PO-15384

Ombudsman's Determination

Applicant	Miss N
Scheme	NHS Pension Scheme
Respondents	NHS Business Services Authority (**NHS BSA**)

Outcome

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

2. My reasons for reaching this decision are explained in more detail below.

Complaint summary

3. Miss N has complained that her application for the early payment of her benefits on the grounds of ill health has not been considered in a proper manner.

Background information, including submissions from the parties

Background

4. Miss N was employed as a part-time (17½ hours) clerical officer. Her employment ceased in September 2014.

5. The relevant regulations are the NHS Pension Scheme Regulations 1995 (SI1995/300) (as amended). Regulation E2A provides for "Ill health pension on early retirement" as follows:

> "(1) This regulation applies to a member who -
>
> (a) retires from pensionable employment on or after 1st April 2008;
>
> (b) did not submit Form AW33E (or such other form as the Secretary of State accepted) together with supporting medical evidence if not included in the form pursuant to regulation E2 which was received by the Secretary of State before 1st April 2008, and
>
> (c) is not in receipt of a pension under regulation E2.

(2) A member to whom this regulation applies who retires from pensionable employment before normal benefit age shall be entitled to a pension under this regulation if -

(a) the member has at least 2 years qualifying service or qualifies for a pension under regulation E1; and

(b) the member's employment is terminated because of physical or mental infirmity as a result of which the member is -

(i) permanently incapable of efficiently discharging the duties of that employment (the **"tier 1 condition"**); or

(ii) permanently incapable of regular employment of like duration (the **"tier 2 condition"**) in addition to meeting the tier 1 condition."

6. Further extracts from the regulations are provided in Appendix B.

7. Miss N applied for early payment of her benefits in September 2014. Part C of the application form was completed by her employer's occupational health doctor. The names and addresses for Miss N's consultant and GP were also provided.

8. Initial decisions as to a member's eligibility for early payment of benefits on the grounds of ill health are taken by NHS BSA's medical advisers under delegated authority. At the time, this was OH Assist. It wrote to Miss N, on 19 February 2015, informing her it was unable to accept her application. It quoted from the doctor who had reviewed her case. The doctor had expressed the opinion that Miss N did not meet the tier 1 condition. He/she had said Miss N was more likely than not going to improve with treatment such that she would be capable of undertaking her former NHS role before her normal benefit age. Summaries of the medical reports relating to Miss N's case are provided in Appendix A.

9. Miss N appealed the decision under the Scheme's two-stage internal dispute resolution (**IDR**) procedure. NHS BSA referred her case back to OH Assist for further advice.

10. NHS BSA issued a stage one IDR decision on 22 May 2015. It declined Miss N's appeal on the grounds that she was not permanently incapable of carrying out the duties of a clerical officer. It quoted the advice it had received from OH Assist and said it could see no reason to disagree with the advice.

11. In June 2015, Lancashire County Council provided funding for certain mobility aids to be installed at Miss N's home.

12. Miss N submitted a further appeal. Her case was referred back to OH Assist for further review. NHS BSA wrote to her, on 7 January 2016, declining her appeal. It said it was accepting the advice it had received, from OH Assist, that she did not satisfy the conditions laid down in regulation E2A (see above). NHS BSA then quoted

the advice it had received. It said the OH Assist doctor was of the view that, with appropriate medical treatment such as Cognitive Behavioural Therapy (**CBT**) and Graded Exercise Therapy (**GET**), Miss N was likely to recover sufficiently before age 60 to allow a return to her NHS employment. NHS BSA said it could see nothing in the doctor's analysis or the evidence upon which it was based which would cause it to disagree with her findings.

