CAS-73860-B7Z6

Ombudsman's Determination

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

Outcome

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

Complaint summary

2. Miss U has complained that NHS BSA incorrectly decided, in January 2021, to decline her application for ill health early retirement (**IHER**) benefits from the Scheme.

Background information, including submissions from the parties

3. The relevant regulations are the National Health Service Pension Scheme Regulations 2015 (as amended) (**the Scheme Regulations**).

4. On retirement from active service, regulation 90[1], of the Scheme Regulations, provides 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[2] incapable of efficiently discharging the duties of his/her NHS employment; and

   Tier 2: in addition, the member is permanently incapable of engaging in regular employment of like duration[3] .

5. If a member satisfies the Tier 1 condition, he/she is entitled to the retirement benefits that he/she has earned to date in the Scheme without actuarial reduction for early payment. If a member also meets the Tier 2 condition, then his/her accrued benefits

[1] Relevant sections of this regulation have been set out in Appendix One below.

[2] "permanently" means the period until Normal Pension Age. In Miss U's case, her Normal Pension Age is 67 years.

[3] "like duration" means, in summary, a regular employment for similar hours to the member's NHS job.

are enhanced by 50% of his/her prospective membership up to Normal Pension Age (**NPA**).

6. Tier 2 benefits are payable only if a member is accepted as permanently incapable of both doing his/her NHS job and regular employment of like duration to his/her NHS job.

7. Miss U was previously employed by the NHS as a part-time healthcare support worker.

8. Miss U applied for IHER benefits from the Scheme using form AW33E prior to leaving NHS employment on 9 November 2020[4]. At the time, she had been diagnosed by her Occupational Health (**OH**) doctor as suffering from: (a) a right coronoid fracture; (b) chronic elbow pain; and (c) depression.

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

10. In December 2020, Medigold requested further medical evidence from Miss U's General Practitioner (**GP**), Dr Needham, before making its decision.

11. In its letter dated 15 January 2021, Medigold informed Miss U that her application for IHER benefits had been declined. Relevant paragraphs from this letter including the opinions expressed by one of its Medical Advisers (**MAs**) are set out in Appendix Two below.

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

13. At both stages of the IDRP, NHS BSA informed Miss U that her complaint was not upheld because it agreed with the medical advice given by its MA that she did not satisfy the Tier 1 condition at the time she left NHS employment on 9 November 2020.

14. The MAs at each stage of the IDRP did not have any previous involvement with Miss U's case.

15. Relevant paragraphs from the Stage One and Stage Two IDRP decision letters dated 23 February 2021 and 21 April 2021, including the opinions expressed by the MAs, are set out in Appendix Two.

16. Following the complaint being referred to The Pensions Ombudsman (**TPO**), Miss U and NHS BSA made further submissions that have been summarised in paragraphs 17 to 25 below.

[4] NHS BSA received the completed form AW33E after Miss U had left NHS employment on 9 November 2020.

Miss U's position

17. She has experienced financial difficulties after leaving NHS employment.

18. She has problems paying her bills and cannot afford private treatment in order to get better.

19. Receipt of an IHER pension from the Scheme would help ease her financial problems.

20. She did her "best for everyone" while working for the NHS. She feels that she has now "just been put on one side and forgotten".

21. She has received counselling to help her cope with her problems. She is taking medication for both high blood pressure and depression.

22. She says that:

> "They should give me my pension money that I have while I was there to sort out my life. And most of all compensate me by law for the damages they have caused me mentally and physically which leaves me to deal with it for the rest of my life."

NHS BSA's position

23. NHS BSA refutes any allegation of maladministration on its part. It has correctly considered Miss U's application for IHER benefits. It took into account all the available evidence that was relevant and weighed it appropriately. In making its decision, it followed a proper process and considered the advice of its MAs.

24. 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 the member's employment terminated. Any deterioration in a medical condition after this date cannot be taken into consideration.

