PO-22843

Ombudsman's Determination

Applicant	Mr E
Scheme	NHS Pension Scheme
Respondent	NHS Pensions

Outcome

1. Mr E's complaint is upheld and, to put matters right, NHS Pensions shall allow him a further opportunity to appeal and pay him £500 for significant non-financial injustice.

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

Complaint summary

3. Mr E has complained that his application for the early payment of his pension on the grounds of ill health has not been considered in a proper manner.

Background information, including submissions from the parties

4. Mr E's employment was terminated on the grounds of ill health on 21 October 2015. He applied for the early payment of his benefits in November 2015.

5. The relevant regulations are The National Health Service Pension Scheme Regulations 2015 (SI2015/94) (as amended). Extracts from the relevant regulations are provided in Appendix 1. There are two tiers of ill health retirement benefits provided for under the regulations. In order to receive any ill health retirement benefits, the member must meet the Tier 1 conditions. In order to receive Tier 2 benefits, the member must meet both the Tier 1 and Tier 2 conditions.

6. First instance decisions are made by NHS Pensions' medical advisers under delegated authority. In November 2015, this was OH Assist. It wrote to Mr E, on 11 November 2015, informing him that his application had not been accepted. OH Assist quoted from the medical adviser who had reviewed Mr E's case:

> "This is an initial application for the early payment of deferred benefits on the grounds of ill health …

> Consideration of this application requires a determination of whether there is a physical or mental infirmity which gives rise to permanent incapacity for regular employment of like duration (regard being had to the number of hours, half days and sessions the applicant worked in their last NHS employment).
>
> Permanent incapacity is assessed by reference to the normal benefit age of 60 years."

7. The medical adviser said he/she had considered information provided by Mr E's consultant ENT specialist, Mr Harris, in form AW 240, and advice from an occupational physician, Dr Haq, dated June 2015. He/she went on to say that the medical evidence did not indicate that Mr E had a physical or mental infirmity which made him permanently incapable of regular employment of like duration. The medical adviser said:

> "[Mr E] has been suffering from right endolymphatic hydrops. This condition started in 2010 and has been associated with dizziness and mild fluctuating right sided hearing loss. He has difficulty to mobilise. He was advised by the ENT specialist to reduce salt in his diet and on the benefit of balance therapy, which should improve his condition; his prognosis is good.
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> According to … Dr Haq, he is unfit for his current role as maybe unsafe when seeing patients one-to-one. [Mr E] suggested that he would be willing to explore job roles in ICT. Dr Haq advised that a sedentary, non-patient facing role would be more suitable for him and recommended redeployment.
>
> Dr Haq indicates that Ill Health Retirement would not be appropriate currently as [Mr E] has not explored and availed all the available treatment options. This type of condition can also resolve spontaneously.
>
> The evidence provided indicates that the applicant's condition should resolve with further treatment and is unlikely to be a barrier permanently affecting his ability to undertake regular employment of like duration."

8. Summaries of and extracts from the medical evidence relating to Mr E's case are provided in Appendix 2.

9. Mr E appealed this decision on 2 February 2016. On 14 March 2016, NHS Pensions acknowledged his appeal. It also wrote to his former employer explaining that he should have been considered for "in service" ill health retirement. NHS Pensions requested details of Mr E's absence record, any occupational health doctors' reports and Mr E's job description. It chased up this information on 28 July 2016 and informed Mr E it had done so.

10. NHS Pensions followed up its request for information again on 1 November 2016 and informed Mr E it had done so. Mr E wrote to NHS Pension on 6 February 2017. He set out what he considered to be errors within his employer's termination process. NHS Pensions contacted Mr E's employer again on 1 and 3 March 2017. It wrote to

Mr E on 3 March 2017 to update him. Mr E's employer informed NHS Pensions it had not received its email of 1 March 2017.

11. Mr E emailed his employer, on 21 June 2017, asking it to prioritise the request for information. In response, his employer informed him it had responded to NHS Pensions and was not aware of any outstanding request. Mr E forwarded this email exchange on to NHS Pensions. It telephoned Mr E's employer acknowledging receipt of information on 23 March 2017. NHS Pensions said it had tried to contact the employer on 20 April 2017 and had left a message. It agreed to put the outstanding request for information in an email. NHS Pensions wrote to Mr E, on 23 June 2017, saying it was awaiting a copy of his job description from his former employer.

12. Mr E contacted NHS Pensions, on 5 July 2017, asking if it now had the information it needed. He also provided a copy of a job description for his last position. On 19 July 2017, NHS Pensions informed Mr E that his employer had confirmed that the job description he had provided was relevant.

13. On 2 August 2017, NHS Pensions issued a stage one decision under the two-stage internal dispute resolution (**IDR**) procedure. NHS Pensions apologised for the length of time taken to provide a decision and said this was because of making extensive enquiries with Mr E's employer and waiting for comments from its medical advisers. NHS Pensions also explained that it had asked its medical advisers to consider Mr E's case on the basis of a retrospective application for ill health retirement, rather than early payment of his deferred benefits.

14. NHS Pensions said it was unable to accept that Mr E was permanently incapable of carrying out his former duties and his appeal had been unsuccessful. It quoted from its medical adviser.

