PO-23100

Ombudsman's Determination

Applicant	Ms G
Scheme	NHS Pension Scheme
Respondents	NHS Pensions

Outcome

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

Complaint summary

2. Ms G has complained that her eligibility for ill health retirement from active service has not been assessed in a proper manner.

Background information, including submissions from the parties

Background

3. Ms G was employed by Manchester Mental Health and Social Care NHS Trust (the **Trust**) until May 2015. Her employment ceased on the grounds of capability.

4. The relevant regulations are The National Health Service Pension Scheme Regulations 2015 (SI2015/94) (as amended). Regulation 90 covers ill health retirement benefits and provides for two tiers of benefits. Extracts from the relevant regulations are provided in Appendix 2. In summary, the eligibility conditions are:-

   Tier 1 - the member suffers from a physical or mental infirmity as a result of which s/he is permanently incapable of efficiently discharging the duties of his/her NHS employment.

   Tier 2 - the member suffers from a physical or mental infirmity as a result of which s/he is permanently incapable of engaging in regular employment of like duration.

5. Regular employment of like duration is broadly defined as employment of the same number of hours, half days or sessions worked by the member in his/her NHS employment. Ms G worked for 22.5 hours per week for the Trust.

6. In June 2015, Ms G was informed that she had been awarded Industrial Injuries Disablement Benefit for the period December 2014 to June 2016. The award was

made on the basis that Ms G had a 17% loss of faculty as a result of restricted and painful movement of her wrist.

7. Ms G and the Trust completed an ill health retirement form (AW33E) in October 2015. The Trust's occupational health doctor completed part C of the form in December 2015.

8. First instance decisions on ill health retirement applications are taken by the Scheme's medical advisers under a delegated authority. At the relevant time, this was OH Assist Limited (**OH Assist**).

9. OH Assist informed Ms G, on 13 January 2016, that it had written to her consultant, Professor Lees. It provided an update, on 10 February 2016, explaining that the information requested had not been received, despite being chased. Ms G was asked to provide any recent reports from her doctors.

10. OH Assist wrote to Ms G, on 8 March 2016, notifying her that it was unable to accept her application. It said Ms G's application had been considered by a Scheme Medical Adviser (**SMA**) and quoted the advice received.

11. The SMA had described the eligibility conditions and noted that Ms G's normal benefit age was 67. S/he had noted that Ms G was a part-time (22.5 hours per week) nursing sister and listed the medical evidence considered. The SMA said:

> "I consider that the relevant medical evidence does not indicate that, on the balance of probabilities, the applicant is permanently incapable of efficiently discharging the duties of the NHS employment. The Tier 1 condition is not met. The rationale for this is as follows:
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> Sickness record shows continuous absence from 02/12/14 with musculoskeletal problems cited as nature of illness and with prior absences from 09/06/14 to 30/10/14 with similar cited cause.
>
> The employer states: Structured review process has been ongoing since 02/07/14.
>
> The applicant states: She visited Mr Mistra [*sic*], Plastic Surgeon, on 11/01/16 and to date her diagnoses are: Trigger finger, de Quervain's intersection syndrome and Epicondylitis. She is to have surgery and the minimum recovery time is 3 – 4 years.
>
> Dr Parker states: She has pain, paraesthesia and impaired grip in her right (dominant) hand and forearm, with impaired dexterity (onset June 2014). She has not been seen by a specialist occupational physician since January 2015 (when she was stated to be unfit for all work). She had steroid injections to her forearm without lasting benefit. She is awaiting assessment by the hand surgeon. The cause of her symptoms is not clear and she awaits further investigation. Therefore likely future course is not known at this stage.

