CAS-84421-B4L3

Ombudsman's Determination

Applicant	Mrs N
Scheme	NHS Pension Scheme (**the Scheme**)
Respondent	NHS Business Service Authority (**NHS BSA**)

Outcome

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

Complaint summary

2. Mrs N has complained that in May 2020 NHS BSA incorrectly decided to award her Tier 1 instead of Tier 2 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 NPA. In Mrs N's case, her NPA 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. Mrs N was previously employed by the NHS as a full-time administrator.

8. In February 2020, Mrs N applied for IHER from the Scheme using form AW33E prior to leaving NHS employment. At the time, she had been diagnosed as suffering from severe fibromyalgia with associated symptoms.

9. Decisions on applications for IHER are made by the Scheme's Medical Adviser, 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. An application for IHER benefits is considered at the member's date of date of leaving. However, if the Scheme member has not yet left NHS employment, the assessment is made as at the date of consideration.

11. In its letter of 20 May 2020, Medigold informed Mrs N that her application for IHER benefits had been accepted. It quoted from its medical adviser[4] (**MA**):

> "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:
>
> - referral documents;
> - job description and person specification;
> - form AW33E with part C completed by Dr Goss, Occupational Physician, dated 2 March 2020;
> - a letter from the applicant dated 2 February 2020 with enclosures as listed in that letter;
> - correspondence from Dr Durrani, Consultant Rheumatologist, dated 19 August 2019 with copy prior rheumatology correspondence dated 16 May 2019, 10 June 2019, 23 July 2019 and 28 June 2019 x 2;
> - correspondence from the community therapy team dated 11 December 2019;

[4] Medigold informed NHS BSA in a letter dated 20 May 2020 that the MA was Dr Martins.

- correspondence from DWP dated 19 November 2019;
- a clinic letter from Dr Kodivalasa, Consultant in Pain Medicine, dated 16 September 2010[5] (typed on 2 November 2019), sent by D Kilby, PA to Pain Management, in response to our request, dated 2 April 2020[6], sent to Dr Kodivalasa, for a report to address specific questions. D Kilby advises the following; 'as per departmental policy, we do not provide medical reports."

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.

NHS BSA indicates that NHS employment has not yet been terminated[7] and so evidence now available has been used for this decision.

Sickness record shows continuous absence from 21 May 2019 with 'other musculoskeletal problems' cited as nature of illness. This record begins in December 2014 and shows long absences from December 2014, from June 2016 and from December 2018 with different cited causes.

The employer states that due to her symptoms, rehabilitation measures were considered but could not be implemented. Management have supported rehabilitation previously in a variety of ways…

The applicant states that she has depression, chronic pain and exhaustion… She cannot see herself working again. She lists her medication as follows: morphine-sevodyne, lansoprazole, gabapentin, fluoxetine, amitriptyline, allopurinol and elleste solo.

DWP correspondence indicates that the applicant has an award of Personal Independence Payment (**PIP**) until 2022.

Correspondence from the community therapy team indicates that the applicant was independent with the equipment and aids provided… in December 2019.

[5] This was a typo. The correct year is 2019.

[6] In its letter 2 April 2020 to Dr Kodivalasa, Medigold said that if it did not receive a report from him based on medical notes alone, Mrs N's IHER application might be processed without this supporting evidence.

[7] Mrs N left NHS employment on 3 August 2020.

Rheumatology correspondence indicates:

On 16 May 2019[8]: she had polyarthralgia, irritable bowel and gout with weight 100.75 kg. Since December she has had generalised aches and pains and tiredness throughout the day. She does not report having episodes of gout.

On 23 July 2019[9]: Investigations did not reveal any inflammatory arthropathy. She lost her father in November and this may have triggered fibromyalgia. She is on treatment for gout, she has high body mass index and she has left knee pain. She is under physiotherapy for her left knee, she has been diagnosed with fibromyalgia and help with graded exercise and weight loss is requested. She was advised about reducing her alcohol intake.

On 20 August 2019: The applicant has mechanical, degenerative changes of the left knee (rather than gout) and injection under ultrasound can be arranged.