15. The medical adviser began by confirming that he/she had not previously been involved in Mr E's case. He/she then summarised the eligibility requirements for Tier 1 and Tier 2 benefits and said permanent incapacity was assessed by reference to a normal benefit age of 67. The medical adviser said he/she had been asked to advise whether the evidence submitted with the initial application would have resulted in support for ill health retirement. He/she listed the medical evidence considered and noted that some of it post-dated Mr E's original application. The medical adviser went on to say:

> "Reviewing the previous evidence provided I note that [Mr E] had a history of right sided endolymphatic hydrops causing him dizziness, loss of balance and fluctuating hearing loss. This appears to have been ongoing since 2010 with intermittent periods of his symptoms being more severe than at other times. Mr Harris … had indicated … that it was felt that [Mr E's] prognosis would be good with balance therapy.
>
> Reviewing the Occupational Health reports I do note that it was indicated that [Mr E] was unfit for his current role … but it was deemed that he would be fit to consider some form of redeployment … It was also felt at the time by the

> Occupational Health Physician that ill health retirement would not be appropriate because [Mr E] had not explored and availed himself of all the available treatment options. I would agree that even if the application had been made on AW33E the evidence suggested at the time that [Mr E's] prognosis was good and that permanency had not been established in particular as there was further treatment that had not been explored including balance therapy, transtympanic steroid injection, further vestibular or tinnitus therapy including the use of tinnitus masking agents and surgical intervention which would be available and on the balance of probabilities would result in a significant improvement in [Mr E's] condition such that he could be capable of undertaking his substantive duties for which he was employed in the NHS …
>
> I note also that [Mr E] has submitted further evidence … dated 24th April 2017, which again outlines [Mr E's] ongoing difficulties … Again it is indicated that there is further intervention and treatment that [Mr E] would benefit from including the repeat steroid injection (he has undergone one initial steroid injection in June 2016 I understand), further surgical options, as well as vestibular or tinnitus therapy including the use of tinnitus masking agents.
>
> Reviewing [Mr E's] personal statement, I note that he has indicated that he does not wish to pursue further medical intervention as he is concerned about the potential effects on the hearing to his right side.
>
> Clearly that is [Mr E's] decision as to whether the potential risks are acceptable to him or not. The evidence is however that it is likely on the balance of probabilities that [Mr E] would recover sufficiently to be able to resume his substantive role."

16. NHS Pensions said it could see no reason to disagree with its medical adviser's conclusions.

17. Mr E submitted a further appeal on 13 September 2017. He also submitted a report from a hearing and balance therapist, Mr Wood, dated 9 August 2017. NHS Pensions issued its stage two IDR decision on 1 May 2018. The decision had been delayed whilst NHS Pensions' medical advisers sought further information from Mr Harris.

18. In its stage two decision letter, NHS Pensions quoted the advice it had received from its own medical adviser. The medical adviser began by confirming that he was required to provide advice as to whether Mr E was likely to have met the Tier 1 conditions at the time he left employment in October 2015 and, if so, whether he also met the Tier 2 conditions. He noted that permanent incapacity was to be assessed by reference to a normal benefit age of 67. He listed the medical reports considered and noted that some of these post-dated Mr E's last day of service. He noted that changes in Mr E's condition after he left employment were not relevant. The medical adviser explained that he had taken into consideration those elements of such reports which related to or provided insight into Mr E's condition at the relevant time.

19. The medical adviser said that the evidence indicated that, at the time his employment ceased, Mr E had been unfit for his normal role and regular employment of like duration. He said the question was whether this incapacity was likely to be permanent. The medical adviser said the natural history of Meniere's Disease was for it to resolve spontaneously. He referred to Mr Harris' report (see Appendix 2) and a comment that 50% of cases resolved within two years and 70% resolved after eight years. He acknowledged that it was not clear whether Mr Harris was referring specifically to the probability of improvement in 2010 (diagnosis) or 2015. He noted that Mr Harris was responding to specific questions and said, therefore, he had inferred that the response related to Mr E's situation in 2015. He said this would be consistent with earlier advice from Mr Harris that Mr E's prognosis was good.

20. The medical adviser also said:

> "Since, at the time [Mr E] left employment, he still had almost 19 years remaining before he reached scheme pension age, such improvement was likely to have occurred before [Mr E] reached pension age, Therefore, in my opinion, on balance of probability, at the time [Mr E] left employment, even in the absence of future treatment, his incapacity was unlikely to have been permanent.
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> … It is most unfortunate that [Mr E's] symptoms have not improved as Mr Harris anticipated and that there has been no response to subsequent treatment. I note from Mr Harris' last two reports that he does now regard [Mr E's] disability as being permanent. While I sympathise with [Mr E's] difficulties, the fact that [Mr E's] illness has not followed the course that was expected in October 2015 is not relevant to whether the scheme criteria were met at that time …"

21. The medical adviser then noted that Mr E had raised a concern with Mr Harris' report because of a factual error. He said Mr Harris had been asked to clarify as follows:-

    - It was his understanding that there was a 50% probability of Mr E's condition resolving within two years and a 70% probability of resolution within eight years as at October 2015. Was that correct?
    - Did Mr E receive a intratympanic steroid injection in June 2015; not October 2016 as stated?
    - Did this alter his opinion as to Mr E's prognosis was likely to have been in October 2015?