> Dr Suckley states: 31/07/15: MRI was reported as normal and neurological examination did not demonstrate any evidence of radiculopathy or peripheral nerve entrapment. 17/11/15: (referral letter to Professor Lees, Hand Surgeon) I am at a loss to explain her symptoms and she lost her job because of them.
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> Mr Mistra [*sic*] states: She has a number of pathologies going on which would come under the umbrella of degenerative tendinopathy: de Quervain's, intersection syndrome, lateral epicondylitis and trigger thumb (grade 1). Nerve conduction studies have been requested. If nerve compression is excluded we will consider possible steroid injections. Nerve function is very difficult to treat and very few therapies can offer complete resolution. Review is planned for 2 months time.
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> The evidence indicates that treatment is ongoing for degenerative tendinopathy and that nerve compression is not diagnosed (and was excluded by Dr Suckley) but the possibility is again under investigation.
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> This applicant's diagnosed conditions are more likely than not to improve sufficient [*sic*] to be clinically capable of her NHS employment, with ongoing specialist treatment, within the period to normal benefit age."

12. Summaries of and extracts from the reports referred to and other medical evidence relating to Ms G's case are provided in Appendix 1.

13. Ms G submitted an appeal under the two-stage internal dispute resolution (IDR) procedure. She submitted reports from two consultant rheumatologists, Dr Sanders and Professor Barton.

14. NHS Pensions issued a stage one decision on 8 September 2017. It did not uphold Ms G's appeal.

15. NHS Pensions said it had undertaken a full review of Ms G's case with an SMA who had not previously been involved. It then quoted the advice it had received from the SMA. The SMA said his/her understanding was that s/he was required to provide advice as to whether Ms G was likely to have met the Tier 1 condition at the time she left employment on 21 May 2015 and, if so, whether she also met the Tier 2 condition. S/he then described the Tier 1 and 2 conditions and the approach s/he would take in assessing Ms G's case.

16. The SMA expressed the view that, at the time her employment ceased, Ms G did have a physical or mental infirmity which gave rise to incapacity for the efficient discharge of her NHS employment. S/he said the cause was unclear. The SMA noted that the diagnoses had changed over the period since Ms G's employment ceased. At the time, de Quervain's tenosynovitis and intersection syndrome were under consideration but she had since been diagnosed with fibromyalgia and ulnar nerve compression. The SMA described the former conditions as the "working diagnoses" at the time. However, s/he thought it likely that the latter conditions were the cause of Ms G's incapacity at the time but had not then been diagnosed. S/he said it was less

clear whether Ms G was also incapable of regular employment of like duration when she left her employment.

17. The SMA said, on the basis of the working diagnoses at the time Ms G's employment ceased, surgery would have been expected to alleviate her symptoms in the long-term.

18. The SMA said that, with the benefit of hindsight, Ms G's symptoms were most probably the result of fibromyalgia and ulnar nerve compression. S/he went on to say that, even if these conditions had been diagnosed at the time, Ms G's incapacity would have been considered unlikely to be permanent.

19. The SMA said fibromyalgia was best treated with a multidisciplinary approach: lifestyle changes, graded exercise, drug treatment and psychological intervention. S/he said these were generally of benefit and Ms G's symptoms would have been expected to improve before pension age such that they no longer posed an obstacle to her working. The SMA said ulnar nerve compression may not improve spontaneously but surgical treatment produced a good outcome for 80% of individuals. S/he said it would have been expected to resolve Ms G's symptoms before pension age.

20. NHS Pensions said it saw no reason to disagree with the SMA's conclusions.

21. Ms G appealed this decision. She made the following points:-

    - The diagnoses of de Quervain's tenosynovitis and intersection syndrome were not working diagnoses; they remained current. At the time her employment ceased, the only treatment option suggested by her consultant was to exhaust all conservative options. She did not have surgery until February 2017, as a last resort. The surgery had not been successful and she remained in intense pain.

    - The medical evidence had been disregarded and her medical presentation was being retrospectively reinvented to avoid liability.

    - If she had been suffering from fibromyalgia since 2015, surgery was not a treatment option.

    - She was adhering to a multidisciplinary treatment plan but this was not relevant to the treatment options which had been offered to or available to her at the time her employment ceased. All her consultants and her physiotherapist advised conservative treatment.