On 16 September 2019, Dr Kodivalasa wrote:

The applicant reports having pain since December 2018 and worsening since May 2019, becoming widespread and severe and affecting quality of life. She reports that her pre-existing depression has worsened and she does not drink excessive alcohol. She takes Pregabalin (and previously tried Duloxetine and Amitriptyline) and Co-codamol, 8 tablets daily. She reported she was attending physiotherapy and doing swimming and yoga. She has gout, depression and osteoarthritis in her medical history and she takes hormone replacement therapy. She was given advice and education on the following:

- the nature of chronic, widespread pain;
- the difficulty treating chronic pain that has been present for longer than 3 months and the rationale for biopsychosocial and multidisciplinary approach in managing such pain;
- graded exercise therapy;
- the main goal of management being maintaining or improving functionality and quality of life;

[8] This was the date on which Mrs N had a meeting Dr Krishna, a locum Consultant in Rheumatology. In his letter dated 30 May 2019 to her GP, Dr Krishna said that Mrs N "gave up smoking 30 years ago and drinks 2-3 bottles of wine per week".

[9] Following a meeting with Mrs N on 28 June 2019, Dr Durrani, Consultant in Rheumatology, wrote in his letter dated 23 July 2019 to her GP, "We have talked about her alcohol intake as well and she will try to reduce it".

- the limited role of medications in managing chronic widespread pain and the long-term side effects of pregabalin and opioids and the lack of evidence and long-term side effects of cannabis oil.

She was offered Lidocaine Infusion as a management option, this has equivocal evidence with regards to benefits and she was not keen. She was given information about the Pain Management Programme (**PMP**) and it was highlighted that there is positive evidence of this towards maintaining functionality. She agreed to referral for this programme. She was discharged from follow up so that she could attend the PMP.

Dr Goss states:

The applicant was diagnosed with fibromyalgia in 2019 and reported severe physical and cognitive symptoms of this are the cause of current incapacity. She reports that all ordinary day to day physical and cognitive functions are affected to some degree. She reports being housebound 90% of the time. She attended assessment in a wheelchair in December 2019 and, in January 2020, she reported having had 2 emergency hospital admissions for pain control and she awaited some local anaesthetic injection treatments from the pain management service. She has had appropriate medical treatment including various types of pain relief medication and antidepressant medication. (This indicates that treatment received is appropriate but does not confirm that all reasonable treatment has been completed – my parenthesis). 'It is difficult to speculate on the future course of her health and function over the period to normal pension age, because of the potentially variable course of fibromyalgia. However, in view of the reported severity and duration of her present symptoms, it would appear that resolution compatible with a return to any work activities in the near future is unlikely.' In her job, she is required to spend periods of several hours duration undertaking desk-based work, checking case notes and inputting data. She was undertaking her duties without specific modifications before this absence started.

The evidence indicates, on balance, that this applicant is currently incapable of the NHS job and of regular employment of like duration. This is because of significant reported (subjective) symptoms of relatively recently diagnosed fibromyalgia, likely triggered by bereavement, in the context of high body mass index, possible overindulgence in alcohol, treated gout and osteoarthritis left knee.

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.

The evidence indicates, on balance, that sufficient spontaneous improvement to render the applicant clinically capable of and resilient to the NHS job or

regular employment of like duration within the period to the normal benefit age, is not likely.

Reasonable treatment in this case would likely include:

- Specialist multidisciplinary team management of fibromyalgia using a biopsychosocial approach and following NICE guidelines and ongoing good self-management;
- Weight reduction measures including with specialist services involvement to optimise general wellbeing and energy and to improve musculoskeletal ergonomics and loading;
- Measures to achieve/maintain safe levels of alcohol consumption including with involvement of relevant services if indicated;
- 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 depression.
- Bereavement interventions if indicated.

Since her health issues are likely to be interacting and aggravating each other, simultaneous treatment of each is likely to optimise outcome. 14 years remain to her normal benefit age and this is considered to be sufficient time to complete and reap maximum benefit from reasonable treatment.

She describes current high levels of disability with effect on her basic daily function, but absence is of 1 year's duration. On balance, it is considered to be unlikely that, even with reasonable treatment, that this applicant will become clinically capable of and resilient to, the demands of her NHS job within the period to her normal benefit age. This is because her job requires long periods of intensive concentration and significant levels of responsibility.

It is considered that this applicant is more likely than not to be clinically capable of and resilient to, retraining for and undertaking, less demanding, regular employment of like duration (full time), within the period to her normal benefit age, given compliance with reasonable treatment.