25. In medical matters, decisions are seldom "black or white". A range of opinions may be given from various sources, all of which must be considered and weighed appropriately. The fact that Miss U does not agree with the conclusions drawn in this case, and the weight attached to individual pieces of evidence, does not mean that the conclusion NHS BSA reached is flawed.

Adjudicator's Opinion

26. Miss U'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 set out in paragraphs 27 to 47 below.

27. Under regulation 90 of the Scheme Regulations, Tier 1 IHER benefits were available to Miss U if NHS BSA, acting on medical advice, decided that her medical conditions would prevent her from permanently discharging the duties of her NHS employment efficiently. Its decision was made on the balance of probabilities.

28. So, for Miss U to meet the criteria for Tier 1 IHER benefits, she must be considered by NHS BSA to be permanently incapable of undertaking efficiently the duties of her NHS post until her NPA of 67 years.

29. If NHS BSA considered that Miss U was, more likely than not, also permanently incapable of regular employment of "like duration" to her NHS role, she would be entitled to Tier 2 IHER benefits.

30. It is not the role of the Pensions Ombudsman (**the PO**) to review the medical evidence and come to a decision of his own as to Miss U's eligibility for IHER benefits from the Scheme.

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

32. If the PO finds that the decision-making process was flawed, or that the decision reached by NHS BSA was not supported by the evidence, the case is normally remitted to NHS BSA to reconsider. The PO cannot overturn the decision just because he might have acted differently when presented with the same evidence.

33. It was for NHS BSA (Medigold in the first instance) to decide the weight to attach to any of the evidence, including whether to give some of it little or no weight. It was open to NHS BSA to prefer evidence from its own medical advisers; provided, that is, there was no good reason why it should not do so. The kind of things the Adjudicator had in mind were errors or omissions of fact or a misunderstanding of the relevant regulations. Moreover, NHS BSA was not expected to challenge medical opinion unless the evidence on which the medical opinion was based was obviously flawed or insufficient.

34. On reviewing the evidence, the Adjudicator was satisfied that Medigold's decision, to decline Miss U's IHER application, was taken after its MA had carefully considered the medical evidence provided with the application, which it listed in its letter dated 15 January 2021. Medigold had to weigh the medical evidence and take a decision based on the balance of probabilities.

35. At the time her employment ended, Miss U suffered from a right coronoid fracture, chronic elbow pain and depression. The MA was required to consider whether Miss U's incapacity for her NHS role was at that time likely to be permanent; that is, whether it was likely to last until her NPA of 67 years.

36. In Miss U's case, it was the MA's medical opinion that:-

- Natural recovery of her conditions was likely to occur during the next 17 to 18 years until her 67th birthday.

- Even if this did not occur, appropriate medical treatment would be beneficial to the extent to allow a return to her NHS employment.

- Such treatment for her right elbow pain would include physiotherapy, use of the tennis elbow band, local steroid/anaesthetic injections and surgery.

- With regards to her anxiety and depression, further treatment such as: (a) antidepressant/anxiolytic medications; (b) mood stabilising drugs; (c) referral, assessment and treatment by the community mental health team and/or a consultant psychiatrist; and (d) specialist psychological therapies would provide sufficient recovery to enable Miss U to return to her NHS role in the time before age 67.

37. Based on the evidence presented, the MA concluded, on the balance of probabilities, that:

- Miss U's conditions did not permanently prevent her from efficiently discharging the duties of her NHS employment up to her NPA of 67 years; and so

- the Tier 1 condition for IHER had not been met.

As Miss U did not meet the Tier 1 condition the Tier 2 condition was also not met.

38. Miss U was dissatisfied with the outcome of her IHER application and appealed it twice under the IDRP. On each occasion, after carrying out a thorough assessment, NHS BSA informed Miss U that her appeal had been unsuccessful because it accepted the view of its MA.

39. NHS BSA listed the medical evidence which its MAs had considered in its IDRP decision letters. The medical evidence submitted by the OH physician and Miss U's treating doctors were on these lists. The Adjudicator was satisfied that all the medical evidence that pertained to Miss U's conditions at the time her NHS employment ended was considered.