22. The medical adviser said Mr Harris had confirmed his understanding of the references to the probability of resolution. He said Mr Harris had acknowledged the factual error relating to the date of Mr E's intratympanic steroid injection but had confirmed that this did not affect his opinion as to the likely prognosis in October 2015.

23. NHS Pensions said it saw no reason to disagree with its medical adviser's conclusions and declined Mr E's appeal.

Mr E's position

24. Mr E submits:-

- NHS Pensions has departed from the Scheme's regulations and misinterpreted the Pensions Act 1995.
- It has failed to acknowledge confirmation of the permanency of his medical condition as detailed in medical evidence from his specialist.
- The reference to his prognosis being good with balance therapy has been ascribed an imbalanced and disproportionate importance or greater value than the confirmation of permanency (as required by the Act) without a proper explanation.
- His former employer dismissed him without a proper assessment of his entitlement to ill health retirement. His employer knew very little of his condition at the time of his dismissal. The decision not to grant ill health retirement was based on incomplete medical records. He was not given clear reasons for the decision or advised of his right of appeal.
- Mr Harris' observation that prognosis would be good with balance therapy does not give much detail. He failed to indicate the type of symptoms experienced or give a timeframe for improvement.
- Permanency cannot be ruled out when symptoms are in quiescence and could occur later without warning. A good prognosis does not rule out permanence because some symptoms are permanent whilst others improve.
- A condition can be permanent and have a good prognosis; as is often the case with Meniere's Disease.
- The comment regarding a good prognosis appears to conflict with reports from Mr Harris, in September 2017 and March 2018, confirming that the condition is permanent. It also conflicts with Mr Wood's report in August 2017.
- Whilst it is for NHS Pensions to determine how much weight to ascribe to any piece of evidence, it must give clear reasons for doing so.
- It should not accept the advice it receives from its medical advisers blindly and should satisfy itself that there are no factual errors.
- At the time Mr Harris made his comment about a good prognosis, he had been undergoing balance therapy for five years with little effect. His tinnitus had been ongoing for six months and should have been classed as chronic and long term.

- Both the occupational health service and Mr Harris considered that he would be unsafe to see patient on a one-to-one basis.
- No report was sought from his GP, who is very familiar with his case.
- NHS Pensions' medical adviser failed to obtain a full description of his medical condition from his specialist.
- There is clear evidence in the medical literature to suggest that tinnitus and Meniere's Disease are permanent conditions. He cites information from the Meniere's Society website, a consultant ENT surgeon's website, NHS Direct and the Express website.
- He decided not to pursue certain treatment options because he did not consider the risks acceptable. He has not been asked the right questions to establish his reasons for refusing treatment.
- NHS Pensions was not required to look at evidence relating to new conditions or a deterioration in existing conditions. Evidence which post-dated the termination of his employment was noted but no indication was given as to whether it was considered relevant or not.
- Mr Harris was asked to give a prognosis for October 2015 some two and a half years later. His recall of events must be less accurate after this time. Mr Harris did not conduct a face to face assessment, questionnaire, or any other type of assessment in October 2015. He had only seen Mr Harris on two occasions; the last was in June 2015.
- He was not made aware of the probability of resolution percentages until March 2018 and was not given the opportunity to appeal.
- A 70% rate of improvement does not rule out permanence because recovery does not mean the complete absence of symptoms.
- Mr Harris referred to a 70% probability of resolution after eight years; whereas NHS BSA's medical adviser referred to a 70% probability of resolution within eight years.
- Statistical probabilities of resolution have been given presidency in his case, over a detailed assessment.
- NHS Pensions should have asked its medical advisers to comment on the likely efficacy of any treatment options. Mr Harris was not asked to give an opinion on outstanding treatment options.
- There was an unacceptable delay in dealing with his appeal at stage one. This resulted in an unnecessary financial burden because he had been declined Personal Independence Payments.

- The failure by NHS Pensions to reach its decision in a proper manner has caused him additional stress at a difficult time and this should be recognised.

NHS Pensions' position

25. NHS Pensions submits:-

- It has declined Mr E's application for ill health retirement benefits because it is of the view that he is not permanently incapable of efficiently discharging the duties of his NHS employment (the Tier 1 condition).
- It is of the view that, as at the date his employment terminated, it could have been expected that Mr E would recover sufficiently to allow a return to his former role.
- It has taken all relevant evidence into account and nothing irrelevant. It has taken advice from appropriate sources, considered and accepted that advice, and come to a decision which it believes is not perverse.
- Its medical advisers' recommendations are based upon the correct interpretation of the relevant regulations and take account of relevant evidence.
- Its medical advisers are not experts in the particular medical condition under consideration, but they are specially trained occupational health physicians. They undertake a forensic analysis of the medical evidence and consider it against the requirements of the Scheme regulations.
- The fact that Mr E does not agree with its decision or the weight it has attached to any of the evidence does not mean that its decision-making process was flawed.
- There was a delay in issuing the stage one IDR decision because it did not receive the requested information from Mr E's former employer until July 2017.
- It accepts that it would be appropriate for Mr E be given a further opportunity to appeal the decision not to award a pension under regulation 90.