Miss N's position

13. Miss N's submissions are summarised below:-

- She worked for the NHS for 28 years and was led to expect ill health retirement because she had paid into the Scheme all that time.
- It is unfair that she has paid into the Scheme for all that time and is not now receiving a pension. It is her money and it should be paid to her when she needs it.
- In 2015, she was diagnosed with pernicious anaemia after her mother paid for private blood tests. She has to buy treatment for this condition herself from Germany and it is costly.
- The decision not to award ill health retirement benefits has been made without anyone seeing her or how she struggles on a day to day basis. She spends 90% of her life in bed and has been housebound since December 2013.
- The evidence referred to by NHS BSA is not up to date. Her condition has deteriorated since the decision was made. Her GP is willing to provide a full report.
- Evidence from Dr Shepherd, at the ME Association, indicates that someone who has suffered from ME for more than three years is unlikely to recover. She has had ME for over three years.

NHS BSA's position

14. NHS BSA's response is summarised below:-

- It has declined Miss N's application for ill health retirement because, based on the available evidence, it concluded that she is likely to be capable of returning to her NHS role before her 60th birthday, with appropriate treatment. The tier 1 condition was not met.
- This decision has been maintained throughout the application and IDR process.
- It has considered Miss N's application properly. It has taken into account all relevant matters and nothing irrelevant. It has taken advice from appropriate

sources; that is, its medical advisers. It has considered and accepted that advice and, as a result, has come to a decision it considers not to be perverse.

- Its medical advisers' recommendations and rationales were founded on the correct interpretation of the Scheme regulations. They took into account relevant evidence and were not perverse.

- In medical matters, decisions are seldom black and white. A range of opinions may be given from various sources; all of which must be considered and weighed. The fact that Miss N does not agree with the conclusions drawn or the weight it has attached to the various pieces of evidence does not mean that its conclusions are flawed.

Adjudicator's Opinion

15. Miss 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 summarised briefly below:-

- The Adjudicator began by explaining it is not the role of the Ombudsman to review the medical evidence and come to a decision of his own as to Miss N's eligibility for payment of benefits under regulation E2A. The Ombudsman is primarily concerned with the decision-making process. The issues considered include: whether the relevant regulations have been correctly applied; whether appropriate evidence has been obtained and considered; and whether the decision is supported by the available relevant evidence. Medical (and other) evidence is reviewed in order to determine whether it supports the decision made. However, the weight which is attached to any of the evidence is for NHS BSA to decide (including giving some of it little or no weight)[1]. It is open to NHS BSA to prefer evidence from its own advisers; unless there is a cogent reason why it should not, or should not without seeking clarification. For example, an error or omission of fact or a misunderstanding of the relevant regulations by the medical adviser. If the decision-making process is found to be flawed, the appropriate course of action is for the decision to be remitted for NHS BSA to reconsider.

- Because Miss N was applying for ill health retirement as an active member, under regulation E2A, she had to meet the criteria for payment at the time her employment ceased; September 2014. The Adjudicator noted that Miss N had explained that her condition had deteriorated since her employment was terminated and she had offered to provide up to date medical evidence. The decision reached by NHS BSA had to be assessed in the light of the evidence which was, or could have been, available at the time it was made. Any

[1] *Sampson v Hodgson* [2008] All ER (D) 395 (Apr)

subsequent deterioration in Miss N's condition was not directly relevant to this assessment; unless it could reasonably have been foreseen at the time of the decision. A report as to Miss N's current condition would not help determine whether there had been any maladministration in the way in which her regulation E2A application was considered.

- The Adjudicator thought it reasonable to say that it was accepted by NHS BSA that Miss N was not capable of efficiently discharging the duties of her NHS employment in September 2014. However, to satisfy the tier 1 condition, Miss N had to be permanently incapable of doing so. In other words, NHS BSA and its medical advisers also had to consider how likely it was that Miss N would recover, at some point before her 60th birthday, such that she would again be able to discharge those duties. If the medical evidence suggested that, on the balance of probabilities, Miss N was more likely than not going to recover sufficiently before her 60th birthday, the tier 1 condition was not met.

- Having reviewed the advice provided by NHS BSA's medical advisers, the Adjudicator said she had seen no evidence of any misunderstanding of the regulations. Nor was there any evidence of an error or omission of fact on the part of the OH Assist doctors.