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 likely to be permanent. The Tier 1 condition is likely to be met for the reasons given above.

There is sufficient uncertainty regarding outcome of treatment and relevant functional prognosis. Therefore, this applicant may request reassessment of the Tier 2 condition, once, within three years, or before normal benefit age,

whichever is the sooner, in addition to recourse under the Internal Dispute Resolution Procedure (**IDRP**)".

12. Mrs N was dissatisfied with the outcome of her IHER application and made a complaint in June 2020 under the Scheme's IDRP.

13. In its response under Stage One of the IDRP dated 3 August 2020, NHS BSA informed Mrs N that:-

- It did not uphold her complaint.
- She had six months from the date of the letter to raise a dispute under the second stage of the IDRP.

14. Relevant paragraphs from the Stage One IDRP letter including the opinions expressed by the MA are set out in Appendix Two below.

15. In August 2021, Mrs N telephoned NHS BSA to enquire about further disputing the decision to award her Tier 1 benefits from the Scheme.

16. On 25 August 2021, NHS BSA informed Mrs N by e-mail that:-

- She had missed the specified deadline to request that her IHER application be considered under Stage Two of the IDRP.
- It had made clear to her in its Stage One IDRP decision letter of 3 August 2020 that such a request had to be made within six months from the date of that letter.
- She still had the right to request one reassessment against the Tier 2 condition within three years from the date of the Tier 1 award notification dated 28 July 2020, that is, by 28 July 2023.

17. In her letter dated 23 December 2021 to NHS BSA, Mrs N formally requested consideration of her IHER application under Stage Two of the IDRP.

18. In January 2022, NHS BSA sent Mrs N a similar reply to its e-mail dated 25 August 2021 and provided her with further details about the reassessment process.

19. Following the complaint being referred to The Pensions Ombudsman (**TPO**), Mrs N and NHS BSA made further submissions that have been summarised in paragraphs 20 to 32 below.

Mrs N's position

20. She did not inform NHS BSA that she wished to appeal its decision under Stage Two of the IDRP by the deadline because: (a) she thought that she had to complete her outstanding medical treatments before doing so; (b) the Covid-19 pandemic had thwarted her attempts; and (c) she had also felt too unwell at the time to appeal.

21. The six months deadline was an “impossible target” given her circumstances. NHS BSA should reconsider her IHER application under Stage Two of the IDRP on an exceptional basis.

22. She is appalled the MAs included in their medical reports hurtful and degrading comments about “harmful misuse of alcohol” that led her to believe her “chronic illness” was self-inflicted. NHS BSA has not provided any medical evidence to substantiate the MA’s “accusations” upon which it had based “a detrimental untrue judgement” on her health.

23. She would like NHS BSA to apologise for the MA’s defamatory remarks that she considers discriminatory. NHS BSA did not apologise when she originally raised this matter in December 2021.

24. Both her GP and the Occupational Health (**OH**) physician consider that she is unlikely to be able to return to work again in the future.

25. Medigold did not obtain “a clinical personal response” from Dr Kodivalasa before reaching its decision on her IHER application in May 2020. Dr Kodivalasa merely sent Medigold a copy of his clinic letter dated 16 September 2019 that did not answer its specific questions about her health and it also “missed several months of medical treatment”.

26. The MA at Stage One of the IDRP said that he preferred Dr Kodivalasa’s medical view on her future ability to work over her GP’s but she cannot see where in Dr Kodivalasa’s clinical letters he gave such an opinion.

27. She says that:

> “I believe…that decisions and judgements have been made to my detriment from reports that I haven’t been privy to, thus not allowing me the opportunity to respond and supply the relevant facts, this has excluded me from obtaining the level of pension that I am entitled too (sic)….I have been in the long term employment of the NHS. I feel that if my illness had allowed me I would have retired at my given time, but my illness has robbed me of being capable to contribute to this and their decisions have robbed me of the tier of retirement benefits that would have given me a sound financial future.”