    - It was irrelevant that she would not have been considered permanently incapacitated in 2015 on the basis of a diagnosis of fibromyalgia.

    - She questioned why, if the SMA's conclusions were correct, she was still unable to work, remained in pain and had been placed in the ESA Support Group.

- She had not been diagnosed with ulnar nerve compression at the time her employment ceased or since.

- She was now experiencing severe anxiety and depression and had only been able to submit an appeal with the help of her union.

22. NHS Pensions issued its second stage IDR decision on 5 February 2018. It said it had undertaken a full review of Ms G's case, taking into account all the available relevant evidence. It said the SMA who had reviewed her case had recommended that Ms G did not satisfy the Tier 1 conditions. NHS Pensions then quoted from the SMA:

> "I consider that the relevant medical evidence indicates that, on the balance of probabilities, at the time of leaving employment, the applicant did not meet the tier 1 condition … The tier 2 condition was therefore not met.
>
> … 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 … is whether the member's current incapacity is likely to be permanent.
>
> … the cause of [Ms G's] incapacity at the time she left employment was somewhat unclear. [Ms G] had been symptomatic for a couple of years with pain and swelling in the region of her right wrist but subsequently developed symptoms in her left arm. A possible diagnosis of de Quervain's tenosynovitis, intersection syndrome and subsequent possible diagnosis of cubital tunnel syndrome …
>
> It is accepted that at the time that she left her employment in 2015 [Ms G] was incapable of undertaking her duties as a part time staff nurse. As has previously been pointed out de Quervain's tenosynovitis, intersection syndrome or the more recent suggestion of cubital tunnel syndrome are conditions that are amenable to surgical intervention. In my opinion at the time that [Ms G] left her employment there would have been a reasonable expectation that with appropriate intervention such as surgical treatment her condition would not be permanent up until her normal retirement date in 2037.
>
> In her letter of appeal [Ms G] makes comment regarding the subsequent diagnosis of fibromyalgia and even in her own statement indicates that this is not a relevant consideration as far as permanency is considered. Again there is further intervention and treatment for fibromyalgia that is reasonably effective in the majority of individuals being able to return to work and therefore again permanency would not have been established for this condition.
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> Taking into account [Ms G's] own comments that her diagnoses were and remain de Quervain's tenosynovitis and 'sibitial tunnel syndrome' (should read cubital tunnel syndrome) with a later confirmed diagnosis of fibromyalgia it is

> my opinion that with suitable surgical intervention on the balance of probabilities [Ms G] would have made sufficient recovery to be able to return to her substantive duties as a part time staff nurse."

23. NHS Pensions said it could see no reason to disagree with the SMA's conclusion nor did it consider the conclusion perverse.

Ms G's position

24. Ms G submits:-

- The overuse of her hands within her NHS role caused significant damage to her nerves and tendons.
- When she was dismissed, she was in intense pain and had been diagnosed with de Quervain's tenosynovitis. She was unable to work and was advised by her consultant that there was no surgical option and treatment would be to exhaust all conservative options.
- The surgery she underwent in 2017 was a last resort because of her continuing loss of function and pain. The surgery has proven to be unsuccessful.
- NHS Pensions, in its second stage IDR decision, stated that with suitable surgical intervention she would have made sufficient recovery to be able to return to her substantive duties as a part time staff nurse. Recovery did not happen and surgery was not indicated by her consultant.
- She has been penalised for not being offered surgical treatment at the time she was dismissed. She is also being penalised for not having recovered sufficiently after surgery.
- NHS Pensions has made assumptions about her treatment and recovery which are not based upon any objective physical assessment of her by a medical expert. Instead, it has relied upon a subjective assessment of the medical correspondence.
- She has been unable to work in any capacity since her surgery and is now in receipt of disability benefits.
- She has suffered loss of income and been unable to make pension contributions since her dismissal. She remains financially vulnerable. She has also experienced severe depression and anxiety as a result of the delays in dealing with her pension dispute.