- In addition, the views expressed by the OH Assist doctors did not appear to be at odds with the opinion given by Dr Binymin in July 2015. He supported the diagnosis of ME and fibromyalgia and thought Miss N was not able to maintain a full-time job. However, he did support a phased return to work and reduced hours. It was not clear whether Dr Binymin was aware that Miss N had not been in a full-time role. Her NHS role was part-time (17½ hours per week) and it was against this that her eligibility for ill health retirement had to be assessed. The evidence provided by Ms Peers, Ms Hesketh and Ms Finch related to Miss N's condition as it then presented and, as such, did not assist in assessing whether her incapacity should be considered permanent.

- The Adjudicator recognised that Miss N did not agree with the views expressed by the OH Assist doctors. She acknowledged that Miss N was still experiencing significant issues with her health. However, the Adjudicator did not believe that there were grounds for finding that NHS BSA should not have accepted the advice it received from OH Assist.

- The Adjudicator noted that Miss N had since been diagnosed with pernicious anaemia. This was not information which was available to NHS BSA or OH Assist at the time of making a decision under regulation E2A. They could not, therefore, have been expected to take it into account. There was provision under the Scheme regulations for Miss N to apply for the early payment of her deferred benefits on the grounds of ill health (regulation L1(3)). She was able to submit an application at any time before her 60th birthday and her recent diagnosis could be considered in relation to such an application. However,

Miss N would have to meet the eligibility criteria set out in regulation L which were much the same as those contained in regulation E2A.

16. Miss N did not accept the Adjudicator's Opinion and the complaint was passed to me to consider. Miss N provided her further comments which do not change the outcome. I agree with the Adjudicator's Opinion and I will therefore only respond to the key points made by Miss N for completeness.

Ombudsman's decision

17. As alluded to above, my concern is with deciding whether or not there has been maladministration on the part of NHS BSA. If I find that NHS BSA did not make a decision in a proper manner, I can direct it to review Miss N's case. I will not, however, decide whether or not she should receive a pension under regulation E2A.

18. NHS BSA based its decision not to pay Miss N's benefits, under regulation E2A, on the advice it received from its own medical advisers. I do not find that it was maladministration for it to do so.

19. Miss N has pointed out that the decision was made without anyone from NHS BSA or its medical advisers having seen her. The Scheme's regulations do not, themselves, require a face-to-face assessment. It is, therefore, largely a matter of professional judgment on the part of the medical advisers as to whether they consider they have sufficient information to offer an opinion without seeing Miss N. I would not expect NHS BSA to require its medical adviser to see an applicant unless there was good reason for it to do so; for example, there was insufficient written medical evidence or that evidence was unclear.

20. Miss N disagrees with the opinions voiced by the OH Assist doctors. However, that advice was based on the correct interpretation of the relevant regulations and did not contain any errors or omissions of fact. Miss N has referred to evidence from Dr Shepherd. She has provided copies of an email exchange she had with Dr Shepherd in August 2015. She argues that this supports her case for receiving a pension under regulation E2A.

21. It is not uncommon for there to be a difference of opinion between doctors as to the likely future course of a medical condition such as ME/CFS, which is still not well understood. A difference of opinion on prognosis is not usually sufficient, in and of itself, for me to find that NHS BSA should not have accepted the advice from its own doctors. In any event, in Miss N's case, I do not find that the OH Assist advice was inconsistent with the views expressed by Dr Shepherd.

22. The evidence provided by Dr Shepherd is general in nature. He too had not seen Miss N at the time of writing nor did he have much information about her particular circumstances. Miss N has referred me to Dr Shepherd's comment that serious consideration should be given to an application for early retirement if someone has been ill with ME/CFS for around four years. I note, however, that he also said a

significant proportion of people with ME/CFS did make some degree of improvement and eventually return to a reasonable level of health. This does not seem particularly inconsistent with the views expressed by the OH Assist doctors; that is, that Miss N was likely to recover, at some point before her 60th birthday, sufficiently to undertake a part-time clerical role.