40. The Adjudicator was also satisfied that NHS BSA addressed the issue of untried treatments properly by asking its MAs to give a view as to their likely efficacy and whether, on the balance of probabilities, Miss U's condition rendered her permanently incapable of discharging the duties of the NHS employment she was engaged in.

41. At the time Miss U left NHS employment in November 2020, she was around 18 years from her NPA. The MA's opinions were that future treatments would, more

likely than not, restore Miss U's fitness for her normal NHS role and for alternative work of like duration before she reached her NPA.

42. The Adjudicator had not identified any obvious error or omission of fact, irrelevant matters or misunderstanding of the Scheme Regulations in the MA's advice which NHS BSA should have queried.

43. So, it was the Adjudicator's view that there was no reason why NHS BSA should not have accepted the advice it received from its MAs in reaching its decision in Miss U's case.

44. The fact that Miss U was still suffering from the same medical conditions did not, in and of itself, invalidate NHS BSA's decision. NHS BSA could only be expected to make its decision based on the medical opinions expressed at the time pertaining to Miss U's health when her employment ended. NHS BSA chose to give more weight to the opinion of its MAs, who are occupational health experts.

45. It was consequently the Adjudicator's opinion that NHS BSA took appropriate action at both stages of the IDRP after obtaining further medical opinions from its MAs. He was also satisfied that NHS BSA: (a) gave proper consideration to Miss U's application at the time by assessing all the relevant medical evidence available, and (b) acted in accordance with the Scheme Regulations and the principles outlined in paragraphs 31 above.

46. The allegations which Miss U had made against her former NHS employer as shown in the summary of her position on the complaint above were matters of pure employment law and it was not in the jurisdiction of the PO to investigate them

47. Miss U did not accept the Adjudicator's Opinion and the complaint was passed to me to consider. Miss U provided her further comments which do not change the outcome.

48. Miss U said that:

> "I didn't ask to (be) put on tier 1 or 2...I could not work, wash and be an independent person anymore, with lots of struggles which included a mortgage to pay and bills. Then Covid hit and made it even harder to seek medical help, I had to pay private physio to help me throughout my struggles. All I asked was a compensation towards my injury and to help me for a lot of things I could not do, work etc…I did not have any positive response to a compensation, which is what should have happened…I have to deal with the pain throughout my life when it's cold or lifting things day to day, I can't be taking medication because of a huge impact just because I was doing my job."

49. I note the additional points raised by Miss U but agree with the Adjudicator's Opinion.

Ombudsman's decision

50. The Scheme Regulations govern the payment of benefits from the Scheme. In its capacity as the administrator of the Scheme, NHS BSA must act in accordance with these regulations and within the framework of the law.

51. Consequently, NHS BSA had to follow the relevant provisions of the Scheme Regulations when assessing Miss U's application for IHER benefits from the Scheme. It could not award Miss U "compensation" in the way she would like NHS BSA to.

52. When considering how a decision has been made by NHS BSA, I will generally look at whether:

- the appropriate evidence had been obtained and considered;
- the applicable scheme rules and regulations have been correctly applied; and
- the decision was supported by the available relevant evidence.

53. Providing NHS BSA has acted in accordance with the above principles and within the powers given to it by the Scheme Regulations, I cannot overturn its decision merely because I might have acted differently. It is not my role to review the medical evidence and come to a decision of my own as to Miss U's eligibility for IHER benefits from the Scheme. I am primarily concerned with the decision making process.

54. Having carefully considered all the available evidence, I am satisfied that NHS BSA did give proper consideration to Miss U's application at the time for essentially the same reasons given by the Adjudicator.

55. I consequently find its decision not to award Miss U IHER benefits from the Scheme was supported by the available evidence and it was within the bounds of reasonableness.

56. That Miss U's condition may not have followed the course anticipated at the time she left employment does not in itself provide evidence that the original decision made in January 2021 was incorrect.

57. Therefore, I do not uphold Miss U's complaint.

Dominic Harris

Pensions Ombudsman
7 May 2025

Appendix One

The National Health Service Pension Scheme Regulations 2015

At the time Miss U's NHS employment ended, 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 NPA;

(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."