25. Ms G has submitted a letter from Ms Chasapi, dated 9 April 2019, to her GP. Among other things, this states that MS G is to be referred for an MRI and for steroid injections. Ms G has also submitted a letter, dated 25 May 2019, from Dr Garikipati which sets out the results of nerve conduction tests carried out on that date.

26. Ms G says:-

- She has never had a written report from a doctor detailing the effect her debilitating condition has on her daily life.
- To do a simple task, such as brushing her teeth, is very painful because she has to bend her elbows.
- She does not think her chronic pain symptoms are being looked at in the context of the severity of pain she experiences every day and the constraints this puts on her daily life.
- She was left in a very bad situation. In February 2013, she was doing two and a half people's jobs and working with mentally ill patients whose medication was so specialised that she did not have the option of protesting. She just got on with it, unaware of the hole she was digging for herself. She loved her job and the patients and she would never put any of them at risk.
- She is of the view that, due to the kind of detriment she is facing, obtaining a long-term prognosis from a consultant would be fair. It was not possible for such an opinion to have been made available at the time her employment ceased.
- By now, she would have expected to have returned to work; not to be considering a second operation let alone waiting for steroid injections.

NHS Pensions' position

27. NHS Pensions submits:-

- It has properly considered Ms G's application, taking into account and weighing all relevant evidence and nothing irrelevant. It took advice from appropriate sources; namely, its medical advisers. It considered and accepted that advice and, as a result, considers that it arrived at a decision which is not perverse.
- It does not agree that Ms G meets the Tier 1 condition. It considers that she will be capable of the duties of her NHS employment before she reaches normal retirement age.
- It has accepted the recommendation from its medical advisers that, at the date her NHS employment ceased, Ms G did not meet the Tier 1 condition.
- Its medical advisers' recommendations and rationales were founded upon the correct interpretation of the Scheme's regulations, took into account the relevant evidence and was not perverse.

- The fact that Ms G does not agree with the conclusions drawn or the weight attached to the various pieces of evidence does not mean that its conclusions were flawed.

Adjudicator's Opinion

28. Ms G's complaint was considered by one of our Adjudicators who concluded that no further action was required by NHS Pensions. The Adjudicator's findings are summarised below:-

- In order to receive any ill health pension under regulation 90, Ms G had to meet the Tier 1 condition as at the date her NHS employment ceased. In summary, this meant that her NHS employment had to have ceased because she was suffering from a physical or mental infirmity as a result of which she was permanently incapable of efficiently discharging the duties of that employment. Permanently meant likely, on the balance of probabilities, to last at least until Ms G's prospective normal pension age. Only if Ms G first met the Tier 1 condition might she also have been considered against the Tier 2 condition.

- The decision as to whether or not Ms G met the Tier 1 condition was for NHS Pensions, acting on behalf of the Secretary of State as Scheme Manager, to make. Initial decisions could and had been delegated to the Scheme's medical advisers.

- The ill health pension payable under regulation 90 was not a discretionary benefit. In other words, if Ms G met the Tier 1 condition, she was entitled to an ill health pension. The level of benefit would then depend upon whether or not she also met the Tier 2 condition.

- In reaching a decision as to Ms G's eligibility for a pension under regulation 90, NHS Pensions and its medical advisers had to:-

  - consider all available relevant information and ignore anything which was irrelevant;

  - apply the law and the Scheme regulations correctly; and

  - not act erratically or without reason.

- However, the weight which was attached to any of the evidence was for NHS Pensions or, where appropriate, its medical advisers to decide (including giving some of it little or no weight[1]). It was open to NHS Pensions to prefer evidence from its own advisers; unless there was a cogent reason why it

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

should not. For example, an error or omission of fact or a misunderstanding of the relevant rules by the medical adviser.