23. Whilst I can understand Miss N's frustration in not being awarded a pension under regulation E2A, NHS BSA can only pay benefits in accordance with the relevant regulations. I acknowledge that Miss N had been contributing to the Scheme for a considerable number of years; as had her employer. However, the benefits promised in return for those contributions were those which are payable in accordance with the Scheme regulations.

24. Therefore, I do not uphold Miss N's complaint.

Anthony Arter

Pensions Ombudsman
20 June 2018

Appendix A

Medical evidence

Mr Majeed, consultant neurologist, 23 May 2014

25. In a letter to Miss N's GP, Mr Majeed said no abnormality had been found on neurological examination. He said Miss N had had an MRI scan of her head and EMG and no abnormality was noted. He said there was nothing to suggest that Miss N's symptoms were due to any neurological disorder.

Dr Drake, gastroenterologist, 28 May 2014

26. Dr Drake said he had first seen Miss N in December 2013. He outlined the tests which had been undertaken and noted the results had been normal or negative. Dr Drake said he had reviewed Miss N in February 2014 and had found it difficult to explain her symptoms. He said he had referred to Mr Majeed and arranged further tests; the results of which were normal. Dr Drake said he thought it unlikely that they would find an underlying physical abnormality.

OH Assist, 19 February 2015

27. The OH Assist doctor said he/she had seen: Part C of the application form; a report from Dr Krishnamoorthy dated 30 December 2014; clinical correspondence from Drs Drake and Majeed dated May 2014; information about sickness absence provided by Miss N's employer; a letter from Miss N and Part B of the application form.

28. The OH Assist doctor said Miss N's employer had reported that a structured review process had been ongoing since January 2014 and that it had been advised Miss N was not fit to return to work in any capacity. He/she noted that the employer's occupational health doctor had listed Miss N's conditions as: Chronic Fatigue Syndrome (**CFS**); asthma; hysterectomy with premature menopause; irritable bowel syndrome; migraine; and self-reported fibromyalgia. He/she then listed Miss N's symptoms. He/she noted the results of the MRI scan were normal and there was nothing to suggest a neurological disorder. He/she noted the test results obtained by Dr Drake had been normal.

29. The OH Assist doctor concluded:

> "On balance it is considered that this applicant has multiple symptoms which are not explained by the assessment and investigation findings. She was very recently assessed by the CFS service. Psychological therapies are very likely to be helpful with her symptoms. She is more likely than not to improve with the above treatments, enough to regain capacity for her NHS role, within the 15 years to normal benefit age."

OH Assist, May 2015

30. The OH Assist doctor said that, for the tier 1 condition to be met, the medical evidence must support incapacity for the NHS role until normal retirement age, which was, in Miss N's case, age 60; some 14 years and 5 months away. He/she noted that Miss N's GP had indicated that she had a number of chronic medical conditions and listed these with comments:

    - Asthma – no evidence to indicate this was brittle, poorly controlled or uncontrollable, such that it would preclude work.
    - Osteopenia – no evidence to indicate that this was poorly controlled or uncontrollable, such that it would preclude work.
    - Raynaud's phenomenon - no evidence to indicate that this was poorly controlled or uncontrollable, such that it would preclude work. If medication did not work, a vascular surgeon's opinion would be expected and this had not been sought as yet.
    - Post-hysterectomy menopause – no evidence to indicate that this caused significant impairment or was poorly controlled or uncontrollable, such that it would preclude work. The menopause, whether induced surgically, chemically or naturally, was a physiological process; the worst effects of which could be successfully ameliorated with medication.
    - Non-specific low back pain – Miss N had been referred for physiotherapy and for assessment of her back pain. Expected levels of 'reasonable appropriate treatment' would include referral to a specialist in pain management, which had not yet occurred.
    - CFS and fibromyalgia – these conditions were poorly understood and there was a large overlap in symptoms between the two. Evidence based treatment, according to NICE guidelines, included pacing therapy, graded exercise therapy (**GET**), cognitive behavioural therapy (**CBT**) and drug treatment. Miss N had only recently been referred to specialist services and her treatment was far from complete. The natural history for this condition was for sustained improvement and functional recovery, although this might not be complete and may take around five years to become evident. It was too early to consider this condition permanently disabling. This was not intended to negate the severe effects upon Miss N currently and for the foreseeable future.