> “My health has worsened since my medical retirement from the NHS of which to date still renders me unable to work. My home has now been medically adapted to suit my medical requirements and use of my electric wheelchair indoors. To-date I have completed all available medical treatments appertaining to my Fibromyalgia which at the time was highlighted by NHS Pensions Medigold as incomplete; outstanding at the time due to Covid restrictions taking place. Severe Covid restrictions continued to then have a knock on affect during recourse under the IDRP delay and then unfortunately the Ombudsman cyber-attack which also impacted on a time delay rendering me unable to request re-assessment within the 3 years for my continual and

> new diagnosis. All of which I have still not been able to recover sufficiently to enable any kind of work/regular employment. My husband is my full time paid carer, I am still in receipt of full PIP (personal independent payment) and full ESA (employment support allowance).
>
> I strongly believe that this continual battle to prove that at times fundamental decisions were made on my medical tiering has been based on untruths, surmised clinical evaluation i.e. diagnosis of Gout (assumed alcohol related), being overweight (fat), all deemed in their report as "subjective" symptoms to my Fibromyalgia and what felt like judgemental..".

28. NHS BSA's decision to decline her application for Tier 2 benefits from the Scheme appears contradictory to what Medigold said in its letter dated 20 May 2020 that:

> "The evidence indicates, on balance, that sufficient spontaneous improvement to render the applicant clinically capable of and resilient to the NHS job or regular employment of like duration within the period to the normal benefit age, is not likely".

NHS BSA's position

29. NHS BSA refutes any allegation of maladministration on its part. It has correctly considered Mrs N'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.

30. It does not consider that Mrs N meets the Tier 2 condition for IHER. In its opinion, she will be capable of regular employment of like duration to her NHS job before she attains NPA.

31. 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 Mrs N 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.

32. It is sorry if Mrs N was offended by the comments made by the MAs in their medical reports about her "alcohol misuse". They were made only after the MAs had carefully considered all the available medical evidence and were "no way intended to cause offence".

Adjudicator's Opinion

33. Mrs N'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 34 to 70 below.

34. 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 Mrs N's eligibility for IHER benefits from the Scheme.

35. The PO is primarily concerned with the decision-making process. Namely, whether NHS BSA's decision was supported by the available medical evidence and any other evidence relevant to the case.

36. The PO would consider: (a) whether the applicable scheme rules or regulations had been correctly interpreted, (b) whether appropriate evidence had been obtained and considered, and (c) whether the decision was supported by the available relevant evidence.

37. 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.

38. The PO cannot overturn the decision just because he might have acted differently.

39. Under regulation 90 of the Scheme Regulations, Tier 1 IHER benefits were available to Mrs N 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.

40. So, for Mrs N 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.

41. If NHS BSA considered that Mrs N 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.

42. On reviewing the evidence, the Adjudicator was satisfied that Medigold's decision, to accept Mrs N's IHER application, was taken after its MA had considered the medical evidence provided with the application, which it listed in its letter dated 20 May 2020. Medigold had to weigh the evidence and take a decision based on the balance of probabilities.

43. At the time Medigold considered her IHER application, Mrs N had been diagnosed as suffering from severe fibromyalgia with associated symptoms. Its MA was required to consider whether Mrs N'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.

44. In Mrs N's case, the MA said that:-

    - Even with reasonable treatment, it was unlikely that Mrs N would become clinically capable of and resilient to, the demands of her NHS job at some point before her NPA of 67. This was because her job required long periods of intensive concentration and significant levels of responsibility.

- Further treatment options[10] were, however, available that would likely alter Mrs N's incapacity for regular employment of like duration to her full-time NHS role.

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

- Mrs N's medical conditions permanently prevented her from efficiently discharging the duties of her NHS employment up to age 67. The Tier 1 condition was met.

- Mrs N was clinically capable of and resilient to, retraining for and undertaking a less demanding full time job in the period to her NPA of 67, given compliance with reasonable treatment. The Tier 2 condition was not met.

46. The MA also recommended that Mrs N should be given an opportunity to seek a further review of her claim against the Tier 2 condition once, within three years from the date of her award notification letter.

47. Mrs N was dissatisfied with the outcome of her IHER application and appealed it under Stage One of the IDRP. After carrying out a thorough assessment, NHS BSA informed Mrs N that her appeal had been unsuccessful because it accepted the view of its MA.

48. Mrs N felt that more weight should have been given by NHS BSA to the medical views expressed by her GP and the OH physician supporting her application for Tier 2 IHER benefits from the Scheme.

49. However, within the bounds of reasonableness, 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 MAs; 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. The reason would have to be obvious to a lay person; NHS BSA was not expected to challenge medical opinion. It might, however, be expected to seek an explanation if its own MA's opinion was at variance to that held by Mrs N's own doctors, if one had not already been provided.