Appendix Two

Relevant excerpts from Medigold's decision letter dated 15 January 2021 to Miss U

"This is an initial application for ill health retirement benefits under the Scheme…

Permanent incapacity is assessed by reference to the normal benefit age of 67 years.

The medical evidence considered:

- The referral documents.
- AW33E Part C, dated 6/11/20, completed by Dr Naleem, Occupational Physician.
- A commissioned report from the GP, Dr Needham, undated, including:
- A report form Dr Zachariah, Consultant Endocrinologist, dated 15/11/19.
- A report from G Markova, Counsellor, dated 29/9/20.
- Reports from Specialist Registrars in Orthopaedics – Dr Sadasivan (dated 17/1/20), Mr Singh (dated 14/4/20), Mr Jahangiri (dated 8/7/20) and Mr Chandrasekaran (dated 6/10/20).

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

Having considered the application and evidence there is, in my opinion, reasonable medical evidence that the member has a physical or mental infirmity as a result of which the member is currently incapable of efficiently discharging the duties of their employment. The key issue in relation to the application is whether the member's current incapacity is likely to be permanent.

In considering whether a medical condition would be likely to give rise to permanent incapacity, I would first consider whether, in the absence of future treatment, the incapacity would be likely to be permanent and, if so, then go on to consider whether future treatment would be likely to alter this.

In this case, 'permanent' means at least until normal NHS pension age of 67, which is currently 17 years and 9 months in the future.

Employee records indicate long-term absence since 24/9/19 due to unrecorded causes.

On 6/11/20, Dr Naleem wrote "seen originally in fracture clinic in September 2019 following an incident at work…when she was assisting a patient she

banged her elbow against the headboard sustaining an injury…started on Citalopram in January 2020 due to low mood arising since she has been on long term sickness absence…from my assessment is unlikely that the same level of incapacity will persist until retirement…depression has caused her to feel she cannot reasonably work again in the NHS…describes chronic arm pain and limited mobility in her right arm…alternative roles have not yet been explored, since the client wished to pursue ill health retirement rather than be considered for medical redeployment".

On 29/9/20, the report from G Markova, Counsellor, indicated that she had received a total of 10 sessions of psychological support / therapy, including one session of self-help guided CBT (cognitive behavioural therapy) and 9 sessions of counselling. Her objective scores for depression and anxiety (PHQ9 and GAD7 respectively) remained largely unchanged pre and post treatment, including the antidepressant medication.

She suffered a right (dominant arm) elbow fracture, apparently as a result of the incident outlined above by Dr Naleem, which was treated conservatively (non-surgically). The fracture itself has now healed. She has been reviewed by orthopaedic specialists several times since.

On 17/1/20, Dr Sadavisan wrote "have reassured her that these things will usually settle down". That is, there was thought to be a greater than 50% probability of recovery.

On 8/7/20, Mr Jahangiri noted normal nerve conduction studies and solely inflammation of an extensor tendon at the right elbow on MRI scanning. She was referred to physiotherapy. He wrote "with the physiotherapy she will improve the elbow function…some time it can take long and she may need to have steroid injections…discharging her from the clinic".

On 6/10/20, Mr Chandrasekaran stated her diagnosis to be right lateral epicondylitis (tennis elbow) and wrote "Management plan…continue physio…tennis elbow band…review in three months' time…have explained to her the options of considering a steroid injection to her tender spot on the right lateral condyle and surgery as an option to be considered in future…she is not keen on any intervention such as injections or surgery at the moment…have convinced her to continue with conservative management for now…have asked her to wear the tennis elbow band and avoid lifting anything heavy on the right forearm or hand".

The medical evidence is that Mrs (sic) U is unfit for her usual NHS role, due to chronic right elbow pain (as a result of post-traumatic lateral epicondylitis, of some 15 months' standing) and mixed anxiety and depression, in the context of chronic pain and long-term work absence, together with her perceptions of workplace injury and inadequate training for the work environment in which this injury occurred.

