot be employed either in her current role or any regular employment.

Dr Millar indicates, that, at the date of termination of NHS employment, this applicant was incapable of the NHS job because of her perceptions about this role being stressful and adversely impacting on her cancer prognosis. However, this was in the context of her breast cancer that had been treated with curative intent and in the context of her having declined recommended chemotherapy. The evidence indicates that she was working privately as a therapist at that time. This is work that requires a significant degree of emotional equilibrium and poise. The evidence also indicates that she declined counselling for her reported profound psychological issues and that no other treatment has been given. Her reported symptoms are reported to continue.

On balance it is considered that, at the date of termination of her NHS employment, this applicant lacked resilience to the demands of her NHS role.

The evidence indicates, on balance, that, at the date of termination of NHS employment, this applicant was not incapable of regular employment of like duration, for example, working as a private therapist for 22.5 hours per week, at home.

When considering if a medical condition is 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.

At the date of termination of NHS employment, spontaneous overall improvement, sufficient to restore capacity for the NHS job within the period to normal benefit age, was dependent on her own perceptions and motivation to improve. Since she had decided against return this was unlikely.

At the date of termination of NHS employment, reasonable treatment/remedial measures likely included:

- Medications from different classes (at adequate dosage, for adequate duration and perhaps in combination and including augmentation and mood stabilisation), psychological therapy, behavioural therapy and specialist/specialist services involvement for any profound psychological disability.
- Address of any perceived stressors with her employer.
- Ongoing treatment and review for prevention of breast cancer recurrence and for osteoporosis.

It is considered that, at the date of termination of employment, this applicant was more likely than not to be clinically capable of and resilient to, the NHS job, 22.5 hours per week, within the 15-year period to her normal benefit age, given compliance with reasonable treatment and remedial measures.

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."

Dr Still (GP/Assoc Doctor at Penny Brohn UK cancer charity), 11 December 2019

78. In an open letter, Dr Still said he supported Ms R's stance that she was unable to return to her NHS role, or any other of like duration, as in addition to performance related difficulties, doing so would not aid her recovery and might put her at a higher risk of recurrence of her cancer.

79. Dr Still said there was a growing body of scientific data and research which showed how stress impacted all aspects of our lifestyle and physical health, and there was certainly adequate cause for Ms R to want to avoid working in stressful environments.

80. Dr Still added that Ms R was really the only person who could determine whether her working environment was stressful. Dr Still said the NHS clinical environment was highly pressurised and provided ample scope to induce stress within the workforce as evidenced by the high rates of burnout/stress-related sick leave. So, he supported Ms R's decision to retire from NHS work and seek to draw her pension.

81. At the end of his letter, Dr Still quoted extracts from a book 'Anti-cancer Living' detailing evidence for a link between chronic stress and cancer occurrence/recurrence.

MA, stage one IDRP, 23 January 2020

82. The MA noted the medical element of the Scheme's conditions for Tier 1 and Tier 2 ill health retirement, Ms R's age, NPA, occupation and hours of work.

83. The MA detailed the evidence they had considered as the documents submitted in respect of the original application and the stage one IDRP review. The latter comprised:-

- Referral documents.
- Report from Dr Still dated 11 December 2019.
- Ms R's appeal statement.
- An article on IAPT.
- A paper on 'Predictors of emotional exhaustion, disengagement and burnout amongst IAPT practitioners'.
- An article on stress and depression among psychological therapies staff.
- A paper on burnout in IAPT staff.
- Package information from Ms R's medication.

84. The MA noted that some of the medical reports post-dated Ms R's last day of service and said they had only taken into consideration those elements of the reports that related to, or provided insight into, Ms R's circumstances at the time she left her NHS employment.

85. The MA considered the medical evidence indicated that, on the balance of probabilities, at the time Ms R left employment she did not meet the Tier 1 condition. So, the Tier 2 condition was not met. The MA detailed their rationale for this as:

> "Having considered the application and evidence there is, in my opinion, reasonable medical evidence that, at the time of leaving employment, the applicant had a physical or mental infirmity as a result of which the applicant was incapable of efficiently discharging the duties of their NHS employment. The key issue in relation to the application is whether the applicant's incapacity was likely to have been permanent.
>
> There is conflicting medical evidence about [Ms R's] capacity for work at the time she left employment. On form AW33E, Dr Millar does state that [Ms R] was unfit for work. Dr Millar then goes on to report [Ms R's] belief that she was incapable of working reliably in either her own role or alternative employment. Dr Millar also states in his report of 10 October 2019 that, as of 6 August

2019, [Ms R] was unfit for work. However, Dr Millar ends that report with the statement "…there is no evidence to support her assertion that she cannot be reliably employed either in her current role or any regular employment." I am also mindful of Mr Graja's statement in his report of 19 July 2019 that [Ms R] was working privately at home as a therapist. It does therefore seem likely that, at the time she left employment, [Ms R] had retained some capacity for employment.