Adjudicator's Opinion

26. Mr E's complaint was considered by one of our Adjudicators who concluded that further action was required by NHS Pensions. The Adjudicator's findings are summarised below:-

- Mr E's entitlement to the early payment of his pension due to ill-health had to be determined by reference to the Scheme regulations. The Scheme regulations determined the circumstances in which he was eligible for early payment of his pension, the conditions which he had to satisfy and, to an extent, the way in which decisions about ill-health benefits had to be taken.

- Mr E's initial application was for the early payment of his deferred benefits on the grounds of ill health (regulation 94). It was on this basis that OH Assist assessed his eligibility for payment of his pension. However, NHS Pensions subsequently determined that Mr E's application should be treated as a retrospective application for immediate payment of his pension on cessation of his NHS employment.

- In view of this, the relevant regulations were 90 and 91 (see Appendix 1). Regulation 90 sets out the conditions which Mr E had to satisfy in order to receive ill health retirement benefits; the Tier 1 and Tier 2 conditions. In order to receive any ill health retirement benefits, Mr E had to satisfy the Tier 1 conditions. In particular, he had to be suffering from a physical or mental infirmity as a result of which he was permanently incapable of efficiently discharging the duties of his former NHS employment. Permanently meant the incapacity was likely to last at least to normal pension age.

- In order to receive his pension under regulation 90, Mr E had to satisfy the Tier 1 conditions at the time his NHS employment ceased in October 2015. In other words, at the time Mr E's employment ceased, it must have been considered unlikely that he would recover sufficiently before normal pension age to be capable of undertaking his former role.

- Under regulation 90(2)(c), it was for NHS Pensions, acting on behalf of the scheme manager[1], to satisfy itself that Mr E met the Tier 1 conditions in October 2015. If it was satisfied that Mr E met the relevant conditions, he was entitled to immediate payment of his pension.

- The Scheme regulations themselves did not require NHS Pensions to seek an opinion from a registered medical practitioner. Paragraph 15 of Part 6 of Schedule 3 (see Appendix 1) provided NHS Pensions with the discretion to delegate decisions to a medical practitioner or a body which employed medical practitioners. It also provided NHS Pensions with the discretion to require a member to submit to a medical examination.

- NHS Pensions had delegated first instance decisions to its medical advisers. Although not specifically required to do so, it also took advice from its medical advisers when reviewing decisions under the IDR procedure. In the Adjudicator's view, this was in accordance with the Scheme regulations and good practice.

- One of the specific obligations on decision-makers was to consider all relevant information which was available to it and ignore all irrelevant information. However, the weight which was attached to any of the evidence was for the decision-maker to determine (including giving some of it little or no weight[2]). It

[1] The Secretary of State
[2] *Sampson v Hodgson* [2008] All ER (D) 395 (Apr)

was open to NHS Pensions to prefer evidence from its own advisers; unless there was a cogent reason why it should not have or should not have without seeking clarification. For example, an error or omission of fact or a misunderstanding of the relevant regulations by the medical adviser.

- In its first instance decision, OH Assist concluded that Mr E did not satisfy the eligibility conditions for the early payment of his deferred benefits. Although NHS Pensions subsequently determined that Mr E's case should be treated as a retrospective application under regulation 90, it was not inappropriate for OH Assist to process his application as a request for early payment of his deferred pension at the time. This was the nature of the application it had received.

- At stage one and two of the IDR procedure, Mr E's application was assessed by reference to the conditions set out in regulation 90. Having reviewed the advice provided for NHS Pensions, the Adjudicator was of the view that its medical advisers were aware of and applied the correct regulatory requirements. In addition, they were aware that they were required to consider what the position would have been in October 2015; when Mr E ceased his NHS employment. She was also of the view that they had taken appropriate steps, in seeking an opinion from Mr Harris, to obtain relevant evidence on which to base a decision. She noted Mr E's comment that no report was sought from his GP. There was no specific requirement for such a report to be obtained.

- With regard to factual errors, Mr E highlighted an incorrect date in Mr Harris' 2018 report. Clarification was sought from Mr Harris and he confirmed that this did not affect his opinion. In the Adjudicator's view, appropriate action was taken to address this matter.

- Mr E argued that NHS Pensions and its medical advisers had failed to acknowledge the permanency of his medical condition, as detailed in medical evidence from his specialist. He also considered that the reference to his prognosis being "good with balance therapy" had been given a disproportionate importance. He argued that a condition could be permanent and have a good prognosis and he suggested this was the case with Meniere's Disease.

- The Adjudicator clarified that the question to be addressed by NHS Pensions and its medical advisers was whether or not Mr E's incapacity for efficiently discharging the duties of his former NHS employment was permanent. This was not quite the same as asking whether or not the medical condition from which he was suffering was permanent. It might be that an individual was suffering from a permanent medical condition, but their capacity for employment was expected to improve over time.

- Mr E argued that Mr Harris' comment concerning his prognosis lacked detail and a timeframe. He had pointed out that Mr Harris had not undertaken an

assessment of his condition in October 2015. He had suggested that, by the time Mr Harris was asked for an opinion, his recollection could not be relied upon.

- The Adjudicator acknowledged that Mr Harris' comment concerning prognosis was brief and did not give a timeframe. However, he was responding to a request for a prognosis to normal pension age. It would not be unreasonable to infer, therefore, that this was the timeframe he had in mind.