Dr Krishnamoorthy, consultant in anaesthesia and pain relief, 18 May 2015

31. In a letter to Miss N's GP, Dr Krishnamoorthy outlined the results of an MRI scan of Miss N's spine. He said there was degenerative disc disease in the cervical and lumbar regions but the thoracic spine was normal. He noted mild impingement of the right S1 nerve root. Dr Krishnamoorthy said Miss N would benefit from a small dose of Pregabalin in view of the extensive spinal degenerative changes. He said Miss S

had decided to self-manage her pain and he was discharging her back into the care of her GP.

Ms Peers, occupational therapist, 17 June 2015

32. In an open letter, Ms Peers explained that she was an occupational therapist at the CFS/ME clinic which Miss N was attending. She listed the symptoms which Miss N was experiencing and then explained the nature of CFS/ME in general terms. Ms Peers went on the say that Miss N described herself as practically housebound and was only able to leave the house if someone accompanied her. She said Miss N could only walk short distances and struggled to wash, dress and, sometimes, to feed herself. She said Miss N's ability to perform household tasks was very limited and fluctuated.

33. Ms Peers expressed the view that Miss N was currently incapable of sustaining any employment. She said stress around employment could perpetuate the symptoms of CFS/ME because the individual was unable to rest effectively. Ms Peers said Miss N was attending the clinic to manage her condition. She said, because of the nature of the condition, progress was often slow. She said people could achieve some recovery, which improved their quality of life. Ms Peers said someone on the moderate to severe spectrum, such as Miss N, could achieve some recovery but a return to previous levels of function may not be possible.

Joint report by Ms Hesketh, clinical specialist physiotherapist, and Ms Finch, occupational therapist, 18 June 2015

34. Ms Hesketh and Ms Finch provided a report at Miss N's request. They said Miss N had been referred to physiotherapy by a locum consultant rheumatologist, in December 2014, for assessment and treatment of her Fibromyalgia. They outlined the problems which Miss N had reported and said she had scored 75.5 on the Fibromyalgia Impact Questionnaire, which was considered severe impact. They said Miss N had scored 119/150 in a pain disability questionnaire. Ms Hesketh and Ms Finch then explained what treatment Miss N would receive.

Dr Binymin, consultant rheumatologist, 15 July 2015

35. In a letter to Miss N's GP, Dr Binymin said Miss N had features which were highly suggestive of ME and fibromyalgia. He said she had been referred to an ME programme and had received CBT. He said Miss N had attended for physiotherapy but had found it too difficult. Dr Binymin noted that Miss N had applied for early retirement unsuccessfully and that she was feeling very low and frustrated. He said the issue of retirement was very stressful and had compounded Miss N's symptoms.

36. Dr Binymin described Miss N's symptoms and previous medical history. He outlined the results of an examination. Dr Binymin said he thought the most likely diagnosis remained fibromyalgia and ME. He said he had arranged for some tests. He went on to say:

> "… I do not think that she is in a position to maintain a full time job given the level of difficulty that she is facing even at home. She cannot do most of the chores let alone having a job.
>
> I informed [Miss N] … that I am happy to support the diagnosis of ME and fibromyalgia. I am also happy to support a possible phased return or a reduction of hours in the working week. I am pretty certain that she will not be able to perform full time duties on a regular basis. This is based on my assessment today and the fact that she has not been to work for the last 2-3 years. I would therefore, suggest that she would be disadvantaged in the open labour market because of her fibromyalgia and ME and that will be true for the foreseeable future."