50. Medigold and NHS BSA listed the medical evidence which the MAs considered in their decision letters dated 20 May 2020 and 3 August 2020 respectively. The medical evidence submitted by Mrs N's GP and the OH physician were on these lists.

51. So, the Adjudicator was satisfied that the MAs considered all the medical evidence that pertained to Mrs N's conditions at the relevant time. Furthermore, the Adjudicator noted that the MA at Stage One of the IDRP acknowledged that his views differed to that expressed by Mrs N's GP and explained why this was.

[10]These options have been set out in paragraph 11 above.

52. It should also be noted that a difference of opinion between doctors, in and of itself, was not usually sufficient for the PO to find that by preferring the opinion of its MA meant that NHS BSA's decision was not properly made.

53. It was for the MAs to decide whether they had sufficient medical evidence to give their opinion or require further information from the applicant's treating doctor(s), OH or Mrs N's former employer.

54. In its letter of 2 April 2020 to Dr Kodivalasa, Medigold said that if it did not receive a report from him based on medical notes alone, Mrs N's IHER application might be processed without this supporting evidence.

55. Instead of submitting a report, Dr Kodivalasa chose to send Medigold a copy of his letter dated 16 September 2019 because it was his clinic's policy not to provide medical reports. In my view, given Dr Kodivalasa's stance on this matter: (a) there was clearly little point for Medigold to insist that he answered its questions in a report; and (b) it was not improper for Medigold and NHS BSA to have accepted his letter as additional medical evidence for consideration when making their decisions on Mrs N's IHER application.

56. Mrs N was upset that the MAs had said in their medical reports that she might have had an alcohol problem in the past. She considered their views to be unjustified and discriminatory. However, I note that:-

- In his letter dated 30 May 2019 to Mrs N's GP, Dr Krishna said that Mrs N "drinks 2-3 bottles of wine per week".

- In his letter dated 23 July 2019 to her GP, Dr Durrani said that he had discussed with Mrs N about her alcohol intake and she replied that she would try to reduce it.

- In his letter dated 16 September 2019 to her GP, Dr Kodivalasa said that Mrs N did not drink excessive alcohol.

57. In the Adjudicator's opinion, the MAs' comments about Mrs N's previous alcohol consumption in their reports were made after considering the above medical evidence and based on their understanding of readily available NHS guidelines for alcohol intake. The Adjudicator saw no reason to dispute NHS BSA's position that the MAs' views were not intended to cause her any offence. Furthermore, the Adjudicator noted that NHS BSA had now sincerely apologised to Mrs N for the MAs comments, as requested by her.

58. 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, Mrs N's conditions rendered her permanently incapable of undertaking regular employment of like duration up to her NPA of 67 years.

59. At the time Mrs N left NHS employment in August 2020, she was around 13 years from her NPA. The MAs' opinions were that future treatments would, more likely than not, restore Mrs N's fitness for alternative work of like duration before she reached her NPA.

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

61. 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 Mrs N's case.

62. The fact that Mrs N 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 her health when her employment ended. NHS BSA chose to prefer the opinion of its MAs, who are experts in occupational health.

63. It was consequently the Adjudicator's opinion that NHS BSA took appropriate action at Stage One of the IDRP after obtaining a further medical opinion from its MA. The Adjudicator was also satisfied that NHS BSA: (a) gave proper consideration to Mrs N'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 paragraph 36 above.

64. In the Adjudicator's view, its decision not to award Mrs N Tier 2 IHER benefits from the Scheme was consequently supported by the available evidence and within the bounds of reasonableness.

65. Mrs N said that she was in receipt of ESA and PIP from the DWP. Receipt of these benefits did not, however, mean that Mrs N would automatically qualify for Tier 2 IHER benefits from the Scheme because the criteria used to determine whether or not she qualified for ESA and PIP were different and less stringent.

66. NHS BSA had chosen to adopt a two stage IDRP and there were time limits within which complaints needed to be brought to it.

67. NHS BSA clearly specified in its Stage One IDRP decision letter the deadline by which Mrs N must request her complaint to be considered under Stage Two of the IDRP, that is, within six months from 3 August 2020.

68. The Adjudicator was consequently satisfied that NHS BSA had made it clear to Mrs N that if she had been unhappy with the decision at Stage One of the IDRP and the way in which NHS BSA reached it, she had to request a review under the second stage by 3 February 2021.