- With regard to the elapse of time between seeing Mr E and giving an opinion, this was largely a matter for Mr Harris' professional judgment. The Adjudicator noted that Mr Harris had completed form AW 240 on 12 October 2015 and Mr E said he had not seen him since June 2015. Clearly, Mr Harris had been content to complete the form on that basis. She did not consider that it was inappropriate for NHS Pensions or its medical advisers to then take account of Mr Harris' opinion.

- Mr E was of the view that Mr Harris' comment, in October 2015, was at odds with the reports he provided in 2017 and 2018, which he considered confirmed the permanence of the condition in question. He also considered it at odds with the report from Mr Wood in 2017. However, in 2018, Mr Harris was specifically asked to give a retrospective opinion as to the expected probability of Mr E's condition resolving as at October 2015. He had commented that, at that time, there was a 50% probability of Mr E's condition resolving within two years and a 70% probability of resolution after eight years. The Adjudicator did not consider this to be inconsistent with his October 2015 prognosis. Mr Wood's report related to the position in 2017 and did not comment on what might have been expected in 2015.

- The Adjudicator noted Mr E had highlighted the difference between Mr Harris' reference to 70% resolution after eight years and the medical adviser's quote of resolution within eight years. She did not consider this to have unduly impacted on the outcome of his case since the period under consideration was nearly 19 years; to Mr E's normal pension age of 67.

- Mr E had argued that NHS Pensions should have asked the medical advisers to comment on the likely efficacy of any treatment options. The Adjudicator said she understood him to be referring to the opinion provided by the OH Assist medical adviser in relation to the first instance decision.

- The Adjudicator said she would agree that, if it was the case that a medical adviser considered that there were outstanding treatment options, then it was necessary for an assessment of their likely efficacy to be made. It was not sufficient simply to identify that there were outstanding treatment options. In Mr E's case, the medical adviser had said that his "condition should resolve with further treatment and is unlikely to be a barrier permanently affecting his ability to undertake regular employment of like duration". In the Adjudicator's view,

this did represent an assessment of efficacy; inasmuch as the medical adviser was expressing the view that the treatment was likely to improve Mr E's condition sufficiently for him to undertake regular employment of like duration to his NHS employment. It would, however, have been helpful if the medical adviser had specified the treatment he had in mind.

- Having said this, the Adjudicator noted that at stage one of the IDR procedure the medical adviser had referred to specific treatment. This included "balance therapy, transtympanic steroid injection, further vestibular or tinnitus therapy including the use of tinnitus masking agents and surgical intervention".

- The Adjudicator noted also that the final advice NHS Pensions had received was that, at the time he left employment, Mr E's incapacity was unlikely to have been considered permanent even in the absence of future treatment. The failure to give specific details of future treatment options in the initial decision was unlikely to have impacted on the eventual outcome of Mr E's case.

- NHS Pensions and its medical advisers had to follow proper procedure when making decisions about ill-health benefits. However, not all procedural failings would mean that the decision could not be allowed to stand. For example, if procedural failings occurred at an early stage in the process and the impact of the failing was corrected later, the Ombudsman might take the view that the procedural failings did not invalidate the decision. The Adjudicator was of the view that this was the case here.

- Mr E disagreed with the weight which NHS Pensions and its medical advisers had attached to the statistical probability of his condition resolving before his normal pension age. He did, however, acknowledge that it was for NHS Pensions to determine what weight to attach to any of the evidence. However, Mr E also made the point that he had only became aware of this information at stage two of the IDR procedure and had not had an opportunity to appeal.

- Because his application had been initially treated as a request for early payment of deferred benefits, Mr E had only had the opportunity to appeal the decision not to pay a pension under regulation 90 on one occasion. He would normally have had two opportunities for appeal. In the Adjudicator's view, Mr E should have been given a further opportunity to appeal the regulation 90 decision. In her view, Mr E's complaint could be upheld to this extent.

- Mr E had also highlighted the time taken for NHS Pensions to consider his case at stage one of the IDR procedure. Mr E had submitted his appeal in February 2016 and NHS Pensions issued a decision in August 2017; some 18 months later. The Adjudicator acknowledged that NHS Pensions had explained that it had been waiting for information from Mr E's former employer and its medical advisers. The main issue appeared to have been in establishing the grounds on which Mr E's employment was terminated.

- Although NHS Pensions was reliant on an outside source for this information, it was difficult to conclude that more could not have been done to obtain the information it required sooner. The delay would have caused Mr E additional distress at an already distressing time. In the Adjudicator's view it would be appropriate for this to be recognised.

27. NHS Pensions did not fully accept the Adjudicator's Opinion and the complaint was passed to me to consider. I agree with the Adjudicator's Opinion and I will therefore only respond to the key points made by NHS Pensions for completeness.

Ombudsman's decision

28. When someone complains that they have not been awarded the ill health pension they think they should get, my prime concern is with the way in which the decision has been reached. It is not my role to review the medical evidence and come to a decision of my own as to whether or not Mr E should be awarded an ill health pension.

29. Among other things, I will look at whether the decision-maker has obtained appropriate evidence upon which to base its decision. I will consider whether or not the relevant regulations have been applied correctly. And I will consider whether or not the decision reached is supported by the available relevant evidence.