There is no evidence to suggest that this lady has any serious underlying mental illness, or pre-disposition thereto. The current episode of mixed anxiety and depression is considered reactive to events and chronic pain.

The natural history of both lateral epicondylitis and an episode of mixed anxiety & depression is one of gradual improvement and recovery, although the time period may be protracted (particularly where there are perceptions, on her part, of management issues at work). Treatments are likely to bring about such resolution more quickly. However, in my opinion, spontaneous recovery is more likely than not to occur, on balance of probability, during the next 17.75 years until her 67th birthday, such that she will become capable of her usual NHS role and duties during this time.

Even if this were not to prove the case and she remained unfit for her NHS role without treatment, the effects of future treatment, during the next 17.75 years, must then be considered.

Future treatments for her right elbow pain include further physiotherapy, use of the tennis elbow band, local steroid / anaesthetic injections and surgery. It may prove necessary to refer her on to a specialist in pain management, if orthopaedic interventions were unsuccessful. As of now, all of these remain outstanding.

In relation to her mental health, the following might be reasonably considered:

- Antidepressant / anxiolytic medications, at appropriate therapeutic doses, including several different types of drug and / or in combination.
- Mood stabilising drugs.
- Low-dose anti-psychotic drugs for particular issues relating to agitated anxiety or severe insomnia.
- Referral to, assessment and treatment by the community mental health team.
- Referral to, assessment and treatment by a consultant psychiatrist.
- Specialist psychological therapies.

On balance of probability, it is considered more likely than not that such treatments would enable sufficient and sustained symptomatic and functional recovery, during the next 17 years and 9 months until her normal pension age, for her to able to resume her normal NHS duties, at some point during this time.

Thus, permanent incapacity for the NHS employment is not supported by the medical evidence and the medical criteria for the tier 1 condition are not satisfied, on balance of probability.

I note that my opinion accords with that of the occupational physician in the AW33E Part C.

In my opinion, the member does have physical or mental infirmity, as a result of which the member is currently incapable of efficiently discharging the duties of their employment. This incapacity is unlikely to be permanent. The tier 1 condition is unlikely to be met for the reasons given above.

Relevant excerpts from the Stage One IDRP decision letter dated 23 February 2021

"…I have undertaken, together with the Scheme's MA, a very full and thorough review of your case taking into account all the available evidence…

The MA…has commented:

My understanding is that I am required to provide advice as to whether the applicant was likely to have met the tier 1 condition at the time the applicant left employment on 9 November 2020 and, if so, to also advise on whether the applicant also met the tier 2 condition…

Medical Evidence

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

- The referral documents.
- Letter from applicant, dated 4 February 2021.

I have also considered the documents submitted in respect of the original application, specifically:

- The referral documents submitted with the original application.
- Undated report from GP, Dr Needham, but written in response to request from Medigold dated 3 December 2020
- …

I note that Dr Needham's report postdates the applicant's last day of service. Changes in the applicant's health after the applicant left employment are not relevant to the determination of whether the applicant satisfied the pension scheme definitions at the time of leaving employment. I have therefore not taken the subsequent course of the applicant's illness into account. I have, however, taken into consideration those elements of the reports that relate to, or provide insight into, the applicant's circumstances at the time the applicant left employment.

I note that Mrs U[5] has submitted no new medical evidence in support of this request for review.

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

I consider that the relevant medical evidence indicates that, on the balance of probabilities, at the time of leaving employment, the applicant did not meet the tier 1 condition of permanent incapacity for the efficient discharge of the duties of the NHS employment. The tier 2 condition was therefore not met.

The rationale for this is as follows:

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.

The medical evidence is that, at the time she left employment, Mrs U was unfit for her normal role. Most probably, Mrs U was also unfit for alternative regular employment for 23 hours per week, this being of like duration to her normal NHS role. Mrs U's incapacity was the result of symptoms arising in her right elbow in association with features of depression.