Dr Shepherd, August 2015

37. Miss N has submitted copies of an email exchange with Dr Shepherd, Hon. Medical Adviser to the ME Association. In an email to Miss N, Dr Shepherd said that, on the basis of published evidence and reports from people with ME/CFS, the percentage of people who recover and return to full health was small. He said a significant proportion of people with ME/CFS did make some degree of improvement and eventually return to a reasonable level of health. He said this could occur over a prolonged period and may take several years. Dr Shepherd said researchers agreed on three points:-

    - Prognosis was extremely variable but health and functioning rarely recovered completely.
    - Many people who fulfil the criteria for CFS/ME experienced the majority of their improvement relatively quickly.
    - In those who did not recover relatively quickly, the illness had a tendency to become more prolonged and, in a minority, the duration was very long.

38. Dr Shepherd said those who had been affected for several years seemed less likely to recover and full recovery after more than five years was rare. He said:

> "As a rough guideline, my personal view is that an application [for ill health retirement] should normally be given serious consideration if someone has been ill with ME/CFS for around 4 years, has not been able to return to work, is not making any significant progress, and has tried all appropriate forms of management. But there will be exceptions - for example someone who is nearing retirement age, or has other medical problems in addition to ME/CFS."

39. Dr Shepherd referred Miss N to various booklets published by the ME Association. He also referred to information relating to the ME Association's submissions to NICE relating to the effectiveness of CBT and GET.

OH Assist, January 2016

40. NHS BSA quoted the OH Assist doctor in its stage two decision letter. The doctor began by outlining her understanding of the tier 1 and tier 2 conditions. She noted that permanent incapacity was to be assessed by reference to a normal benefit age of 60. She listed the additional medical evidence she had reviewed as follows: the letter, dated 17 June 2015, from Ms Peers; the letter, dated 18 May 2015, from Dr Krishnamoorthy; an MRI scan dated 5 May 2015; the letter, dated 18 June 2015, from Ms Hesketh and Ms Finch; a personal statement by Miss N; and the letter, dated 15 July 2015, from Dr Binyamin.

41. The OH Assist doctor noted Miss N had been absent from work since 2013 due to chronic widespread pain, fatigue and irritable bowel symptoms. She said this condition fell into the category of functional somatic syndrome, including the bowel symptoms. She noted the application form had referred to premature menopause, migraine and asthma. She said there was no evidence that these conditions had a significant adverse effect upon Miss N's fitness to work. The OH Assist doctor noted Miss N received medication for Raynaud's syndrome. She said warm clothing and work indoors would be suitable to ensure the symptoms were not a problem at work.

42. The OH Assist doctor noted Miss N had been referred for specialist therapy for CFS. She said the recommended treatments were GET and CBT. She noted an MRI scan had shown no evidence of a physical source for Miss N's pain. The doctor referred to the reports provided by Ms Peers, Ms Hesketh and Ms Finch, and Dr Binymin. She said none of the reports, except that from Dr Binymin, provided an opinion on long term prognosis for work. The doctor then referred to various statistics relating to recovery rates for sufferers of CFS and fibromyalgia. She expressed the view that current treatment recommendations, GET and CBT, were likely to result in greater improvements than the historical studies indicated. She then referred to two further studies. She noted that NICE recommended CBT, GET and activity management. The doctor said the NICE guidance was now out of date and evidence in support of GET and CBT had since strengthened.

43. The OH Assist doctor referred to two documents which Miss N had submitted: "Why severe Myalgic Encephalomyelitis patients are housebound and bedbound", which indicated that over-exertion could cause death, and "101 reasons why it is wrong to provide CBT and GET to ME patients", which questioned the value of these treatments. The doctor said she did not accept that the content of these documents provided evidence that Miss N would not benefit from these treatments. She said they indicated that Miss N was likely to have false beliefs about possible harm from exercise which would be a barrier to recovery. She said this could be addressed if Miss N attended for GET.