30. In Mr E's case, appropriate steps were taken to obtain the relevant evidence, including evidence from his treating specialist, Mr Harris. In addition, steps were taken to clarify matters with Mr Harris when there was ambiguity or error within the medical evidence.

31. I acknowledge that Mr E disagrees with the conclusions drawn by NHS Pensions' medical advisers. So far as their medical opinions are concerned, the medical advisers do not come within my jurisdiction. They are answerable to their own professional bodies and the General Medical Council. My concern is with deciding whether or not there was any reason why the decision-maker should not have relied on the advice given; such as an error or omission of fact or a misunderstanding of the Scheme's regulations.

32. Mr E did identify an incorrect date in Mr Harris' 2018 report. Clarification was sought from Mr Harris and I find that this was an appropriate and proportionate response. Mr E's other issues with the reports provided by NHS Pensions' medical advisers are, essentially, differences of opinion. He disagrees with the way in which certain information has been interpreted or the weight which has been placed on it. A difference of opinion is not sufficient for me to find that the decision-makers should not have relied on the advice in question.

33. Throughout the process, the decision-makers and their advisers have sought to determine whether or not Mr E's incapacity is, more likely than not, going to be permanent. As mentioned by the Adjudicator, this is a slightly different question to

asking whether or not Mr E's medical condition is permanent. It is the likely duration of his incapacity for employment which is the key issue in deciding his eligibility for a pension under regulation 90.

34. In relation to the original decision, OH Assist looked at whether or not it was likely that Mr E would be capable of regular employment of like duration (regard being had to the number of hours, half days and sessions he had worked in his last NHS employment). This is the condition which must be met for early payment of a deferred pension. Regulation 90, which applies to retirement from active service, provides for two sets of conditions: the Tier 1 conditions and the Tier 2 conditions. These require the additional assessment of Mr E's capacity to discharge the duties of his former NHS employment.

35. Mr E's application for a pension had been submitted to OH Assist on the basis that this was an application for payment of his deferred pension. Arguably, it was therefore appropriate for it to proceed on the basis of assessing it as such. However, at the first stage of Mr E's appeal, NHS Pensions identified the fact that he could make a retrospective claim for ill health retirement from active service. There is no obvious reason why this could not have been picked up by OH Assist from the initial application. I find, however, that this oversight was addressed on appeal; inasmuch as both appeal reviews assessed Mr E by reference to the requirements of regulation 90.

36. Apart from the exception referred to in paragraph 35 above, I consider the decision-making process in Mr E's case to have been carried out in a proper manner. However, the consequence of his case having started off as a request for payment of his deferred pension is that Mr E has only had an opportunity to appeal the regulation 90 decision on one occasion; he would normally have had two opportunities to appeal. I find that Mr E should have been offered a further appeal option. I note that NHS Pensions accepts this and I need not make any further directions concerning this aspect of Mr E's complaint.

37. It remains for me to consider the time taken to deal with Mr E's appeal. It took from February 2016 to August 2017 for NHS Pensions to deal with the first stage; a period of 18 months. It has explained that it was waiting for information from Mr E's former employer. I am not unfamiliar with the problems which can arise in trying to obtain information from a third party. However, the correspondence indicates that there were several occasions during this time when little or nothing was being done by NHS Pensions.

38. I find that, on this occasion, NHS Pensions has acted with a lack of appropriate urgency. This is particularly regrettable when a case relates to ill health retirement because the applicant is likely already to be experiencing a high level of distress. I find that this lack of urgency in Mr E's case amounts to maladministration and, as a consequence, he will have experienced significant distress and inconvenience. I uphold this aspect of his complaint.

Directions

39. Within 21 days of the date of this Determination, NHS Pensions shall pay £500 to Mr E for the significant distress and inconvenience which he has suffered.

Anthony Arter

Pensions Ombudsman
1 July 2019

Appendix 1

The NHS Pension Scheme Regulation 2015 (SI2015/94) (as amended)

40. As at the date Mr E's employment ceased, regulation 90 provided:

"(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 has not attained normal pension age;

(b) M has ceased to be employed in NHS employment;

(c) the scheme manager is satisfied that M suffers from a physical or mental infirmity as a result of which M is permanently incapable of efficiently discharging the duties of M's employment;

(d) M's employment is terminated because of the physical or mental infirmity; and

(e) M claims payment of the pension.

(3) The Tier 2 conditions are that -

(a) the Tier 1 conditions are satisfied in relation to M; and

(b) the scheme manager is also satisfied that M suffers from a physical or mental infirmity as a result of which M is permanently incapable of engaging in regular employment of like duration.

(4) ...