In summary, Mrs U sustained an undisplaced fracture of the coronoid of her right ulna. The coronoid is essentially the part of the ulna that articulates with the humerus to form the elbow joint. The injury was treated conservatively, i.e. by non-surgical means. This is the standard treatment for a minimally or undisplaced fracture of this type where the elbow joint is stable.

Mrs U continued to have symptoms in her elbow and when reassessed in early 2020, had features of lateral epicondylitis (tennis elbow). There was some concern that Mrs U might have some nerve irritation. However, nerve conduction studies were normal. The last review by the orthopaedic team prior to Mrs U leaving employment was in October 2020. This assessment appears to represent the medical assessment most contemporaneous with Mrs U leaving employment. At that assessment the extant diagnosis continued to be lateral epicondylitis. This diagnosis appears to have been made clinically and confirmed by imaging. It was decided to continue with non-operative management of this with physiotherapy and to review Mrs U's progress after a further three months. It is clear from Mr Chandrasekaran's report that further treatment options were available, including a steroid injection and surgery, should Mrs U's symptoms not settle with the treatment she was already receiving. I note from Mr Jahangiri's report that Mrs U had been advised that

[5] Miss U has been referred as Mrs U throughout this letter.

symptoms can sometimes take a long time to spontaneously resolve. There is no indication in the orthopaedic reports provided that the original coronoid fracture did not heal satisfactorily. It is explicitly documented that Mrs U had a full range of movement at the right elbow and that there were no signs to suggest that the elbow joint was unstable. The most common complication of this type of injury is a loss of range of movement, which Mrs U did not have.

Mrs U's mental health was adversely affected by the loss of function and inability to work following her injury. She displayed features of both depression and anxiety that did not improve on treatment with a single antidepressant drug, given in combination with cognitive behavioural therapy and counselling.

The combined impact of Mrs U's symptoms at the time she left employment was such that she was unfit for her normal job and, most probably, was also unfit for alternative regular employment for 23 hours per week.

The key consideration is therefore whether, at the time of leaving employment, Mrs U's incapacity would have been likely to be permanent.

At the time Mrs U left employment, the extant diagnosis for her right elbow symptoms was that of lateral epicondylitis. The natural history of lateral epicondylitis is that it can resolve spontaneously, though this may take 12 to 18 months to come about.

The natural history of depression is also such that it can improve with the passage of time, generally within a couple of years or so. At the time Mrs U left employment she was almost 18 years from reaching scheme pension age. It was therefore at least possible that, even in the absence of future treatment, Mrs U's incapacity for her normal role might not have been permanent.

Even if Mrs U's symptoms did not improve spontaneously, she was still at an early stage in her therapeutic journey.

In so far as Mrs U's epicondylitis was concerned, treatment was ongoing in the form of a non-steroidal anti-inflammatory drug and physiotherapy. This combination of treatment is of benefit in over half of the patients with epicondylitis. Further non-surgical treatment options were available in the form of corticosteroid injections and a variety of other non-surgical interventions are sometimes used. The literature indicates that the majority (over 70%) of individuals with lateral epicondylitis do respond to non-surgical treatment, though it may take 12 to 18 months for maximum improvement to come about. In those individuals with lateral epicondylitis who do not recover, either spontaneously or with non-surgical treatment, surgery is a further treatment option. This gives rise to complete pain relief in approximately 85% of patients. It would have been reasonable to have expected the benefits of treatment to be realised within a timescale of a couple of years or so, i.e. well before Mrs U reached scheme pension age.

With regard to Mrs U's depression, I only have evidence of treatment with psychological intervention and a single antidepressant drug, citalopram, used in submaximal dosage. This level of treatment is insufficient to demonstrate that a depressive illness is likely to be refractory to treatment. There would have been scope to increase the dose of citalopram. Approximately half of all individuals with depression do not respond adequately to the first antidepressant drug they are prescribed. There would have been scope to change to an alternative antidepressant drug, perhaps from a different therapeutic class and with a different mode of action. There would also have been scope to use combinations of antidepressant drugs or to combine an antidepressant drug with a mood stabilising agent. These drug treatments could have been combined with further psychological intervention.