69. When Mrs N formally asked NHS BSA in December 2021 to reconsider her IHER application under Stage Two of the IDRP, she had consequently missed the deadline by some 10 months.

70. NHS BSA had discretion to extend this time limit but chose not to do so. Given Mrs N had the right to request one reassessment against the Tier 2 condition within three years from the date of the Tier 1 award notification dated 28 July 2020, in the Adjudicator's view, the decision made by NHS BSA not to exercise its discretion to review Mrs N's application was not unreasonable.

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

Mrs N's further comments

72. The MAs' comments about her "alcohol misuse" was based on "general advice given to everyone…asked questions around diet, smoking and alcohol and how to improve or reduce their dietary intake etc" by her consultant rheumatologists.

73. She was advised that she could not ask for a reassessment of the Tier 2 condition while her complaint was being investigated by TPO.

74. She did everything to meet "the framework of the appeal structure" and it was unfair to be penalised because of all the extenuating circumstances that she faced.

75. She says that:

> "My health now is worse than before and I have attempted every therapy to improve my quality of life, all which renders me unable to return to any type of employment. In closing I just cannot understand given that everybody knows the reasons why I was unable to meet these deadlines a more sympathetic approach I feel has not been taken."

76. I note the additional points raised by Mrs N but agree with the Adjudicator's Opinion.

Ombudsman's decision

77. At the outset, it is important to highlight my role in this process. I am not tasked with reviewing the medical evidence and deciding whether Mrs N should in fact receive a Tier 2 IHER pension – that decision is made by NHS BSA (as set out in paragraph 9 above) in accordance with the Scheme Regulations. Rather, my role and that of my office is to look at the process followed by NHS BSA.

78. 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 were correctly applied; and

- the decision was supported by the available relevant evidence.

79. 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 Mrs N's eligibility for Tier 2 IHER benefits from the Scheme. I am primarily concerned with the decision making process.

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

81. I consequently find its decision not to award Mrs N Tier 2 IHER benefits from the Scheme was supported by the available evidence and it was within the bounds of reasonableness.

82. The fact that Mrs N is still suffering from the same medical condition does not impact upon the validity of the original decision. NHS BSA could only be expected to make its decision in May 2020 on the basis of the condition as it was understood at the time and to reconsider that decision in light of the medical prognosis available at each stage of the review process.

83. That Mrs N'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 May 2020 was incorrect.

84. Mrs N feels that it is unfair NHS BSA decided not to reconsider her application for Tier 2 IHER benefits at Stage Two of the IDRP.

85. Section 50B(3)(b) of the Pensions Act 1995 stipulates that the IDRP:

> "may include provision about the time limits for making such other applications for the resolution of pension disputes as are specified."

86. So NHS BSA may include a reasonable time limit of its choosing for complainants at each stage of the IDRP to appeal. NHS BSA chose to adopt what the Pensions Regulator typically deemed to be a reasonable period as currently set out in its General Code of Practice (and previously in its dispute resolution code of practice), that is, six months.

87. I cannot disregard the fact that NHS BSA made it clear to Mrs N in its Stage One IDRP decision letter that she had to make a request at Stage Two by 3 February 2021 and she had consequently missed this deadline by some 10 months. Furthermore, as NHS BSA had given Mrs N the right to ask for one reassessment of the Tier 2 condition within three years from the date of the Tier 1 award notification, 28 July 2020, I agree with the Adjudicator that NHS BSA's decision not to exercise its discretion to review Mrs N's application at Stage Two was reasonable.

88. In its letter of 20 May 2020, Medigold informed Mrs N that:

> "…this applicant may request reassessment of the Tier 2 condition, once, within three years, or before normal benefit age, whichever is the sooner, in addition to recourse under the IDRP…"

89. I am consequently satisfied that Mrs N had been made sufficiently aware that she could ask for a reassessment of the Tier 2 condition until 20 July 2023 on a without prejudice basis while continuing with her complaint under the IDRP and subsequently with TPO. By deciding not to explore that possibility before the specified deadline elapsed, Mrs N regrettably lost her right to seek reassessment.

90. Mrs N says that she was told that she could not do this but I have seen no clear evidence to substantiate her contention.