(5) In paragraph (3)(b), **"regular employment of like duration"** means -

(a) …

(b) in any other case, where prior to ceasing NHS employment, M was employed -

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

(ii) on a part-time basis, regular employment on a part-time basis, regard being had to the number of hours, half days and sessions M worked in the employment …"

41. Regulation 91 provided:

> "(1) For the purpose of determining whether a member (M) is permanently incapable of discharging the duties of M's employment efficiently, the scheme manager must -
>
> (a) have regard to the factors in paragraph (2), no one of which is to be decisive; and
>
> (b) disregard M's personal preference for or against engaging in the employment.
>
> (2) The factors mentioned in paragraph (1)(a) are -
>
> (a) whether M has received appropriate medical treatment in respect of the infirmity;
>
> (b) M's mental capacity;
>
> (c) M's physical capacity;
>
> (d) the type and period of rehabilitation it would be reasonable for M to undergo in respect of the infirmity, regardless of whether M has undergone the rehabilitation; and
>
> (e) any other matter the scheme manager thinks appropriate.
>
> (3) For the purpose of determining whether M is permanently incapable of engaging in regular employment of like duration as mentioned in paragraph (3)(b) of regulation 90, the scheme manager must -
>
> (a) have regard to the factors in paragraph (4), no one of which is to be decisive; and
>
> (b) disregard the factors in paragraph (5).
>
> (4) The factors mentioned in paragraph (3)(a) are -
>
> (a) whether M has received appropriate medical treatment in respect of the infirmity;
>
> (b) such reasonable employment as M would be capable of engaging in if due regard is given to -
>
> (i) M's mental capacity;
>
> (ii) M's physical capacity;
>
> (iii) M's previous training; and
>
> (iv) M's previous practical, professional and vocational experience,

irrespective of whether or not such employment is available to M.

(c) the type and period of rehabilitation it would be reasonable for M to undergo in respect of the infirmity, regardless of whether M has undergone the rehabilitation, having regard to -

(i) M's mental capacity; and

(ii) M's physical capacity;

(d) the type and period of training it would be reasonable for M to undergo in respect of the infirmity, regardless of whether M has undergone the training, having regard to -

(i) M's mental capacity;

(ii) M's physical capacity;

(iii) M's previous training; and

(iv) M's previous practical, professional and vocational experience; and

(e) any other matter the scheme manager thinks appropriate.

(5) The factors mentioned in paragraph (3)(b) are -

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

(b) the geographical location of M.

(6) In this regulation -

"appropriate medical treatment" means such medical treatment as it would be normal to receive in respect of the infirmity, but does not include any treatment that the scheme manager considers -

(a) that it would be reasonable for M to refuse;

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

(i) discharging the duties of M's employment efficiently for the purposes of paragraph (2)(c) of regulation 90; or

(ii) engaging in regular employment of like duration for the purposes of paragraph (3)(b) of that regulation;

(c) that, through no fault on the part of M, it is not possible for M to receive before M reaches normal pension age.

"permanently" means until M attains M's prospective normal pension age; and

“regular employment of like duration” has the same meaning as in regulation 90.”

42. Paragraph 14 in Part 6 of Schedule 3 provides:

“(1) Except as otherwise provided by these Regulations, any question arising under this scheme is to be determined by the scheme manager.

(2) Any such disagreement as is referred to in section 50 of the 1995 Act (resolution of disputes) must be resolved by the scheme manager in accordance with any arrangements applicable under that section.”

43. Paragraph 15 provides:

“(1) The scheme manager may make arrangements for functions under this scheme in relation to decisions to which sub-paragraph (2) applies that are exercisable by the scheme manager to be discharged by -

(a) a medical practitioner (whether practising alone or as part of a group) whom the scheme manager has approved to act on the scheme manager's behalf; or

(b) a body (incorporated or unincorporated) which -

(i) employs medical practitioners (whether under a contract of service or for services); and

(ii) is so approved.

(2) This paragraph applies to a decision as to a person's health or degree of physical or mental infirmity that is required for the purposes of this scheme and, in particular, a decision required for the purposes of -

(a) …

(c) regulation 90(2)(c) or (3)(b) (early retirement on ill health: active members); …

(3) In relation to such a decision, the scheme manager may require a person entitled or claiming to be entitled to benefit under this scheme to submit to a medical examination by a medical practitioner selected by the scheme manager.

(4) The scheme manager must also offer the person an opportunity to submit a report from the person's own medical adviser following an examination of the person by the medical adviser.

(5) In taking a decision mentioned in sub-paragraph (1), the scheme manager must take into consideration both -

(a) the report mentioned in sub-paragraph (4); and

(b) the report of the medical practitioner who carries out the medical examination mentioned in sub-paragraph (3).”

Appendix 2

Medical evidence

Occupational Health and Wellbeing Service

44. Mr E was assessed at the Occupational Health and Wellbeing Service on a number of occasions from October 2013 to June 2015. In 2013, they advised that Mr E was able to return to work. In December 2014, they advised that Mr E was unable to work in his then current role. Mr E was seen by the Occupational Health and Wellbeing Service in March, April, May and June 2015. The advice remained that he was unable to work in his then current role. On 30 June 2015, Dr Haq said:

> "… [Mr E] confirms that he went off sick initially due to what he believes to have been PTSD and thereafter developed symptoms of Endolymphatic hydrops, an ear condition which gives rise to symptoms of dizziness, imbalance and tinnitus. Since the onset of these symptoms as of early March he has found it hard to manage and feels it is affecting his mood. Clearly he is unfit for his current role as he may be unsafe when seeing patients on a one-to-one.
>
> We discussed what options there maybe for a return to work. He advised me that he has ICT skills (networking) and would be willing to explore potential job roles in ICT. In my opinion, a sedentary role, non patient facing would be more suitable than his current role. Hence I would suggest redeployment to this type of role would be beneficial …
>
> I do not feel Ill Health retirement would be appropriate currently as [Mr E] has not explored and availed all the available treatment options. This type of condition can also resolve spontaneously."