The timescale for the benefits of treatment of depression to be realised is generally measurable in months or a small number of years. The benefits of treatment would therefore have been anticipated to occur before Mrs U reached scheme pension age.

I note that in none of the medical reports provided does the author express the opinion that Mrs U's incapacity is likely to be permanent.

In summary, looking at Mrs U's circumstances holistically, at the time she left employment, either with the passage of time or in response to future treatment, Mrs U's capabilities would have been expected to improve sufficiently for her to undertake her normal role. This improvement would have been expected to come about within a small number of years. At the time of leaving employment Mrs U was almost 18 years from reaching scheme pension age. The improvement was therefore likely to be realised before Mrs U reached scheme pension age. In my opinion, on the balance of probability, at the time Mrs U left employment, her incapacity was unlikely to have been permanent.

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

I note that my advice is in agreement with that of my colleague who considered the original application.

I note the contents of Mrs U's recent correspondence. I do not doubt that Mrs U is currently symptomatic and unable to work. She has my sincere sympathy. However, the outcome of this application is not dependent upon Mrs U's current incapacity; rather it depends upon whether her current incapacity is likely to continue until she reaches scheme pension age. This will be in 2038.

For the reasons I have explained above, I think it is unlikely that Mrs U's incapacity will persist until that time."

Relevant excerpts from the Stage Two IDRP decision letter dated 21 April 2021

"NHS Pensions takes advice on medical matters from professionally qualified, experienced and specially trained OH doctors who also have access to expert resource where necessary.

I have undertaken a very full and thorough review of your application, taking into account all the available relevant evidence.

The MA considering your case has recommended that you do not satisfy the tier 1 condition laid down in Regulation 90 of the Scheme Regulations (as amended) for payment of ill health retirement benefits. I have accepted the MA's recommendation...

In reaching the recommendation the MA…has provided the following comments…

Medical Evidence

I have considered the documents submitted in respect of this second stage IDR review, specifically:

- The referral documents;
- Personal statement dated 1 March 2021;
- Further copies of statement with IDR 1, dated 4 February 2021 and previously submitted specialist reports (see below);
- Notice of booking physiotherapy assessment, dated 25 October 2019;
- Referral by physiotherapist to orthopaedic surgeon, dated 28 September 2020, from advanced physiotherapist M Crebbin;
- Notice of appointment with Talking Therapy video appointment, dated 3 March 2021

I have also considered the documents submitted in respect of the first stage IDR review and the original application, specifically…

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

I consider that the relevant medical evidence indicates that, on the balance of probabilities, at the time of leaving employment, the applicant did not meet the

tier 1 condition of permanent incapacity for the efficient discharge of the duties of the NHS employment. The tier 2 condition was therefore not met...

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

In the initial summary document, the OH physician describes Mrs U's[6] conditions as being a thyroid gland problem from summer 2019, an injury to the right elbow complex (a fracture to the coronoid process on the inside and just forwards of the elbow on the ulna bone) in September 2019 and symptoms of depression and anxiety from January 2020. The ongoing functional incapacity was that Mrs U had continued pain and reduced function of her right arm (which is her dominant arm) and had persisting low mood and that this meant that it affected both the small and large, light and heavy manual handling aspects and functioning of the right arm.

The GP summary also includes the injury from September 2019 to the right elbow, confirmed that non-steroidal anti-inflammatory drug pain killers continue to be prescribed; and that Mrs U had received talking therapy from the 23 March 2020 through to the 29 September 2020 and that this had included cognitive behavioural therapy; and the GP reported that Mrs U had been treated for a transient period of overactive thyroid gland at the end of 2019. The latter is confirmed in a letter from the department of endocrinology and that the blood test indicate that the thyroid function had returned to normal.