44. The OH Assist doctor concluded that Miss N was currently unfit for her NHS role and was currently severely affected by ME/fibromyalgia. She said recovery was likely over a period of five to ten years, if Miss N was compliant with medical advice. The doctor said she had noted Miss N's difficult personal circumstances but she could not

consider this to be a medical condition. She acknowledged this could have a negative effect on Miss N's mood and mental health functioning but expressed the view that this would respond to CBT and involvement from other services. The doctor concluded:

> "The applicant's job is part-time and clerical in nature and I believe this is an achievable target within the period to age 60, probably within five to ten years. This is in agreement with Dr. Binymin's view that she is unlikely to be fit for full time work in the future. I believe this is supported by the general evidence base for this condition as cited above. The positive factors are her young age, the short duration of her symptoms and the long period of time for her to make recovery. The non-manual and part-time nature of the job are substantial positive factors. Recovery will of course be dependent upon the applicant receiving CBT and GET and learning to implement positive coping strategies for her condition."

Appendix B

The NHS Pension Scheme Regulations 1995 (SI1995/300) (as amended)

45. As at the date Miss N's employment ceased, regulation E2A provided:

"E2A Ill health pension on early retirement

(1) [see above]

(2) [see above]

…

(13) For the purposes of determining whether a member is permanently incapable of efficiently discharging the duties of the member's employment under paragraph (2)(b)(i), the Secretary of State shall have regard to the factors in paragraph (15) (no one of which shall be decisive) and disregard the member's personal preferences for or against engaging in that employment.

(14) For the purposes of determining whether a member is permanently incapable of regular employment under paragraph (2)(b)(ii), the Secretary of State shall have regard to the factors in paragraph (16) (no one of which shall be decisive) and disregard the factors in paragraph (17).

(15) The factors to be taken into account for paragraph (13) are -

(a) whether the member has received appropriate medical treatment in respect of the incapacity;

(b) the member's -

(i) mental capacity; and

(ii) physical capacity;

(c) such type and period of rehabilitation which it would be reasonable for the member to undergo in respect of the member's incapacity, irrespective of whether such rehabilitation is undergone; and

(d) any other matter which the Secretary of State considers appropriate.

(16) The factors to be taken into account for paragraph (14) are -

(a) whether the member has received appropriate medical treatment in respect of the incapacity; and

(b) such reasonable employment as the member would be capable of engaging in if due regard is given to the member's -

(i) mental capacity;

(ii) physical capacity;

(iii) previous training; and

(iv) previous practical, professional and vocational experience,

irrespective of whether or not such employment is actually available to the member;

(c) such type and period of rehabilitation which it would be reasonable for the member to undergo in respect of the member's incapacity (irrespective of whether such rehabilitation is undergone) having regard to the member's -

(i) mental capacity, and

(ii) physical capacity:

(d) such type and period of training which it would be reasonable for the member to undergo in respect of the member's incapacity (irrespective of whether such training is undergone) having regard to the member's -

(i) mental capacity,

(ii) physical capacity,

(iii) previous training, and

(iv) previous practical, professional and vocational experience, and

(e) any other matter which the Secretary of State considers appropriate.

(17) The factors to be disregarded for paragraph (14) are -

(a) the member's personal preference for or against engaging in any particular employment; and

(b) the geographical location of the member.

(18) For the purpose of this regulation -

“appropriate medical treatment” means such medical treatment as it would be normal to receive in respect of the incapacity, but does not include any treatment that the Secretary of State considers -

(a) that it would be reasonable for the member to refuse,

(b) would provide no benefit to restoring the member's capacity for -

(i) efficiently discharging the duties of the member's employment under paragraph (2)(b)(i), or

(ii) regular employment of like duration under paragraph (2)(b)(ii),

before the member reaches normal benefit age; and

(c) that, through no fault on the part of the member, it is not possible for the member to receive before the member reaches normal benefit age;

"permanently" means the period until normal benefit age; and

"regular employment of like duration" means -

(a) …

(b) in all other cases, where prior to retiring from employment that is pensionable the member was employed -

(i) on a whole-time basis, regular employment on a whole-time basis;

(ii) on a part-time basis, regular employment on a part-time basis,

regard being had to the number of hours, half-days and sessions the member worked in that employment."