- In the initial decision made by OH Assist in March 2016, the SMA had summarised the Tier 1 and Tier 2 conditions and listed the medical evidence considered. S/he had concluded that Ms G's diagnosed conditions were, more likely than not, going to improve sufficiently with ongoing specialist treatment for her to be capable of her NHS employment within the period to her normal benefit age.

- OH Assist's letter indicated that the SMA had understood and correctly applied the Tier 1 condition. The letter indicated that all the available medical evidence had been considered and there was no indication of anything irrelevant being taken into account.

- The conclusions drawn by the SMA did not, on the whole, appear to be inconsistent with the available medical evidence. However, the SMA did not explain what s/he had in mind when referring to specialist treatment. Dr Hughes had said that nerve function was difficult to treat and few therapies could offer complete resolution. This was noted by the SMA. In view of this, it would have been prudent for OH Assist to ask the SMA to be more specific.

- NHS Pensions and its medical advisers had to follow the proper procedure when making decisions about ill-health benefits. However, not all procedural failings meant that a 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. It was necessary to consider, therefore, if the failure to provide sufficient reasoning was addressed later on in the process.

- Stages one and two of the IDR procedure were undertaken by NHS Pensions. However, it took further advice from its medical advisers in coming to its IDR decisions. In Ms G's case, it relied heavily on the advice it received and it was, therefore, appropriate to consider this in detail.

- In support of her appeal, Ms G had submitted reports from Dr Sanders and Professor Barton. These were reviewed by the SMA, together with the medical evidence previously considered. There was no indication that the SMA had taken any irrelevant matters into account.

- In her second appeal submission, Ms G had expressed the view that her medical condition was being "retrospectively reinvented". She was of the view that it was irrelevant that she would not have been considered permanently incapacitated in 2015 on the basis of a diagnosis of fibromyalgia. This was in response to the SMA's comment that Ms G's symptoms, in 2015, had probably not been due to de Quervain's tenosynovitis or intersection syndrome. S/he

had suggested they were more likely due to fibromyalgia and bilateral compression of the ulnar nerves in her elbows.

- By the time of the first IDR decision, it was over two years since Ms G's NHS employment had ceased. The Adjudicator noted that the SMA referred to the fact that s/he was required to provide advice as to whether Ms G met the Tier 1 condition when her employment ceased in 2015. In her view, this was correct. In addition, she was of the view that the summaries of the Tier 1 and Tier 2 conditions provided by the SMA accorded with regulation 90.

- The ongoing investigation into Ms G's condition had resulted in an evolving diagnosis. At the time her NHS employment ceased, the diagnosis appeared to have been de Quervain's intersection syndrome, as evidenced by Dr Suckley's letter of 31 July 2015. In January 2016, Dr Hughes had referred to "a number of pathologies … which would come under the overall umbrella of degenerative tendinopathy". In March 2017, Dr Sanders had noted that the previous diagnoses of de Quervain's tenosynovitis and intersection syndrome had not been confirmed by subsequent investigation. He had referred to late onset Raynaud's disease and bilateral ulnar nerve compression. He had diagnosed fibromyalgia, bilateral ulnar nerve compression at the elbows and possible soft tissue rheumatism affecting Ms G's right shoulder. In May 2017, Professor Barton had diagnosed possible mixed connective tissue disease and fibromyalgia on a background of anxiety.

- In general, when assessing whether an ill-health retirement decision had been taken correctly, it was the diagnosis which was extant at the time of the decision which was relevant. The approach taken by the SMA at the stage one appeal was to consider both the diagnoses prevailing at the time Ms G's NHS employment ceased and the later ones. In the Adjudicator's view, it was not inappropriate for Ms G's eligibility for a pension under regulation 90 to have been considered against both the diagnoses prevailing in 2015 and the later diagnoses. She said she would not go as far as to say that assessing Ms G's eligibility by reference to a subsequent diagnosis of fibromyalgia amounted to taking irrelevant matters into account.

- The Adjudicator noted that the first stage appeal advice had included references to particular treatment options which the SMA considered likely to have been expected to improve Ms G's condition. In the Adjudicator's view, this reference to specific treatment options addressed the flaw she had identified in the initial advice.