The specialist letters from January 2020 through to October 2020 describe the injury in September 2019 as being an avulsion fracture of the right elbow's coronoid process (avulsion normally means that the attached tendon or ligament, ligament in this case, pulls off the associated area of bone) which was initially missed, but found a week later as a non-displaced fracture. Of note the coronoid process is on the inside of the elbow. The reason for referral to orthopaedics was the development and persistence of pain on the outside of the right elbow. This was clinically found to be inflammation of the point at which the muscles that straighten the hand and the wrist attach to the outside of the elbow. There were some signs that on the inside of the elbow there may have been compression of the nerve as it runs around the inside of the elbow. Nerve conduction studies were normal. An MRI scan showed inflammation at the attachment of the outside of the right elbow. As of the clinic review in October 2020 Mrs U was found to have persisting pain of the outside of the

[6] Miss U has been referred as Mrs U throughout this letter.

elbow, no tenderness on the inside of the elbow and no abnormality of nerve function. The specialist discussed the consideration of further treatment with a steroid injection, but at that time she was not keen to go ahead and the specialist encouraged greater use of the tennis elbow pressure band. This had been showing some benefits.

The discharge letter from talking therapies in September 2020 showed that Mrs U had been adversely affected by her elbow pain, loss of function and impending loss of job. She had initially been measured as having moderate to severe depression and moderate anxiety and on discharge had moderate depression and continuing moderate anxiety. There was consideration that she had benefitted from the counselling and other aspects of the service and she had been discharged to the care of her GP. There is no indication of the level of her symptoms, however her referral back to talking therapies would indicate that at least these remain unchanged. Mrs U's statements indicate that a significant factor in her depression and anxiety has been her elbow injury and the subsequent loss of her employment.

There is no indication of prognosis from the orthopaedic surgeon. I note however that the scientific literature supports a likelihood of recovery upwards of 70% towards 95% using non-surgical techniques, but that these may take 12-18 months. Surgical treatment of lateral epicondylitis has a greater than 50% improvement to function, but would only be undertaken with successful and comprehensive use of non-surgical techniques. No prognosis was given by psychological treatment teams, however especially in circumstances such as situational depression and anxiety which Mrs U is experiencing, as her treatment to her elbow proceeds there would be an expectation of good to very good responses to psychological therapies in conjunction with effective doses or alternative antidepressant medications and I note that the mid-therapeutic current dose of Mrs U's antidepressant medication has been previously noted and would concur with earlier medical advisors that an increase in dose and use of alternative or concurrent antidepressant, anti-anxiety medications would be appropriate. The expectation would be of good responses to treatment, but even more so with the expectation of the likelihood of recovery from her elbow pain and loss of function.

The OH physician has identified that she is experiencing long term right arm pain and depression since being on long term sickness absence. The physician does not give an opinion on whether this would allow her to return to her NHS employment. The occupational physician goes on to state that it may be possible that she may be able to fill an alternative role that does not involve manual handling, but states that redeployment options were not considered.

This medical evidence indicates that Mrs U's physical and psychological functioning was impaired to the extent that she was incapable of work and from the physical perspective it was explicit that there were future treatments that could be employed; and from a psychological perspective, other than

continuing medication, at the time at the end of her employment only medication was being utilised. The prospect for future treatment was that there was a likelihood that both non-surgical or surgical treatments would restore function and reduce pain with an improvement in functioning that would allow for a return to manual handling duties before the normal pension age, and that there was a likelihood of improvement in psychological functioning with use of other doses and other medications together with further psychological therapies and that this likelihood would have been further reinforced by a reduction in her physical conditions level of impairment and that this would have been seen before her normal pension age as well.

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...

It is my opinion that relevant medical evidence has been considered in this case and, on the balance of probabilities, indicates:

That the applicant is not permanently incapable of the NHS employment; the tier 1 condition is not met;

That the applicant is not permanently incapable of regular employment of like duration; the tier 2 condition is not met.

The MA has explained that having considered the evidence presented and scientific literature, it is his clinical opinion that as at your last day of employment, i.e., 9 November 2020, you were not permanently incapable of discharging the duties of your NHS employment; the tier 1 condition has not been met…

Having very carefully considered the comments of the MA I can see no reason to disagree with his conclusion…”