I have great sympathy for [Ms R] and can understand why she might not wish to continue working. However, regulation 90 requires that the scheme member's incapacity for the employment in question is the result of a physical or mental infirmity. Also, regulation 91(1)(b) and regulation 91(5)(a) explicitly state that the member's preference for or against engaging in the employment in question is disregarded when determining whether the tier 1 and tier 2 conditions are met.

If one gives the greatest weight to Dr Millar's closing remarks in his report of 10 October 2019 it would be reasonable to conclude that, at the time [Ms R] left employment, she was capable of undertaking her normal role. It would follow from this that the tier 1 condition (and hence the tier 2 condition also) would not be met for that reason.

However, I think the weight of evidence does support the conclusion that, at the time [Ms R] left employment she was incapable of undertaking her normal NHS role because of impaired psychological health following her being diagnosed with breast cancer. I will therefore provide advice on that basis.

In summary, [Ms R] was diagnosed with breast cancer in 2018. The tumour was at an early stage as evidenced by its being staged as T1N0M0, which indicates that while there was localised disease it had not spread elsewhere. [Ms R] was treated with surgery and radiotherapy. This was followed by hormone manipulation therapy which was ongoing at the time [Ms R] left employment and was scheduled to continue for 5 years. [Ms R] was also recommended to have chemotherapy to reduce the risk of recurrence of her breast cancer. She declined this treatment. There is positive evidence that the benefits of chemotherapy and the rationale for offering chemotherapy were explained to [Ms R] and that she made an informed decision not to have chemotherapy. While the regulations do require that whether the member has received appropriate medical treatment is considered, regulation 91(6) states that appropriate medical treatment does not include any treatment that the scheme manager considers it would be reasonable for the member to refuse. I think [Ms R's] decision to decline chemotherapy was reasonable. It certainly could not be considered to be perverse.

Whether I, or indeed anyone else, would have made the same decision is not relevant. For avoidance of doubt, the fact that [Ms R] decided not to have chemotherapy is not a factor that I have taken into account in considering

whether the scheme criteria were, or were not, likely to have been met at the point of her leaving employment.

[Ms R's] treatment was given with curative intent. At the time she left employment no particular treatment for the breast cancer was required other than the ongoing hormone manipulation treatment that was being given to reduce the risk of recurrence. [Ms R] was also receiving treatment for osteoporosis. However, I have no evidence that the osteoporosis itself was giving rise to incapacity for employment.

The weight of evidence indicates, in my opinion, that, at the time [Ms R] left employment, her incapacity for her normal role was due to the adverse effect that the diagnosis of breast cancer had had on her psychological health. There was no sign of recurrence of the breast cancer. There was no evidence that the breast cancer itself had adversely affected her capacity to work. There was no evidence that the treatment for breast cancer had adversely affected her ability to work. The outcome of this application does not depend upon [Ms R's] incapacity at the time she left employment; rather it depends upon whether, at the time she left employment, her incapacity was likely to have continued until she reached scheme pension age at the end of 2033. At that time, this was over 14 years in the future.

There is much evidence that the normal human response to adversity is one of positive psychological change. This phenomenon has been observed in many studies, including individuals with life threatening illness. I think that, at the time she left employment, even in the absence of future treatment, [Ms R's] psychological health was likely to have improved with the passage of time. I think that it would have been more likely than not that this improvement would have been sufficient to overcome the obstacles to [Ms R] undertaking her normal NHS role at some point during the 14 years before she reached scheme pension age, particularly if combined with actions to address the aspects of [Ms R's] role that she perceived as being stressful. While noting that [Ms R'S] attempted return to work was not successful, the lack of success at that stage does not preclude successful rehabilitation at a point in the future when her psychological health and resilience had improved.

While noting [Ms R's] comments about the actions that she was taking to improve her psychological health and wellbeing, she was at an early stage in her therapeutic journey. She had not had the benefit of psychiatric assessment. This would have been expected, at the very least, to have led to the identification of the treatment approach likely to have been most efficacious for her specific circumstances. [Ms R] does not appear to have had the benefit of a treatment programme under the supervision of a psychological therapist nor any medication to help alleviate her psychological distress.

I think that at the time [Ms R] left employment her mental health and capacity for employment were likely to improve with the passage of time. Given that

> [Ms R] had resumed some employment activity outside the NHS by the time she left employment, I think that at the time she left employment, it would have been more likely than not that her health and capacity for work would improve, either with the passage of time or in response to future treatment and that this improvement would have been sufficient, when combined with vocational rehabilitation, to have enabled [Ms R] to return to her normal NHS role at some point before she reached scheme pension age.
>
> …
>
> I note Mr Graja's comment that [Ms R] may not be able to return to her normal role for the foreseeable future. I do not infer from this statement that it was Mr Graja's opinion that [Ms R's] incapacity was likely to be permanent. In drawing this conclusion I am guided by the determination of the Pensions Ombudsman in the case of Cookson v Cabinet Office[4] in which he stated that, in his view, the term "foreseeable future" is simply not the same as the actual period until normal retirement date.
>
> I note Dr Still's support for [Ms R's] application. However, Dr Still's opinion does not appear to have been made with reference to the pension scheme criteria and why those criteria are likely to be met.