- At stage two, Ms G had not provided any additional evidence and the SMA had reviewed that which had already been provided. The summary of the Tier 1 condition provided by the SMA accorded with regulation 90.

- The SMA had accepted that, both at the time her NHS employment ceased and at the time of the appeal, Ms G had been incapable of efficiently

discharging the duties of her former employment. S/he had noted that the key issue was whether or not Ms G's incapacity was likely to be permanent.

- With regard to the diagnoses of de Quervain's tenosynovitis and intersection syndrome, the SMA had said these were conditions which were amenable to surgical intervention. S/he had expressed the view that, at the time Ms G's employment ceased, there would have been a reasonable expectation that her condition would not be permanent. With regard to the later diagnosis of fibromyalgia, the SMA had said there was further intervention and treatment which was reasonably effective in the majority of individuals. S/he had expressed the view that permanency would not have been established for this condition either.

- So far as their medical opinions are concerned, the Scheme's medical advisers were not within the Ombudsman's jurisdiction. They were answerable to their own professional bodies. The question for the Ombudsman was whether there was anything in the advice provided which NHS Pensions could have been expected to query before relying on it in making its decisions. For example, an error or omission of fact or a misunderstanding of the relevant regulations. The Adjudicator said she had not identified any such reason why NHS Pensions should not have relied on the advice from the SMA in reaching its decisions.

- Ms G felt that she was being penalised for not being offered surgery in 2015 and because she had not recovered sufficiently since. The Adjudicator said she could understand why Ms G questioned the validity of the decision not to award her a pension when she was still unable to work some four years after her NHS employment ceased. Ms G had also referred to the fact that she had been awarded disability benefits.

- However, the key question in Ms G's case was whether it was more likely than not that her incapacity for her NHS employment would last at least until her normal pension age in 2037. The advice NHS Pensions had received was that, in 2015, the expectation was that Ms G's incapacity would not last until her normal pension age. On that basis, its decision not to pay her an ill health pension under regulation 90 could not be said to be unreasonable.

29. Ms G did not accept the Adjudicator's Opinion and the complaint was passed to me to consider. Ms G 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 Ms G for completeness.

Ombudsman's decision

30. It is clear from Ms G's submissions that she is still experiencing significant issues with her health. However, the decision not to award her ill health retirement benefits under regulation 90 must be considered by reference to her health situation at the time her

NHS employment ceased. In particular, the decision must be considered by reference to the likelihood of recovery before normal pension age expected at that time. It is not a question of applying hindsight. It is for this reason that the latest medical reports provided by Ms G do not assist me in determining her complaint.

31. In order for her to qualify for benefits under regulation 90, the expectation in 2015 must have been that Ms G would not be capable of discharging her NHS duties at any time before 2037.

32. OH Assist took the view that, whilst Ms G was at that time incapable of discharging her NHS duties, this was not likely to be permanent. It had applied the correct eligibility test but did not explain its reasons for reaching its conclusions. In particular, the SMA did not say why s/he thought Ms G's condition would improve or what "specialist treatment" s/he had in mind. It is important that a decision is explained so that a member may understand it and either accept it or prepare a properly informed appeal. I find that the initial decision from OH Assist fell short of what I would expect by way of explanation.

33. The SMAs who reviewed Ms G's case at stages one and two of the IDR procedure also concluded that she did not meet the Tier 1 condition. They acknowledged that Ms G had been unable to discharge her NHS duties at the time her employment ceased. However, they did not consider this situation likely to be permanent. The SMAs concerned provided more by way of explanation as to why they had reached the conclusions they had. In particular, they explained what treatment they thought was likely to help Ms G's recovery.

34. I am aware that Ms G does not agree with the conclusions reached by the SMAs. She has pointed out that, in 2015, she was not being offered surgery and that this was a last resort option in 2017. She has also pointed out that the surgery has not been successful. It is not my role to review the medical opinions provided by the SMAs. My concern is with the decision-making process and my interest in the SMAs' reports extends to determining whether or not there was any reason why NHS Pensions should not have relied on them in reaching a decision.