Mr Harris, consultant ENT surgeon, 12 October 2015

45. Dr Harris competed Part 2 of the application form (AW 240). He said Mr E had been diagnosed with right endolymphatic hydrops. He gave a date of onset of 2010 and said it caused dizziness and fluctuating hearing loss. He said it was currently worse for Mr E in the mornings. With regard to prognosis, Dr Harris said:

> "Good prognosis with balance therapy."
>
> "Mild swimming sensation [?] should respond to balance therapy. Used to have episodes [?] → now [?]
>
> Mild ® hearing impairment."

Ms Flowerday, hearing therapist, 1 February 2016

46. Ms Flowerday said Mr E had been referred to the tinnitus clinic in November 2015. She said his pre-therapy tinnitus functional score had been 78%, which she said was in the "very big" problem category. She said Mr E's condition led to variable tinnitus in

tone and intensity and he experienced sudden exacerbations; it was more intrusive in quiet situations. Ms Flowerday said Mr E was participating in a recommended tinnitus therapy programme, but the unpredictability of his episodes made progress more difficult. She said Mr E's symptoms had made a big impact on his daily functioning and increased his anxiety. She said it was difficult to predict progress.

Mr Amin, specialist registrar, 24 April 2017

47. In a letter to Mr E's GP, Mr Amin said Mr E had not noticed much change in his symptoms of imbalance and he still had right-sided tinnitus. He said he had explained the options available, including repeat steroid injection and surgery, and the high risk of hearing loss with these. He said Mr E was not keen to undergo either option. Mr Amin said he had also explained the option of further tinnitus therapy, but Mr E felt he had explored these options as much as he would like to at that time.

48. Mr Amin referred to Mr E's concern about financial instability due to his difficulty in finding work and said he had suggested he visit the GP and local job centres. He said Mr E appeared keen to work.

49. Mr Amin said he was discharging Mr E into the care of his GP.

Mr Wood, hearing and balance therapist, 9 August 2017

50. Mr Wood said he had first seen Mr E in 2010 for a balance retraining therapy (**BRT**) programme. He said Mr E had since been diagnosed with Meniere's Disease. He went on to describe Mr E's symptoms.

51. Mr Wood said that, for people with Meniere's Disease, BRT could only help to control and limit the symptoms, rather than offer a permanent solution. He said that, although Mr E had made a small amount of progress over the past seven years, his balance was still extremely poor. He said that, in addition, Mr E was in a constant state of anxiety and found it hard to concentrate. Mr Wood said Mr E became disorientated walking to his local shops and had days when he was virtually unable to carry out any meaningful activities. He said he was unable to say when they could expect to see any significant improvement.

Mr Harris, 3 October 2017

52. In a letter to Mr E's GP, Mr Harris said Mr E had had all the medical and therapeutic input he thought they could give him. He noted that a trans-tympanic steroid injection had not been effective. He said he had discussed the remining management options with Mr E.

53. Mr Harris explained that the option of a further injection might make Mr E's tinnitus and overall balance worse. He said the other option of endo lymphatic duct blockage was an invasive procedure and would not have any positive effect on Mr E's hearing, tinnitus or overall balance. He said literature suggested there was an approximately 90% chance of stopping the attacks of vertigo.

Mr Harris, 14 February 2018

54. Mr Harris provided his answers to specific questions put to him by NHS BSA's medical advisers as follows:-

- What treatment had Mr E had and what treatments were available at the time his NHS employment was terminated?

  Mr E had received balance therapy, salt restriction and a trans-tympanic injection of steroid.

- Given available treatment (and any spontaneous improvement), what was the statistical likelihood of sufficient improvement in Mr E's symptoms to restore capacity for (a) his NHS job, (b) full time regular employment within the general field of employment within the period to age 57 (*sic*)?

  50% resolve within two years and 70% resolve spontaneously after eight years.

- Was it reasonable for him to refuse any available treatments and, if so, why?

  Yes, it was entirely reasonable for Mr E to refuse available treatments because some of them are associated with side effects, some he would have to self-fund and none have demonstrated a better outcome than spontaneous resolution.

- Was Mr E regarded as unfit for work in October 2015?

  Mr Harris said he could only provide a symptom profile for Mr E. He expressed the view that the fact that Mr E was not physically or mentally able to work suggested that he was unfit for work. He said this was not uncommon for someone with Meniere's Disease. He acknowledged that some patients were able to carry on. He then went on to describe Mr E's symptoms.

55. Mr Harris said Mr E had persistent dizziness, a sensation of disassociation and of the world swimming around him, which was worse in the morning. He said a trans-tympanic steroid injection in October 2016[3] had not alleviated any of Mr E's symptoms. Mr Harris also said that Mr E had a permanent disability which stopped him from working which was intrusive tinnitus. He said anxiety and depression were associated with Meniere's Disease and impacted on the severity of the condition, the symptoms and the ability to cope and work.

[3] Mr Harris subsequently confirmed that this should be a reference to 2015.