MA, stage two IDRP, 16 June 2020

86. The MA noted the medical element of the Scheme's conditions for Tier 1 and Tier 2 ill health retirement, Ms R's age, NPA, occupation and hours of work.

87. The MA detailed the medical evidence they had considered as the documents submitted in respect of: the original application, first stage IDRP review and second stage IDRP review. The latter comprised referral documents and Ms R's February 2020 appeal statement.

88. The MA said, on the balance of probabilities, that Ms R did not meet the Tier 1 condition at the time she left NHS employment. So, the Tier 2 condition was not met. The MA detailed his rationale for this as:

> "[Ms R] was diagnosed with breast cancer in June 2018. She was treated with surgery; right wide local excision and sentinel lymph node biopsy (removal of a lymph node in the armpit to check for the presence of cancer). She declined adjuvant chemotherapy. She received adjuvant radiotherapy and was prescribed letrozole (hormone manipulation therapy) scheduled to continue for 5 years. Mr Graja, consultant surgeon, in his letter of 19 July 2019 stated:
>
> "She had treatment with curative intention and we hope that her breast cancer will never return. She had normal mammograms in May this year (2019) to

[4] In the case of Cookson v Cabinet Office (Determination PO-142), the then Deputy Pensions Ombudsman said: "In my view, the term "foreseeable future" is simply not the same as the actual period to normal retirement date…"

both breasts showing post-operative changes on the right side only. She is now exactly 1 year since her cancer diagnosis and surgery for this. She has always struggled with the diagnosis of cancer and unfortunately things have not resolved over the last year. [Ms R] wanted to return to work early this year, but unfortunately she found that her job is much too stressful and she would be unable to cope with this. She is currently on unpaid leave and working privately at home as a therapist. She is reporting various symptoms of tiredness and feeling generally unwell. In summary, [Ms R] did not cope with the diagnosis and treatment and 12 months later the picture stays the same. I am concerned that her return to her previous job may not be possible for the foreseeable future."

Dr Millar, GP, in the medical report on form AW33E states that [Ms R] was unfit for work. In the report of 10 October 2019, Dr Millar states that, as of 6 August 2019 [Ms R] was unfit for work but also states "there is no evidence to support her assertion that she cannot be reliably employed either in her current role or any regular employment".

In her stage 2 IDR letter of appeal [Ms R] complains that disproportionate weight is given to the "unsubstantiated statement from Dr Millar in his report of 10 October 2019".

There is nothing to suggest that this report was given disproportionate weight. It was considered as one of a number of medical reports and the MA at stage 1 IDR states "I think the weight of evidence does support the conclusion that, at the time [Ms R] left employment she was incapable of undertaking her normal NHS role because of impaired psychological health following her being diagnosed with breast cancer. I will therefore provide advice on that basis". [Ms R] also complains that "working privately as a therapist was not, is not, and never will be regular employment of like duration to my NHS role. My private work is not, and will never be, as stressful as working for the NHS was, nor will it ever be of like duration". However, the fact that she has been able to undertake private work as a therapist, albeit less pressurised work than her NHS role does indicate capacity for employment.

When considering if a medical condition is 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.

At the time she left her NHS employment [Ms R] was some 14 years from her scheme pension age. In my opinion, on the balance of probability, it is more likely than not that her psychological health would improve over that period sufficiently to allow her to regain fitness for her previous NHS role. She comments in her letter that the physical issues resulting from the treatment for breast cancer have been overlooked in the IDR1 report. However, no evidence has been provided that the initial treatment (surgery and adjuvant

radiotherapy) produced symptoms. The hormone manipulation treatment (letrozole) is due to finish in 2023. It is more likely than not that any physical as well as the psychological symptoms that [Ms R] was experiencing at the time she left employment would improve in time, within the 14 year period to her scheme pension age.

In my opinion, on the balance of probability, in the absence of future treatment, at the time she left NHS employment, [Ms R's] incapacity for her normal NHS role was not likely to have been permanent.

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.

I note Mr Graja's comment "I am concerned that her return to her previous job may not be possible for the foreseeable future". Foreseeable future does not mean permanent and is not the same as until normal pension age.

I note Dr Still's comment "I therefore support her in her decision to retire from NHS work and to seek to draw down her pension". However, Dr Still makes no reference to the criteria for ill health retirement under the NHS Pension Scheme and offers no rationale as to whether the criteria are likely to be met."