35. The kind of things I have in mind are those which a lay person could reasonably be expected to notice and, where appropriate, query. These would include errors or omissions of fact, irrelevant matters taken into account or a misinterpretation of the relevant regulations. The SMAs' suggestions concerning treatment or their views on the likely outcome of treatment would not normally be something I would expect NHS Pensions to query. If, for example, there was an obvious disparity between the SMAs' views and those of the member's treating physicians, I would expect this to be explained to NHS Pensions and to Ms G. However, no such obvious disparity arises in Ms G's case.

36. In summary, I find that there was no reason why NHS Pensions should not have relied on the advice it received from the SMAs in reaching its decision. In view of that advice, the decision not to award benefits to Ms G under regulation 90 was

reasonable. The fact that Ms G's recovery since has not been as positive as might have expected in 2015 does not undermine NHS Pensions' decision.

37. I do not uphold Ms G's complaint.

Anthony Arter
Pensions Ombudsman

7 August 2019

Appendix 1

Medical evidence

Dr Dagens, consultant occupational physician, 15 January 2015

38. Dr Dagens said Ms G had had a good initial response to treatment but that this had not been sustained. He said her symptoms had deteriorated and she was unfit for all work at that time. Dr Dagens commented that, whilst a prompt recovery had been anticipated following Ms G's first steroid injection, timeframes for recovery and return to work were now less certain.

Mr Shrimpton, specialist physiotherapist, 2 February 2015

39. Mr Shrimpton said Ms G's diagnosis was unclear. He said her neck and shoulder pain had largely settled down but swelling and pain in her right forearm remained an issue. He said Ms G's right hand was generally problem free. Mr Shrimpton commented that generalised fear avoidance and deconditioning was a factor, but that Ms G had reported using her right upper limb more.

Dr Suckley, consultant physiotherapist and osteopath, 31 July 2015

40. In a letter to Ms G's GP, Dr Suckley said she had reviewed Ms G and requested an ultrasound of her left forearm. She said an examination indicated a diagnosis of De Quervain's intersection syndrome. She said neurological examination had not demonstrated any evidence of radiculopathy or peripheral nerve entrapment.

Dr Parker, occupational health doctor, 8 December 2015

41. In Part C of AW33E, Dr Parker said Ms G had been experiencing pain in her right hand and forearm since June 2014. He said, when she had seen Dr Dagens, she had been unable to grip and use her right hand for any tasks requiring manual dexterity. He said she had not been seen by a specialist occupational physician since January 2015. Dr Parker said Ms G was awaiting assessment by Professor Lees, a hand surgeon.

42. Dr Parker said that the cause of Ms G's forearm pain and functional problem with grip and dexterity was, as yet, undiagnosed. He noted that she was awaiting further investigations and said he could not comment on the likely future course of her problem at this stage.

Dr Hughes, STLAS in plastic and hand surgery, 28 January 2016

43. Dr Hughes said she had seen Ms G with Mr Mishra, consultant plastic, hand and reconstruction surgeon. She said:

> "We explained that [Ms G] has a number of pathologies going on which would come under the overall umbrella of degenerative tendinopathy. She has got de Quervain's in addition to intersection syndrome and also a lateral epicondylitis

> (tennis elbow). Also I note she has a grade one triggering of her right thumb, which would also be consistent with this overall diagnosis.
>
> To exclude any nerve involvement, I have requested nerve conduction studies … If nerve compression is excluded … then we will consider possible steroid injections.
>
> I did explain to [Ms G] that nerve function is very difficult to treat and that very few therapies can offer complete resolution …"

Dr Sanders, consultant rheumatologist, 29 March 2017

44. In a letter to Ms G's GP, Dr Sanders said Ms G had a number of musculo-skeletal symptoms dating back to 2013. He referred to previous diagnoses of de Quervain's tenosynovitis and intersection syndrome and noted that these had not been confirmed by subsequent investigation. Dr Sanders said an MRI scan from 2014 and an ultrasound from 2015 had not shown any significant abnormality.