91. Needless to say, the decision made by NHS BSA would appear unfair to Mrs N. However, NHS BSA has a duty to pay benefits in accordance with the Scheme Regulations.

92. While I sympathise with Mrs N's circumstances, the evidence does not support a finding of maladministration by NHS BSA in coming to the decision it did.

93. Therefore I do not uphold Mrs N's complaint.

Delete as applicable
Dominic Harris

Pensions Ombudsman
12 December 2025

Appendix One

The National Health Service Pension Scheme Regulations 2015

At the time Mrs N'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 the Stage One IDRP decision letter dated 3 August 2020

"In my role as Dispute Officer I have undertaken, together with the Scheme's Medical Adviser, a very full and thorough review of your application, taking into account all the available evidence…

The MA, Dr Fisher…, has commented:

"My understanding is that I am required to provide advice as to whether the member was likely to have met the tier 2 condition at the time the member left employment on 24 June 2020 and, if so, to also advise on whether the member also met the criteria for the HMRC serious ill-health condition (SIHC) test.

Medical Evidence

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

- The referral documents;
- An undated submission from the applicant;
- A report from the GP, Dr Edwards, dated 5 June 2020;
- A report from Dr Kodivalasa, Consultant in Pain Management, dated 3 February 2020[11];
- A report from Miss Malik, Consultant Gynaecologist, dated 4 March 2020;
- A copy of her prescription dated 5 June 2020.
- An ultrasound report, dated 22 January 2020, completed by Ultra sonographer V. Fothergill.
- An undated extract from 'debilitatingdiseases.net'.

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

…

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

[11] This was typed on 14 March 2020.

I consider that the relevant medical evidence indicates that, on the balance of probabilities, at the time of leaving employment, the applicant was not permanently incapable of regular employment of like duration. The tier 2 condition was 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 member had a physical or mental infirmity, as a result of which the member was incapable of regular employment of like duration. The key issue in relation to the application is whether the member's incapacity was likely to have been permanent.

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

In this case, 'permanent' means at least until normal NHS pension age of 67, which was 13 years and 8 months in the future, as of 24 June 2020.

The evidence is that this lady is currently unfit for any kind of regular full-time employment. This is due to fibromyalgia syndrome (FMS), otherwise known as chronic widespread pain syndrome, together with treated gout, untreated obesity[12], depression[13], previous harmful alcohol misuse and early osteoarthritis. The primary cause for incapacity is the FMS which gives rise to chronic, severe musculoskeletal pain, in the context of significant depression. It is noted that her physical pain symptoms coincided with a severe bereavement reaction, such that psychological stressors are likely to be implicated in the causation of her physical symptoms. Excess loading through the skeleton, due to obesity, is also likely to aggravate her chronic widespread pain, which would therefore be likely to improve with appropriate weight loss measures.

It is also noted that she reports abdominal/pelvic pain, originally thought to be associated with the FMS. However, recent imaging has found a pelvic cyst (most likely an ovarian cyst), for which she is awaiting review by Miss Malik, Consultant Gynaecologist. If her abdominal pain is caused by the cyst, it may be possible to resolve this particular aspect of her illness, surgically.

The evidence is that this lady is in the relatively early phase of FMS but is currently suffering from moderately severe symptoms and functional

[12] Mrs N says that after implementing "changes", she has now lost two and a half stones.

[13] Mrs N says that she has been prescribed antidepressants of "various classes and dosages" and also previously received CBT therapy..

impairment. As is typical with this illness, there is significant variation in symptoms but it is persistent.

Evidence-based treatments for FMS include:

- Exercise therapy (supervised by an appropriate therapist), including graded exercise therapy.
- Specialist Pain Management interventions, including attendance at a holistic pain management programme.
- A range of analgesic and neuropathic pain medications (she has tried most types of these, without much benefit, so far).
- Psychological pain interventions, such as CBT (cognitive behavioural therapy).

As of 24 June 2020, all but the medication options remained outstanding.

On 3 February 2020, Dr Kodivalasa stated "has now decided to try intravenous lidocaine infusion[14] before Pain Management Program…informs me that she has had to attend A&E twice (with #999 call) for her abdominal pain…scans organised by her GP she was found to have a mass on her ovary…I have explained to Mrs N that physiotherapy is the mainstay of treatment and reiterated the importance of graded exercises therapy…I have explained the limited evidence for IV lidocaine infusion in chronic widespread pain management…with her consent, I have booked her for the procedure…Pain Management Program would be our next option…discussed the long-term side effects of Gabapentin and opioids…advised her to wean and stop Gabapentin and opioids with the help of her GP…could continue Amitriptyline to help her with the sleep"

As of 24 June 2020, both the graded exercise therapy and the holistic pain management programme remained outstanding[15].