45. Dr Sanders noted that Ms G's NHS employment had been terminated and said that she described being bored and "down in the dumps". He went on to say that she had a positive outlook and had applied for work in the civil service for which she had an upcoming interview.

46. Dr Sanders went on to describe Ms G's medication and symptoms. He thought she might have late onset Raynaud's disease. He noted that a nerve conduction test, in February 2016, had shown bilateral ulnar nerve compression. He noted that Ms G had undergone decompression surgery on her right side and this had settled the tingling in her right hand. Dr Sanders said Ms G was awaiting similar surgery for her left ulnar nerve.

47. Dr Sanders then described the outcome of his examination. He said he had felt that a number of Ms G's symptoms were suggestive of fibromyalgia and he had asked her to complete a symptom questionnaire. He said her results were highly suggestive of this diagnosis, although there were separate problems with her ulnar nerve entrapment. Dr Sanders said he had mentioned various treatment options for fibromyalgia. He noted that Ms G knew about CBT because of her former employment but had not been keen to be referred for this; she had not felt that she would benefit from it. He suggested referring her for graded exercise.

48. Dr Sanders concluded:

> "My diagnoses are:-
>
> Fibromyalgia
>
> Bilateral ulnar nerve compression at the elbows
>
> Possible soft tissue rheumatism affecting right shoulder

> I would feel that currently [Ms G] is not fit for a return to her previous work. This is because of her ongoing symptoms for the above conditions which are still very troublesome. It is possible that this situation may eventually improve in the future if ongoing and suggested treatments are successful."

Professor Barton, consultant rheumatologist, 15 May 2017

49. In a letter to Ms G's GP, Professor Barton gave diagnoses of: possible mixed connective tissue disease; widespread muscular tenderness in keeping with fibromyalgia; previous surgery to right elbow and awaiting surgery to left elbow; low mood and poor sleep. Having described Ms G's medical history and the results of his examination, Professor Barton concluded:

> "In summary, this lady has had a very stressful few years and she now has symptoms and signs of some fibromyalgia on a background of anxiety with some widespread muscular tenderness and a variety of symptoms. You have noted that she has had recent onset Raynaud's and she does have some weak auto antibodies in the blood stream which would fit with a mixed connective tissue type picture and more specifically with Sjogren's picture. However she denies any dryness of her eyes or elsewhere at the moment.
>
> I have arranged to update her blood tests and referred her to physiotherapy for advice regarding fibromyalgia and a generalised exercise programme about that. Given her auto antibodies, I have arranged to see her again in clinic in 12 months' time just to check that nothing else has developed but there is certainly no suspicion of scleroderma today in clinic."

Dr Sanders, 7 June 2017

50. In another letter to Ms G's GP, Dr Sanders said, further to his letter of 29 March 2017, he had noted that Ms G's rheumatoid factor was also strongly positive. He said, although this would mean that she may be at high risk of developing rheumatoid arthritis, it did not alter his clinical opinion that there were no physical signs to support such a diagnosis when he saw her.

Professor Barton, 31 January 2018

51. In a letter to Ms G's GP, Professor Barton said he had reviewed Ms G and she continued to have widespread pain. He said she was attending weekly fibromyalgia exercise classes and seeing an occupational therapist. He said she was not working and did not feel able to work at that time. Professor Barton said he had updated Ms G's blood tests and planned to see her in 12 months' time. He explained that, if Ms G's situation remained stable, he planned to discharge her into the care of her GP. He also explained he had referred her to a urologist.

Appendix 2

52. Regulation 90

"(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 has claimed 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.

(6) A pension under this regulation is payable for life: …"

53. “**Permanently**” is defined, in regulation 91, as lasting until the member attains his/her prospective normal pension age.