On 5 June 2020, Dr Edwards, GP, stated "from a medical point of view her fibromyalgia is very unlikely, on the balance of probability, to get any better than it currently is". In my opinion, the GP's view is not consistent with the body of medical opinion, nor with that of the treating specialist. Dr Kodivalasa's opinion is therefore preferred and accords with my own

[14]Mrs N says that she started having Lidocaine infusion two or three times a year from October 2020 which helped with her condition for approximately 8 to 10 weeks afterwards.

[15] Mrs N says that prior to 24 June 2020, she had graded exercise therapy and also aqua therapy. In her view, this sentence was consequently incorrect. She joined the Pain Management Program in August 2021. The delay in joining was caused by "Covid and a further medical condition".

understanding and experience of the treatment options and prognosis for FMS.

It is also noted that this lady reports significant mental health symptoms, which have – in recent times – been complicated by harmful misuse of alcohol. Whilst the latter may have now ceased, there is little evidence to suggest her mental health symptoms have been adequately and appropriately treated, as yet.

Such treatment might comprise:

- 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[16]
- Referral to, assessment and treatment by a consultant psychiatrist.
- Specialist psychological therapies.

The natural history of FMS is one of persistence. Reactive depression and anxiety symptoms can spontaneously resolve, although the chronicity and causation in this particular case would make it unlikely. Spontaneous resolution of either condition is therefore unlikely. That is, in the absence of future treatment, incapacity for any regular full-time employment is considered likely to continue indefinitely and probably beyond her normal NHS pension age of 67, thus being 'permanent'.

However, future treatment, during the next 13.66 years until age 67, is considered likely, at present, to alter the permanence of her incapacity.

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 13 years and 8 months, for her to able to resume some kind of regular full-time employment, at some point during this time.

Thus, permanent incapacity for regular employment of like duration is not supported by the medical evidence and the medical criteria for the tier 2 condition were not satisfied, as of 24 June 2020, on balance of probability.

[16] Mrs N says that: (a) she received weekly "AMICA counselling" during the last year or so working for the NHS; and (b) her GP did not consider it appropriate to refer her to the community health team for treatment because she was receiving "this support" within her workplace.

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 regular employment of like duration. This incapacity was unlikely to have been permanent. The tier 2 condition was unlikely to have been met for the reasons given above.

There is sufficient uncertainty regarding her long-term prognosis and likely functional outcome, in relation to fitness for some kind of regular full-time employment, as to support a review of the tier 2 condition, once within a period of 3 years from the date of notification of the award of tier 1. Therefore, a review, at a date of the applicant's choosing, remains appropriate…"

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

In reviewing your case I have noted that your employer had originally informed us that your contract was going to be terminated on 24 June 2020 but they have now informed us that the contract has actually been terminated on 3 August 2020.

Whilst the medical adviser has referred to a leaving date of 24 June 2020 in their rationale, I believe that their comments still stand when considering your case to 3 August 2020.

You have retained the right to request one reassessment of the Tier 2 conditions within three years, as outlined above.

I should point out here that the onus rests with you to request a Tier 2 reassessment (in writing, to this office) within three years of the date of the Tier 1 award of benefits notification letter of 28 July 2020 and to provide supporting evidence. I should also point out that, where Tier 2 entitlement is established as a result of a reassessment, the Tier 2 benefits become payable from the date on which the Tier 2 decision is reached, they are not backdated to the date from which the Tier 1 benefits were paid...

Next steps

If you remain dissatisfied with my reply for any reason, you have the right to request that your dispute be reviewed under Stage Two of the IDR procedures. A manager who has had no involvement in your case would carry this out. There is no form to complete to request Stage Two IDR consideration but you only have six months from the date of my letter to request a Stage Two review by writing a letter, clearly outlining the nature of your dispute, addressed to the Dispute Manager at the address above. As Stage Two is the final stage of this process, please ensure that you enclose any additional evidence that you wish to be considered with regard to your case if you do request Stage Two IDR consideration."